



**State of Nevada  
Public Employees' Benefits Program**

**Master Plan Document for the  
Self-Funded PEBP PPO Dental Plan  
and  
Summary of Benefits for  
Life and Long-Term Disability Insurance**

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

**[www.pebp.state.nv.us](http://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 PPO Dental 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.

PEBP's Self-Funded PPO Dental Plan, Basic Life Insurance and Long-Term Disability Insurance is available to Participants of both the CDHP and HMO as a part of the Plan's core Benefits. Participants who are enrolled with a Plan through the Medicare Exchange are able to purchase PEBP Dental coverage and if eligible, may receive PEBP's Basic Life Insurance Benefit.

All PEBP Participants choosing the Consumer Driven Health Plan should examine this document, the PEBP Medical and Prescription Drug Master Plan Document (MPD) and the PEBP Enrollment and Eligibility MPD to become more knowledgeable about their health Benefits.

PEBP Participants who choose an HMO option should examine this document, which includes a summary of Benefits for Life and Long-Term Disability (LTD) insurance, and the PEBP Enrollment and Eligibility MPD. 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](http://www.pebp.state.nv.us).

PEBP Retirees covered under the Medicare Exchange who elect PEBP Dental coverage should review this document, which includes a summary of Benefits for Life and Long-Term Disability (LTD) Insurance and the PEBP Enrollment and Eligibility Master Plan Document.

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 (MPD).

Sincerely,

**Public Employees' Benefits Program**

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 Plan Document describes the Self-Funded PPO Dental Plan Benefits offered to Employees and certain Retirees, and their eligible dependents, participating in the Public Employees' Benefits Program, hereafter referred to as PEBP. Additional Benefits for Life and Long-Term Disability are summarized in this document.

- 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 Plan described in this document is effective **July 1, 2016**, and unless stated differently replaces all other Self-Funded PPO Dental Benefit Plan documents previously provided to You.

This document will help You understand and use the Benefits provided by the Public Employees' Benefits Program (PEBP). You should review it and also show it to members of Your family who are or will be covered by the Plan. It will give You an understanding of the coverage provided, the procedures to follow in submitting claims, and Your responsibilities to provide necessary information to the Plan. Be sure to read the Exclusions and Definitions sections. **Remember, not every expense You incur for health care is covered by the Plan.**

**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, be sure to seek help or information. The Participant Contact Guide provides sources of help or information about the Plan Benefits.

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. Any notices or documentation describing a different Benefit or procedure which has been issued after the published Plan Document will supersede the Plan Document. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where You and Your family can find and refer to them.

**This Plan is not established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA.** The Self-Funded portions of this Plan 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 this document. 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 not described here but are discussed in documents provided to You by those HMO insurance companies), Life Insurance, and Long-Term Disability (LTD) Insurance as described in the Dental and Life Insurance Plan Document. **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.

**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, medical and legal terms that appear in the text.
- Review the **Dental Expense, Schedule of Dental Benefits and Dental Exclusions sections**. These describe Your Benefits in more detail. There are examples, charts and tables to help clarify key provisions and details of the Plan Benefits.
- Refer to the **General Provisions and Notices section** for information regarding Your rights and general provisions of the Plan.
- Refer to the **How to File a Dental Claim section** to find out what You must do to file a claim.
- Refer to the **Dental Appeal Process section** to find out how to seek a review (appeal) if You are dissatisfied with a claims decision.
- **The section on Coordination of Benefits** discusses situations where You have coverage under more than one health care plan including Medicare. This section also provides You with information regarding how the Plan Subrogates with a third party who wrongfully caused an injury or illness to You.
- Refer to the **Life and Long-Term Disability section** for information about these Benefits. For detailed information regarding Life and Long-Term Disability Benefits, please refer to the **Participant Contact Guide** for the vendor name, telephone number and website.

## 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 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 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.

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**Words that are capitalized are defined in the Definitions Section.**

## Participant Contact Guide

General Contacts	Service
<p><b>Public Employees' Benefits Program (PEBP)</b> 901 S. Stewart Street, Suite 1001 Carson City, NV 89701 Customer Service: (775) 684-7000 or (800) 326-5496 Fax: (775) 684-7028 <a href="http://www.pebp.state.nv.us">www.pebp.state.nv.us</a></p>	<p><b>Plan Administrator</b></p> <ul style="list-style-type: none"> <li>• Enrollment and eligibility</li> <li>• Certificate of creditable coverage</li> <li>• COBRA information and premium payments</li> <li>• Level 2 claim appeals</li> <li>• External Review coordination</li> </ul>
<p><b>Office for Consumer Health Assistance</b> 555 E. Washington Avenue, Suite 4800 Las Vegas, NV 89101 Customer Service: (702) 486-3587 or (888) 333-1597 <a href="http://www.govcha.state.nv.us">www.govcha.state.nv.us</a></p>	<p><b>Consumer Health Assistance</b></p> <ul style="list-style-type: none"> <li>• Concerns and problems related to coverage</li> <li>• Provider billing issues</li> <li>• External Review information</li> </ul>
<p><b>Nevada Secretary of State Office</b> 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 <a href="http://www.livingwilllockbox.com">www.livingwilllockbox.com</a></p>	<p><b>Living Will Information</b></p> <ul style="list-style-type: none"> <li>• Declaration governing the withholding or withdrawal of life-sustaining treatment</li> <li>• Durable power of attorney for health care decisions</li> <li>• Do not resuscitate order</li> </ul>
<p><b>Consumer Driven Health Plan Medical, Vision and Dental Contacts</b></p>	<p><b>Service</b></p>
<p><b>PEBP Statewide PPO Network</b> Administered by Hometown Health Providers and Sierra Health Care Options Customer Service: (800) 336-0123 <a href="http://www.pebp.state.nv.us">www.pebp.state.nv.us</a></p>	<p><b>In-State PPO Medical Network</b></p> <ul style="list-style-type: none"> <li>• Network Providers</li> <li>• Provider directory</li> <li>• Additions/deletions of Providers</li> </ul>
<p><b>National Network Providers</b> First Health Network/HealthSCOPE Benefits P. O. Box 91603 Lubbock, TX 79403-1603 Customer Service: (800) 226-5116 <a href="http://www.myfirsthealth.com">www.myfirsthealth.com</a></p>	<p><b>National Medical Network/Outside of Nevada</b></p> <ul style="list-style-type: none"> <li>• Network Providers</li> <li>• Provider directory (website only)</li> <li>• Additions/deletions of Providers</li> </ul> <p>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.</p>

Consumer Driven Health Plan Medical, Vision and Dental Contacts	Service
<p><b>National Network Providers</b> <b>Aetna Signature Administrators PPO Network</b> Participants who reside outside of Nevada who need assistance locating a provider may contact HealthSCOPE Benefits at (888) 763-8232 <a href="http://www.aetna.com/asa">www.aetna.com/asa</a></p>	<p><b>National Medical Network/Outside of Nevada</b></p> <ul style="list-style-type: none"> <li>• Network Providers</li> <li>• Provider directory (website only)</li> <li>• Additions/deletions of Providers</li> </ul> <p>The National Medical Network is available to <u>Participants who reside outside of Nevada.</u></p>
<p><b>Wise Provider Networks</b> 6995 Union Park Center #250 Cottonwood Heights, UT 84047 Customer Service: (866) 485-5205</p>	<p><b>Preferred Provider Network offers benefits to members who use the network in:</b></p> <ul style="list-style-type: none"> <li>• Utah</li> <li>• Wyoming</li> <li>• Idaho</li> <li>• Arizona</li> <li>• Colorado</li> <li>• Oregon</li> <li>• Nevada</li> </ul>
<p><b>Diversified Dental Services</b> P O Box 36100 Las Vegas, NV 89133-6100 Customer Service: Northern Nevada: (866) 270-8326 Southern Nevada: (800) 249-3538 <a href="http://www.ddspno.com">www.ddspno.com</a></p>	<p><b>Self-Funded PPO Dental Network</b></p> <ul style="list-style-type: none"> <li>• General information on statewide Dental PPO Providers</li> <li>• General information on national Dental PPO Providers</li> <li>• Dental Provider directory</li> </ul>
<p><b>HealthSCOPE Benefits</b> 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 <a href="http://www.healthscopebenefits.com">www.healthscopebenefits.com</a></p>	<p><b>Claims Administrator/ Third Party Administrator</b></p> <ul style="list-style-type: none"> <li>• Claim submission</li> <li>• Claim status inquiries</li> <li>• Level 1 claim appeals</li> <li>• Verification of eligibility</li> <li>• Plan Benefit information</li> <li>• In-Network pricing tool</li> <li>• Dental Only ID cards</li> <li>• CDHP Plan ID Cards</li> <li>• Health Savings Account (HSA) Administrator</li> <li>• Health Reimbursement Arrangement (HRA) Administrator</li> <li>• Obesity Care Management Program</li> </ul>

Consumer Driven Health Plan Medical, Vision and Dental Contacts	Service
<p><b>Hometown Health Providers</b> Customer Service: (775) 982-3232 or (888) 323-1461 <a href="http://www.stateofnv.hometownhealth.com">www.stateofnv.hometownhealth.com</a></p>	<p><b>Medical Utilization Management &amp; Case Management Services</b></p> <ul style="list-style-type: none"> <li>• Pre-certification, for example: <ul style="list-style-type: none"> <li>○ Inpatient hospital admissions</li> <li>○ Certain Outpatient procedures</li> <li>○ All spinal surgeries</li> <li>○ All bariatric (weight loss) surgeries</li> <li>○ Transgender services</li> <li>○ Outpatient Non-Emergent Cardiac Surgeries</li> <li>○ Any jaw/face/TMJ procedures</li> </ul> </li> <li>• Large Case and Complex Case Management</li> <li>• Disease Management for Diabetes</li> </ul>
Consumer Driven Health Plan Prescription Drug Plan Contacts	Service
<p><b>Retail Pharmacy Services:</b> <b>Express Scripts</b> Customer Service and Prior Authorization (855) 889-7708 <a href="http://www.Express-Scripts.com">www.Express-Scripts.com</a></p> <p>You will need to create a User ID and Password</p> <p><b>Express Scripts Home Delivery</b> PO Box 66566 St. Louis, MO 63166-6566 Customer Service: (855) 889-7708</p> <p>Mail Order forms and online ordering <a href="http://www.Express-Scripts.com">www.Express-Scripts.com</a></p> <p><b>Specialty Pharmacy:</b> <b>Accredo</b> Customer Service: (800) 803-2523</p>	<p><b>Prescription Drug Plan Administrator</b></p> <ul style="list-style-type: none"> <li>• Prescription Drug information</li> <li>• Retail Network Pharmacies</li> <li>• Prior-authorization</li> <li>• Non-Network retail claims payment</li> <li>• Price and Save tool</li> <li>• Mail order service and mail order forms</li> <li>• Diabetic Supplies</li> </ul> <p><b>Specialty Drug Services Provider</b></p> <ul style="list-style-type: none"> <li>• Refills and order status</li> <li>• Doctor referral forms</li> </ul>

Fully Insured Product Contacts	Service
<p><b>The Standard Insurance Company</b> 920 SW Sixth Avenue Portland, OR 97204 Customer Service: (888) 288-1270 <a href="http://www.standard.com/mybenefits/nevada/index.html">www.standard.com/mybenefits/nevada/index.html</a></p>	<p><b>Basic Life Insurance</b></p> <ul style="list-style-type: none"> <li>• Benefits</li> <li>• Filing a life insurance claim</li> <li>• Beneficiary financial counseling</li> <li>• United Healthcare Global travel assistance</li> </ul>
<p><b>The Standard Insurance Company</b> 920 SW Sixth Avenue Portland, OR 97204 Customer Service: (888) 288-1270 <a href="http://www.standard.com/mybenefits/nevada/index.html">www.standard.com/mybenefits/nevada/index.html</a></p>	<p><b>Long-term Disability (LTD)</b></p> <ul style="list-style-type: none"> <li>• Benefits</li> <li>• Filing a Long-Term Disability claim</li> </ul>
<p><b>Hometown Health Plan HMO</b> Customer Service: (775) 982-3232 or (800) 336-0123 <a href="http://www.stateofnv.hometownhealth.com">www.stateofnv.hometownhealth.com</a></p>	<p><b>Northern Nevada Health Maintenance Organization (HMO)</b></p> <ul style="list-style-type: none"> <li>• Medical claims</li> <li>• Pre-authorization</li> <li>• Provider network</li> </ul>
<p><b>Health Plan of Nevada HMO</b> Customer Service: (702) 242-7300 or (877) 545-7378 <a href="http://www.stateofnv.healthplanofnevada.com">www.stateofnv.healthplanofnevada.com</a></p>	<p><b>Southern Nevada Health Maintenance Organization (HMO)</b></p> <ul style="list-style-type: none"> <li>• Medical claims</li> <li>• Pre-authorization</li> <li>• Provider network</li> </ul>
<p><b>Towers Watson's One Exchange</b> 10975 Sterling View Drive, Suite A1 South Jordan, UT 84095 Customer Service: (888) 598-7545 TTY: (866) 508-5123 <a href="https://medicare.oneexchange.com/pebp">https://medicare.oneexchange.com/pebp</a></p> <p><b>PayFlex</b> P.O. Box 3039 Omaha, NE 68103-3039 Customer Service: (888) 598-7545 General Fax: (402) 231-4300 Claims Fax: (402) 231-4310 <a href="http://www.payflex.com">www.payflex.com</a></p>	<p><b>Medicare Exchange</b></p> <ul style="list-style-type: none"> <li>• Supplemental or replacement medical coverage for Retirees and covered dependents with Medicare Parts A and B</li> </ul> <p><b>Health Reimbursement Arrangement</b></p> <ul style="list-style-type: none"> <li>• Health Reimbursement Arrangement for Retirees with Medicare Parts A and B</li> <li>• Premium reimbursement</li> </ul>

Voluntary Product Contacts	Service
<p><b>The Standard Insurance Company</b> 920 SW Sixth Avenue Portland, OR 97204 Customer Service: (888) 288-1270 <a href="http://www.standard.com/mybenefits/nevada/index.html">www.standard.com/mybenefits/nevada/index.html</a></p>	<p><b>Life Insurance – Additional</b> Voluntary Life Insurance Benefits</p>
<p><b>The Standard Insurance Company</b> 920 SW Sixth Avenue Portland, OR 97204 Customer Service: (888) 288-1270 <a href="http://www.standard.com/mybenefits/nevada/index.html">www.standard.com/mybenefits/nevada/index.html</a></p>	<p><b>Short-term Disability Insurance</b> Voluntary Short-term Disability Benefits</p>
<p><b>Liberty Mutual</b> Customer Service: (800) 637-7026 <a href="mailto:Gary.bishop@libertymutual.com">Gary.bishop@libertymutual.com</a></p>	<p><b>Home and Auto Insurance</b></p> <ul style="list-style-type: none"> <li>• Voluntary Homeowners and Auto Insurance</li> <li>• Voluntary RV Insurance</li> </ul>
<p><b>HealthSCOPE Benefits</b> Claims Submission: HealthSCOPE Benefits P.O. Box 3627 Little Rock, AR 72203 Customer Service: (888) 763-8232 Fax: (877) 240-0135</p> <p>Email: <a href="mailto:pebphsahra@healthscopebenefits.com">pebphsahra@healthscopebenefits.com</a> Online Claims Submission: <a href="http://www.healthscopebenefits.com">www.healthscopebenefits.com</a> Click Member Type PEBP as the company name Click Flexible Spending Account (FSA) Status Login to Your Member Dashboard</p>	<p><b>Flexible Spending Accounts</b></p> <ul style="list-style-type: none"> <li>• Medical Flexible Spending Account</li> <li>• Limited Scope Flexible Spending Account</li> <li>• Dependent Care Flexible Spending Account</li> </ul>
<p><b>UNUM Provident</b> Customer Service: (800) 227-4165 Option #4</p>	<p><b>Long-Term Care Insurance</b> Voluntary Long-Term Care Insurance Benefits</p>

## Summary of Benefit Options

	Full-Time Employees			Active Legislator	Retirees (non-Medicare)			Survivors of Retirees (non-Medicare)		COBRA
	State	Non- State	NSHE		State	Non- State	Reinstated (State or Non-State)	Spouse	Dependent Child	
<b>Medical Options</b>										
Consumer Driven Health Plan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hometown Health Plans (HHP) HMO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health Plan of Nevada (HPN) HMO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
<b>Other Options</b>										
Self-Funded PPO Dental	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Basic Life	✓	✓	✓	✓	✓	✓				
Long-Term Disability (LTD)	✓	✓	✓	✓						
					<b>Retirees eligible for Medicare Parts A and B</b>			<b>Survivors of Retirees</b>		
Medicare Exchange for Medicare eligible Retirees and their covered Medicare eligible dependents					✓	✓	✓	✓		
<b>Voluntary Products</b>										
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.

Participants who are covered under the Medicare Exchange and who have elected PEBP Dental Benefits will receive a Dental Benefits only ID card.

Participants who are covered under one of the PEBP sponsored HMO's will receive a Dental Benefits only ID card.

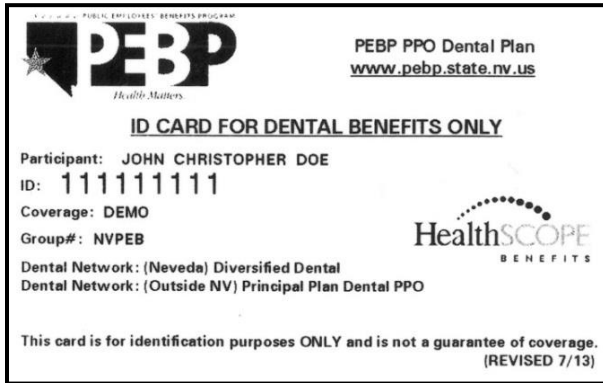
Under normal circumstances only two ID cards are issued. Eligible dependents will not receive individual ID cards. ID cards are issued under the Plan Participant's name and unique ID number only. If additional cards are needed, please contact HealthSCOPE Benefits. Information regarding HealthSCOPE is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

Consumer Driven Health Plan medical, Pharmacy, and Dental Benefits ID card for Participants who reside in Nevada and who may need medical, Pharmacy or Dental services in Nevada or outside of Nevada.



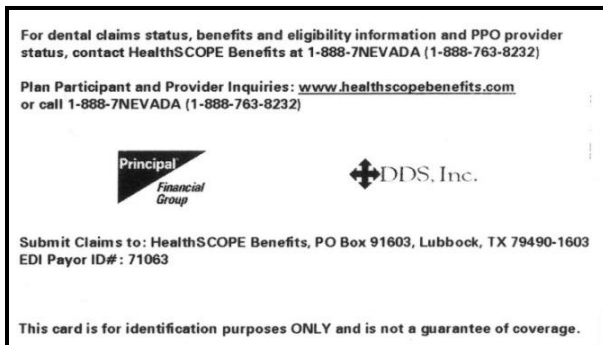
Consumer Driven Health Plan medical, Pharmacy and Dental Benefits ID card for Participants who reside outside of Nevada.





Dental only ID card (front)

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



Dental only ID Card (back)

## Self-Funded PPO Dental Benefits

### Eligible Dental Expenses

You are covered for expenses You incur for most, but not all, Dental services and supplies provided by a Dental Care Provider as defined in the Definitions section of this document that are determined by PEBP or its designee to be "Medically Necessary," but only to the extent that:

- PEBP or its designee determines that the services are the most cost effective ones that meet acceptable standards of Dental practice and would produce a satisfactory result; and
- the charges for them are "Usual and Customary (U&C)" (see the Definitions section under "Usual and Customary").

### Non-Eligible Dental Expenses

The Plan will not reimburse You for any expenses that are not Eligible Dental Expenses. That means You must pay the full cost for all expenses that are not covered by the Plan, as well as any charges for Eligible Dental Expenses that exceed the amount determined by the Plan to be Usual and Customary.

### Out-of-Country Dental Purchases

The Self-Funded PPO Dental Plan provides You with coverage worldwide. Whether You reside in the United States and You travel to a foreign country, or if You reside outside of the United States, permanently or on a part-time basis, and require dental care services, You may be eligible for reimbursement of the cost.

Typically, foreign countries do not accept payment directly from PEBP. You may be required to pay for dental care services and submit Your receipts to PEBP's third party administrator for reimbursement. Dental services received outside of the United States are subject to Plan provisions, limitations and Exclusions, clinical review if necessary and determination of Medical Necessity. The review may include regulations determined by the FDA.

Prior to submitting receipts from a foreign country to PEBP's third party administrator, You must complete the following. (PEBP and PEBP's third party administrator reserve the right to request additional information if needed):

- Proof of payment from You to the Provider of service (typically Your credit card invoice)
- Itemized bill to include complete description of the services rendered
- Itemized bill must be translated to English
- Reimbursement request must be converted to United States dollars.
- Any foreign purchases of Dental care and services will be subject to Plan limitations such as:
  - Deductibles
  - Coinsurance
  - Frequency maximums
  - Annual Benefit maximums
  - Medical Necessity

- 
- FDA approval
  - Usual and Customary (U & C)

If the Provider will accept payment directly from PEBP You must also provide the following:

- Assignment of Benefits signed by You or an individual with the authority to sign on Your behalf such as a legal guardian or Power of Attorney (POA).

Once payment is made to You or to the out of country Provider, PEBP and its vendors are released from any further liability for the out of country claim. PEBP has the exclusive authority to determine the eligibility of any and all Dental services rendered by an out of country Provider. PEBP may or may not authorize payment to You or to the out of country Provider if all requirements of this provision are not satisfied.

**Note:** Please contact PEBP's third party administrator before traveling or moving to another country to discuss any criteria that may apply to a Dental service reimbursement request.

## **Deductibles**

Each Plan Year, You must satisfy the Plan Year Deductible before the Plan will pay Benefits for Basic or Major services. Eligible Dental Expenses for Preventive services are not subject to the Plan Year Deductible or the Annual maximum Benefit. Benefits for some services are available four times each Plan Year, for example preventive cleanings and Periodontal maintenance cleanings. Oral examinations and Bitewing X-Rays are available twice per Plan Year. If a person covered under this Plan changes status from an Employee/Retiree to dependent, or from a dependent to an Employee, and the person is continuously covered under this Plan before, during and after the change in status, credit will be given for portions of the Deductible already met, and accumulation of Benefit maximums will continue without interruption.

There are two types of Deductibles: Individual and Family. The individual Deductible is the maximum amount one covered person has to pay each Plan Year before Plan Benefits are available for Basic or Major services. The Plan's individual Deductible is \$100. The family Deductible is the maximum amount that a family of three or more has to pay each Plan Year. The Plan's family Deductible is \$300. The family Deductible is accumulative meaning that one member of the family cannot satisfy the entire family Deductible. Both In- and Out-of-Network Services are combined to meet Your Plan Year Deductible.

## **Coinsurance**

There is no Coinsurance amount for preventive services, unless services are rendered by a non-PPO Dental Provider. For Basic or Major services, once You have met Your Plan Year Deductible, the Plan pays its percentage of the eligible Usual and Customary Dental expenses, and You are responsible for paying the rest (the applicable percentage paid by the Plan is shown in the Schedule of Dental Benefits). The part You pay is called the Coinsurance. Note that Your out-of-pocket expenses will be less if You use the services of a Dental Care Provider who is part of the Preferred Provider Organization (PPO), also called In-Network.

## Plan Year Maximum Dental Benefits

The Plan Year Maximum Dental Benefits payable for any individual covered under this Plan is \$1,500. The Plan Year Maximum Dental Benefit is for both In-Network and Out-of-Network Services. Under no circumstances will the combination of In-Network and Out-of-Network Benefit payments exceed the \$1,500 Plan Year Maximum Benefit. This maximum does not include Your Deductible or any amounts over Usual and Customary. Benefits paid for eligible preventive Dental services do not apply to the Annual maximum Dental Benefit.

## Payment of Dental Benefits

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

- Fixed Partial Dentures, Bridgework, Crowns, Inlays and Onlays: All services related to installation of fixed Partial Dentures, Bridgework, Crowns, Inlays and Onlays are considered to have been incurred on the date the tooth (or teeth) is (or are) prepared for the installation.
- Removable Partial or complete Dentures: All services related to the preparation of Removable Partial or complete Dentures are considered to have been incurred on the date the Impression for the Dentures is taken.
- Root Canal Treatment (Endodontics): All services related to Root Canal treatment are considered incurred on the date the tooth is opened for the treatment.

## Extension of Dental Coverage

If Dental coverage ends for any reason, the Plan will pay Plan Benefits for You or Your covered dependents until the end of the month in which the coverage ends. The Plan will also pay Benefits for a limited time beyond that date for the following:

- A Prosthesis (such as a full or partial Denture), if the Dentist took the Impressions and prepared the abutment teeth while You or Your dependents were covered and installs the device within 31 days after coverage ends.
- A Crown, if the Dentist prepared the Crown while You or Your dependent(s) were covered and installs it within 31 days after coverage ends.
- Root Canal treatment, if the Dentist opened the tooth while You or Your dependent(s) were covered and completes the treatment within 31 days after coverage ends.

## Dental Pretreatment Estimates

Whenever You expect that Your Dental expenses for a Course of Treatment will be more than \$300, You are encouraged to obtain a pretreatment estimate from the Claims Administrator. This procedure lets You know how much You will have to pay before You begin treatment.

To obtain a pretreatment estimate, You and Your Dentist should complete the regular Dental claim form (available from and to be sent to the Claims Administrator, whose name and address are listed on the Participant Contact Guide in this document), indicating the type of work to be performed also referred to as a treatment plan, along with supporting x-rays and the estimated cost (valid for a 60-day period following the submission of the pretreatment estimate request). Once it is received, the Claims Administrator will review the treatment plan and then send Your Dentist a statement within the next 60 days showing what the Plan may pay. Your Dentist may call the Claims Administrator (whose number is listed on the Participant Contact Guide in this document) for a prompt determination of the Benefits payable for a particular Dental procedure.

### **Prescription Drugs Needed for Dental Purposes**

Necessary Prescription Drugs needed for a Dental purpose, such as antibiotics or pain medications, should be obtained using the Prescription Drug Benefit provided under Your medical Plan.

NOTE: Some medications for a Dental purpose are not payable, such as Fluoride or periodontal mouthwash. See the Medical Exclusions section under Drugs for more information.

### **Schedule of Dental Benefits**

Charts outlining descriptions of the Plan's Dental Benefits are provided on the following pages.

**Schedule of Dental Benefits – Plan Year 2017**

**This chart explains the Benefits payable by the Self-Funded PPO Dental Plan.**

**All Benefits are subject to the Deductible except where noted.**

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><b><u>Preventive Services</u></b></p> <ul style="list-style-type: none"> <li>• Oral examination</li> <li>• Prophylaxis (routine cleaning of the teeth without the presence of Periodontal Disease)</li> <li>• Bitewing X-Rays</li> <li>• Topical application of sodium or stannous Fluoride</li> <li>• Space maintainers</li> <li>• Application of sealants</li> </ul>	<p>Preventive services are not subject to the individual Plan Year Maximum Dental Benefit.</p> <p>Oral examinations are limited to four times per Plan Year.</p> <p>Prophylaxis, scaling, cleaning and polishing limited to four times per Plan year. Even if Your Dentist recommends more than four routine Prophylaxes, the Plan will only consider four for Benefit purposes. You will be responsible for charges in excess of four cleanings in a single Plan Year.</p> <p>Bitewing X-Rays limited to twice per Plan Year.</p> <p>Fluoride treatment for individuals age 18 years and under is payable twice per Plan Year.</p> <p>Application of sealants for children under age 18 years.</p> <p>Initial installation of a space maintainer (to replace a primary tooth until a permanent tooth comes in) is payable for individuals under age 16 years. Plan allows fixed, unilateral (band or stainless steel Crown type), fixed cast type (Distal shoe), or Removable bilateral type.</p> <p>Benefits for preventive Dental services do not apply to the Annual Maximum Dental Benefit.</p>	<p>No Deductible.</p> <p>100% of the discounted PPO allowed fee schedule.</p>	<p>No Deductible.</p> <p>The Plan pays 80% of the In-Network Provider fee schedule for the Las Vegas Service Area.</p> <p>For services outside of Nevada, the Plan will reimburse at the U &amp; C rates.</p>

**Schedule of Dental Benefits – Plan Year 2017**

**This chart explains the Benefits payable by the Self-Funded PPO Dental Plan.**

**All Benefits are subject to the Deductible except where noted.**

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><b>Basic Services</b></p> <ul style="list-style-type: none"> <li>Office Visits during regular office hours for treatment and observation of injuries to teeth and supporting structures (other than for routine operative procedures)</li> <li>Professional Visits</li> <li>After hours for Emergency Dental care</li> <li>Consultation by a specialist for case presentation when a general Dentist has performed diagnostic procedures</li> <li>Emergency treatment</li> <li>Film fees, including examination and diagnosis, except for injuries</li> <li>Dental CT scans are allowed at varying frequencies depending on the type of service.</li> <li>Periapical, entire Dental film series (14 films), including Bitewings as necessary every 36 months <b>or</b> panoramic survey covered once every 36 months.</li> </ul>	<p>Plan Year Deductible applies. Basic services are subject to the individual Plan Year Maximum Dental Benefit.</p> <p>Full-mouth Periodontal maintenance cleanings, payable four times per Plan Year. Even if Your Dentist recommends more than four Periodontal maintenance cleanings, the Plan will only consider four for Benefit purposes. You will be responsible for charges in excess of four cleanings in a single Plan year.</p> <p>Laboratory services, including cultures necessary for diagnosis and/or treatment of a specific Dental condition.</p> <p>For multiple Restorations, one tooth surface will be considered a single Restoration.</p> <p>No coverage for Root Canal Therapy when the pulp chamber was opened before coverage under this Dental Plan began.</p> <p>Dental CT scans, depending on the type and necessity are allowed by the Plan. Contact the Claims Administrator for more information. You must have the CDT code of Your requested procedure before calling.</p> <p>Initial installation of a Removable, fixed or cemented inhibiting Appliance to correct thumb sucking is payable for individuals under age 16 years.</p>	<p>After the Deductible is met, the Plan pays 80% of the discounted PPO-allowed fee schedule.</p>	<p>After the Deductible is met, Plan pays 50% of the In-Network Provider fee schedule for the Las Vegas Service Area.</p> <p>For services outside of Nevada, the Plan will reimburse at the U &amp; C rates.</p>



**Schedule of Dental Benefits – Plan Year 2017**

**This chart explains the Benefits payable by the Self-Funded PPO Dental Plan.**

**All Benefits are subject to the Deductible except where noted.**

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><b>Basic Services (continued)</b></p> <ul style="list-style-type: none"> <li>• Biopsy, examination of oral tissue, study models, microscopic exam</li> <li>• Oral Surgery, limited to alveoplasty or alveolectomy, removal of cysts or tumors, torus and impacted wisdom teeth, including local Anesthesia and postoperative care</li> <li>• Amalgam Restorations for primary and permanent teeth, synthetic, silicate, plastic and composite fillings, retention pin when used as part of Restoration other than a gold Restoration</li> <li>• Appliance for thumb sucking (Individuals under 16 years of age) or night guard for bruxism (grinding teeth)</li> </ul>		<p>After the Deductible is met, the Plan pays 80% of the discounted PPO-allowed fee schedule.</p>	<p>After the Deductible is met, Plan pays 50% of the In-Network Provider fee schedule for the Las Vegas Service Area.</p> <p>For services outside of Nevada, the Plan will reimburse at the U &amp; C rates.</p>

<b>Schedule of Dental Benefits – Plan Year 2017</b> <b>This chart explains the Benefits payable by the Self-Funded PPO Dental Plan.</b> <b>All Benefits are subject to the Deductible except where noted.</b> See also the Exclusions and Definitions sections of this document for important information.			
Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><b><u>Major Services</u></b></p> <ul style="list-style-type: none"> <li>• Gold Restorations (Inlays and Onlays) only when teeth cannot be restored with a filling material</li> <li>• Repair or re-cementing of Inlays, Crowns, Bridges and Dentures</li> <li>• Initial installation of fixed or Removable Bridges, Dentures and full or Partial Dentures (except for special characterization of Dentures) including abutment Crowns</li> <li>• Bridgework, Dentures, and replacement of Bridgework and Dentures which are 5 years old or more and cannot be repaired. Covered expenses for temporary and permanent services cannot exceed the Usual and Customary fees for permanent services</li> <li>• Dental Implants (endosseous, ridge extension, and ridge augmentation only)</li> <li>• Post and core on non-vital teeth only</li> </ul>	<p>Plan Year Deductible applies.</p> <p>Major services are subject to the individual Plan Year Maximum Dental Benefit.</p> <p>No coverage for a Crown, Bridge or gold Restoration when the tooth was prepared before coverage under this Dental Plan began.</p> <p>Facings on Crowns or Pontics posterior to the second bicuspid are considered cosmetic and not covered.</p> <p>If payment is requested for temporary Appliances, the cost of the temporary Appliance will be deducted from the Benefits payable for the permanent Appliance, meaning the Plan will not pay for both a temporary and a permanent Appliance. Under no circumstances will the Benefit paid for a temporary Appliance and permanent Appliance exceed the PPO allowed amount or Usual and Customary allowance.</p>	<p>After the Deductible is met, Plan pays 50% of the discounted PPO-allowed fee schedule.</p>	<p>After the Deductible is met, Plan pays 50% of the In-Network Provider fee schedule for the Las Vegas Service Area.</p> <p>For services outside of Nevada, the Plan will reimburse at the U &amp; C rates.</p>

**Schedule of Dental Benefits – Plan Year 2017**

**This chart explains the Benefits payable by the Self-Funded PPO Dental Plan.**

**All Benefits are subject to the Deductible except where noted.**

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><b>Major Services (continued)</b></p> <ul style="list-style-type: none"> <li>• Denture relining and/or adjustment more than six months after installation</li> <li>• Prosthodontics (artificial Appliance of the mouth). No coverage of fees to install or modify an Appliance for which an Impression was made before coverage under this Dental Plan began</li> <li>• Crown (acrylic, porcelain or gold with gold or non-precious metal), including Crown build up only when teeth cannot be restored with a filling material</li> <li>• Teeth added to a Partial Denture to replace extracted Natural Teeth, including clasps if needed</li> </ul>	<p>Plan Year Deductible applies.</p> <p>Major services are subject to the individual Plan Year Maximum Dental Benefit.</p> <p>No coverage for a Crown, Bridge or gold Restoration when the tooth was prepared before coverage under this Dental Plan began.</p> <p>Facings on Crowns or Pontics posterior to the second bicuspid are considered cosmetic and not covered.</p>	<p>After the Deductible is met, Plan pays 50% of the discounted PPO-allowed fee schedule.</p>	<p>After the Deductible is met, Plan pays 50% of the In-Network Provider fee schedule for the Las Vegas Service Area.</p> <p>For services outside of Nevada, the Plan will reimburse at the U &amp; C rates.</p>

## Dental Network

### In-Network Services

In-Network Dental Care Providers have agreements with the Plan's Preferred Provider Organization (PPO) under which they provide Dental care services and supplies for a favorable negotiated discount fee for Plan Participants. When a Plan Participant uses the services of an In-Network Dental Care Provider, except with respect to any applicable Deductible, the Plan Participant is responsible for paying only the applicable Coinsurance for any Medically Necessary services or supplies. The In-Network Dental Care Provider generally deals with the Plan directly for any additional amount due.

The Plan's Preferred Provider Organization (PPO) is contracted with PEBP to provide a network of Dental Care Providers located within a Service Area (defined below) and who have agreed to provide Dental care services and supplies for favorable negotiated discount fees applicable only to Plan Participants. Because Providers are added and dropped from the PPO network periodically throughout the year, it is the Participant's responsibility to verify Provider participation each time before seeking services by contacting the PPO network. The PPO Dental Network's telephone number and website are listed on the Participant Contact Guide in this document.

If You receive Medically Necessary Dental services or supplies from a PPO Dental Care Provider, You will pay less money out of Your own pocket than if You received those same services or supplies from a Dental Provider who is not a PPO Provider because these Providers discount their fees. Using PPO Dental Care Providers means that You can obtain more Dental services before reaching Your Plan Year Dental Benefit Maximum. In addition to receiving discounted fees for Dental services, the PPO Provider has agreed to accept the Plan's allowed payment, plus any applicable Coinsurance that You are responsible for paying, as payment in full.

The directory of Dental Care Providers is available at [www.pebp.state.nv.us](http://www.pebp.state.nv.us). To request a hard copy of the directory, please call the Self-Funded PPO Dental Network shown in the Participant Contact Guide in this document.

### Out-of-Network Services

Out-of-Network (Non-Network) Dental Care Providers have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. For Participants receiving services outside of Nevada, the Plan will reimburse the Plan Participant for the Usual and Customary Charge for any Medically Necessary services or supplies, subject to the Plan's Deductibles, Coinsurance, copayments, limitations and Exclusions.

If a Participant travels to an area serviced by the Plan's PPO network, the Participant should use an In-Network Provider in order to receive Benefits at the In-Network Benefit level. If a Participant uses an Out-of-Network Provider within this Service Area, Benefits will be considered as Out-of-Network. In-Network Provider contracted rates for the Diversified Dental Las Vegas Service Area will apply to all Out-of-Network Dental claims in Nevada. The Participant may be responsible for any amount billed by the Out-of-Network Provider that exceeds the In-Network Provider

contracted rate. The Annual Benefit Maximum for the Dental Benefit is \$1,500 for each covered individual and includes both In-Network and Out-of-Network Dental services.

Plan Participants may be required to submit proof of claim before any such reimbursement will be made. Non-Network Dental Care Providers may bill the Plan Participant for any balance that may be due in addition to the amount payable by the Plan, also called balance billing. You can avoid balance billing by using In-Network Providers.

### **When Out-of-Network Providers May be Paid as In-Network Providers**

In the event that a Participant lives more than 50 miles from an In-Network PPO Provider, resides, or travels outside of Nevada, Benefits for an Out-of-Network Provider will be considered at the In-Network Benefit level. Usual and Customary allowance will apply. The Participant may be responsible for any amount billed by the Provider that exceeds the Usual and Customary allowance.

A "Service Area" is a geographic area serviced by the In-Network Dental Care Providers who have agreements with the Plan's PPO Dental Network. If You and/or Your covered dependent(s) live more than 50 miles from the nearest In-Network Dental Care Provider, the Plan will consider that You live outside the Service Area. In that case, Your claim for services by an Out-of-Network Dental Care Provider will be treated as if the services were provided In-Network.

## Exclusions: PPO Dental Plan

The following is a list of Dental services and supplies or expenses not covered by the Dental Plan. The Plan Administrator and its designees will have discretionary authority to determine the applicability of these Exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan Benefits in accordance with the terms of the Plan.

**Analgesia, Sedation, Hypnosis, etc.:** Expenses for analgesia, sedation, hypnosis and/or related services provided for apprehension or anxiety.

**Any treatment or service for which You have no financial liability** or that would be provided at no cost in the absence of Dental coverage.

**Concierge membership fees:** Expenses for fees described or defined as membership, retainer or premiums that are paid to a concierge Dental practice in order to have access to the Dental services provided by the concierge Dental practice.

**Cosmetic Services:** Expenses for Dental surgery or Dental treatment for cosmetic purposes, as determined by the Plan Administrator or its designee, including but not limited to veneers and facings. However, the following will be covered if they otherwise qualify as Covered Dental Expenses and are not covered under Your medical expense coverage:

- Reconstructive Dental surgery when that service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;
- Surgery or treatment to correct deformities caused by sickness;
- Surgery or treatment to correct birth defects outside the normal range of human variation;
- Reconstructive Dental surgery because of congenital disease or anomaly of a covered dependent child resulting in a functional disorder.

**Costs of Reports, Bills, etc.:** Expenses for preparing Dental reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken appointments, telephone calls and/or photocopying fees.

**Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan Benefit limitation or Plan Year Maximum Benefits (as described in the Dental Expense Coverage section).

**Drugs and Medicines:** Expenses for Prescription Drugs and medications that are covered under Your medical expense coverage, and for any other Dental services or supplies if Benefits as otherwise provided under the Plan's medical expense coverage; or under any other plan or program that the PEBP contributes to or otherwise sponsors (such as HMOs); or through a medical or Dental department, clinic or similar facility provided or maintained by the PEBP.

**Duplication of Dental Services:** If a person covered by this Plan transfers from the care of one Dentist to the care of another Dentist during the course of any treatment, or if more than one Dentist renders services for the same Dental procedure, the Plan will not be liable for more than the amount that it would have been liable had but one Dentist rendered all the services during each Course of Treatment, nor will the Plan be liable for duplication of services.

**Duplicate or Replacement Bridges, Dentures or Appliances:** Expenses for any duplicate or replacement of any lost, missing or stolen Bridge, Denture or Orthodontic Appliance, other than replacements described in the Major Services section of the Schedule of Dental Benefits.

**Education Services and Home Use:** Supplies and/or expenses for Dental education such as for plaque control, oral hygiene or diet or home use supplies, including, but not limited to, toothpaste, toothbrush, water-pick type device, Fluoride, mouthwash, Dental floss, etc.

**Expenses Exceeding Usual and Customary or the PPO Allowable Fee Schedule:** Any portion of the expenses for covered Dental services or supplies that are determined by the Plan Administrator or its designee to exceed the Usual and Customary Charge or PPO fee schedule (as defined in the Definitions section of this document).

**Expenses for Which a Third Party Is Responsible:** Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortuous or wrongful act of that third party (see the provisions relating to Third Party Liability in the section on Coordination of Benefits).

**Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the Dental program, or after the date the patient's coverage ends (except under those conditions described in the Extension of Dental Benefits in the Dental Expense Coverage section or under the COBRA provisions of the Plan).

**Experimental and/or Investigational Services:** Expenses for any Dental services, supplies, drugs or medicines that are determined by the Claims Administrator or its designee to be Experimental and/or Investigational (as defined in the Definitions section of this document).

**Frequent Intervals Services:** Services provided at more frequent intervals than covered by the Dental Plan as described in the Schedule of Dental Benefits.

**Gnathologic Recordings for Jaw Movement and Position:** Expenses for gnathologic recordings (measurement of force exerted in the closing of the jaws) as performed for jaw movement and position.

**Government-Provided Services (Tricare/CHAMPUS, VA, etc.):** Expenses for services when Benefits are provided to the covered individual under any plan or program in which any government participates (other than as an employer), unless the governmental program provides otherwise.

**Hospital Expenses Related to Dental Care Expenses:** Expenses for hospitalization related to Dental surgery or care, except as otherwise explained in this document. Contact the Claims Administrator for more information if You require this service.

**Illegal Act:** Expenses incurred by any covered individual for injuries resulting from commission, or attempted commission by the covered individual, of an illegal act that PEBP determines involves violence or the threat of violence to another person or in which a firearm is used by the

covered individual. PEBP's discretionary determination that this Exclusion applies shall not be affected by any subsequent official action or determination with respect to prosecution of the covered individual (including, without limitation, acquittal or failure to prosecute) in connection with the acts involved.

**Installation or replacement of Appliances,** Restorations or procedures for altering vertical dimension.

**Medically Unnecessary Services or Supplies:** As determined by PEBP or its designee not to be Medically Necessary (as defined in the Definitions section of this document.)

**Mouth Guards:** Expenses for athletic mouth guards and associated devices.

**Myofunctional:** Therapy Expenses for myofunctional therapy.

**Non-Dental Expenses:** Services rendered or supplies provided that are not recommended or prescribed by a Dentist.

**Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** All expenses incurred by You or any of Your covered dependents arising out of or in the course of employment (including self-employment) if the Injury, Illness or Condition is subject to coverage, in whole or in part, under any Workers' Compensation or occupational disease or similar law. This applies even if You or Your covered dependent were not covered by Workers' Compensation insurance, or if the covered Individual's rights under Workers' Compensation or occupational disease or similar law have been waived or qualified.

**Orthodontia:** Expenses for any Dental services relating to Orthodontia evaluation and treatment.

**Periodontal Splinting:** Expenses for Periodontal splinting (tying two or more teeth together when there is bone loss to gain additional stability).

**Personalized Bridges, Dentures, Retainers or Appliances:** Expenses for personalization or characterization of any Dental Prosthesis, including but not limited to any Bridge, Denture, retainer or Appliance.

**Reconstructive Dental Surgery:** When that service is:

- incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;
- Surgery or treatment to correct deformities caused by sickness;
- Surgery or treatment to correct birth defects outside the normal range of human variation;
- Reconstructive Dental surgery because of congenital disease or anomaly of a covered dependent child resulting in a functional disorder.

**Services Not Performed by a Dentist or Dental Hygienist:** Expenses for Dental services not performed by a Dentist (except for services of a Dental Hygienist that are supervised and billed by a Dentist and are for cleaning or scaling of teeth or for Fluoride treatments).



**Treatment of Jaw or Temporomandibular Joints (TMJ):** Expenses for treatment, by any means, of jaw joint problems including Temporomandibular Joint (TMJ) dysfunction disorder and Appliances.

**War or Similar Event:** Expenses incurred as a result of an injury or illness due to You or Your covered dependents participation in any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

## Self-Funded PPO Dental Claims Administration

### How Dental Benefits are Paid

Plan Benefits are considered for payment on the receipt of written proof of claim, commonly called a bill. Generally, Health Care Providers send their bill to PEBP's third party administrator directly. Plan Benefits for eligible services performed by Health Care Providers will then be paid directly to the Provider delivering the services. When Deductibles, Coinsurance or copayments apply, You are responsible for paying Your share of these charges.

If services are provided through the PPO Dental Network, the PPO Dental Provider may submit the proof of claim directly to PEBP's third party administrator; however, You will be responsible for the payment to the PPO Dental Care Provider for any applicable Deductible, Coinsurance or copayments.

If a Dental Care Provider does not submit a claim directly to PEBP's third party administrator and instead sends the bill to You, You should follow the steps outlined in this section regarding How to File a Claim. If, at the time You submit Your claim, You furnish evidence acceptable to the Plan Administrator or its designee (PEBP's third party administrator) that You or Your covered dependent paid some or all of those charges, Plan Benefits may be paid to You, but only up to the amount allowed by the Plan for those services after Plan Year Deductible, Coinsurance and copayment amounts are met.

### How to File a Dental Claim

All claims must be submitted to the Plan within 12 months from the date of service. No Plan Benefits will be paid for any claim submitted after this period. Benefits are based on the Plan's provisions in place on the date of service.

Most Providers send their bills directly to the PEBP's third party administrator; however, for Providers who do not bill the Plan directly, You may be sent a bill. In that case, follow these steps:

- Obtain a claim form from PEBP's third party administrator or PEBP's website (see the Participant Contact Guide in this document for details on address, phone and website).
- Complete the Participant part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
- The instructions on the claim form will tell You what documents or medical information is necessary to support the claim. Your physician, Health Care Practitioner or Dentist can complete the Health Care Provider part of the claim form, or You can attach the itemized bill for professional services if it contains all of the following information:
  - A description of the services or supplies provided including appropriate procedure codes;
  - Details of the charges for those services or supplies;
  - Appropriate diagnosis code;
  - Date(s) the services or supplies were provided;
  - Patient's name;
  - Provider's name, address, phone number, and professional degree or license;
  - Provider's federal tax identification number (TIN);
  - Provider's signature.

Please review Your bills to be sure they are appropriate and correct. Report any discrepancies in billing to the third party administrator. This can reduce costs to You and the Plan. Complete a separate claim form for each person for whom Plan Benefits are being requested. If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim You submit to this Plan.

To assure that medical, Pharmacy or Dental expenses You incur are eligible under this Plan, the Plan has the right to request additional information from any hospital, facility, physician, laboratory, radiologist, Dentist, Pharmacy or any other eligible medical or Dental Provider. For example, the Plan has the right to deny Deductible credit or payment to a Provider if the Provider's bill does not include or is missing one or more of the following components. This is not an all-inclusive list.

- Itemized bill to include but not be limited to: Proper billing codes such as CPT, HCPCS, Revenue Codes, CDT, ICD 9 and ICD 10.
- Date(s) of service.
- Place of service.
- Provider's Tax Identification Number.
- Provider's signature.
- Operative report.
- Patient ledger.
- Emergency room notes.
- For Providers such as hospitals and facilities that bill for items such as orthopedic devices/implants or other types of biomaterial, the Plan has the right to request a copy of the invoice from the organization that supplied the device/implant/biomaterial to the hospital or facility. The Plan has the right to deny payment for such medical devices until a copy of the invoice is provided to the Plan's Claims Administrator.

**NOTE:** Claims are processed by PEBP's third party administrator in the order they are received. If a claim is held or "soft denied" that means that PEBP's third party administrator is holding the claim to receive additional information, either from the Participant, the Provider or to get clarification on Benefits to be paid. A claim that is held or soft denied will be paid or processed when the requested additional information is received. Claims filed while another is held or soft denied may be paid or processed even though they were received at a later date.

**NOTE:** It is Your responsibility to maintain copies of the Explanation of Benefits provided to You by PEBP's third party administrator or prescription drug administrator. Explanation of Benefits documents are available on the third party administrator's website application but cannot be reproduced.

### **Where to Send the Claim Form**

Send the completed claim form, the bill You received (You keep a copy, too) and any other required information to the third party administrator at the address listed in the Participant Contact Guide in this document.

## Dental Appeal Process

### Written Notice of Denial of Claim

The Plan will notify You in writing if payment of Your claim is denied in whole or in part. It will explain the reasons why, with reference to the Plan provisions on which the denial was based. When applicable, You will be told what additional information is required from You and why it is needed. You will be told what steps You may take to submit Your claim for appeal. Your request for appeal must be made in writing to the office where the claim was originally submitted (the Claims Administrator) within 180 days after You receive a notice of denial. A Participant or their designee cannot circumvent the claims and appeals procedures by initiating a cause of action against the PEBP (or State of Nevada) in a court proceeding.

The appeal process works as follows:

### Level 1 Appeal

If Your claim is denied, or if You disagree with the amount paid on a claim, You may request a review from the Claims Administrator within 180 days of the date You received the Explanation of Benefits (EOB) 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 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 EOB and claim; and
- A detailed written explanation why the claim is being appealed.

You have the right to review documents applicable to the denial and to submit Your own comments in writing. The Claims Administrator will review Your claim (by a person at a higher level of management than the one who originally denied the claim). If any additional information is needed to process Your request for appeal, it will be requested promptly.

The decision on Your appeal will be given to You in writing. Ordinarily, a decision on Your appeal will be reached within 20 days after receipt of Your request for appeal. If the appeal results in a denial of Benefits in whole or in part, it will explain the reasons for the decision, with reference to the applicable provisions of the Plan upon which the denial is based. It will also explain the steps necessary if You wish to proceed to a Level 2 appeal if You are not satisfied with the response at Level 1.

### Level 2 Appeal

To file a Level 2 claim appeal, PEBP encourages You to complete a Claim Appeal Request form. To obtain a Claim Appeal Request form, contact PEBP Customer Services or refer to the PEBP website.

If, after a Level 1 appeal is completed, You are still dissatisfied with the denial of Your claim, rescission of coverage, or amount paid on Your claim You may submit Your written request to the

Executive Officer of PEBP or his designee (see the Plan Administrator's section of the Participant Contact Guide in this document for the address) within 35 days after You receive the decision on the Level 1 appeal, together with any additional information You have in support of Your request. Your Level 2 appeal must include a copy of:

1. The Level 1 review request;
2. A copy of the decision made on review; and
3. Any other documentation provided to the Claims Administrator by the Participant.

The Executive Officer or his designee will use all resources available, including but not limited to, members of the staff of the Board, third party administrator, prescription drug administrator, Internet, and the PEBP Master Plan Document to determine if the claim was adjudicated correctly.

A decision on a Level 2 appeal will be given to You in writing within 30 days after the Level 2 appeal request is received by the Executive Officer or his designee, and will explain the reasons for the decision. If the appeal review results in a denial of Benefits in whole or in part, it will explain the reasons for the decision, with reference to the applicable provisions of the Plan upon which the denial is based. A Level 2 appeal determination is final.

## Coordination of Benefits (COB)

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

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

**NOTE:** This Plan's Prescription Drug Benefit does not coordinate Benefits for prescription medications, or any covered Over the Counter (OTC) medications, obtained through retail or mail order Pharmacy programs. Meaning, there will be no coverage for Prescription Drugs if You have additional prescription drug coverage that is primary.

This Plan operates under rules that prevent it from paying Benefits which, together with the benefits from another source (as described above), would allow You to recover more than 100% of Allowable Expenses You incur. In some instances, You may recover less than 100% of those Allowable Expenses from the duplicate sources of coverage. It is possible that You will incur Out-of-Pocket expenses, even with two payment sources.

### When and How Coordination of Benefits (COB) Applies

Many families that have more than one family member working outside the home are covered by more than one medical or dental plan. If this is the case with Your family, You must let the Plan Administrator or its designee know about all Your coverages when You submit a claim.

COB, operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan, (called the secondary plan) may then pay additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or Dental Allowable Expenses incurred. Sometimes the combined benefits that are paid will be less than the total expenses.

If the PEBP Plan is secondary coverage, the Participant will be required to meet their PEBP Plan Year medical and Dental Deductibles.

For the purposes of this Coordination of Benefits section, the word “plan” refers to any group medical or Dental policy, contract or plan, whether insured or self-insured, that provides benefits payable for medical or Dental services incurred by the covered individual, or that provides medical or Dental services to the covered individual. A “group plan” provides its benefits or services to employees, Retirees or members of a group who are eligible for and have elected coverage.

"Allowable Expense" means a health care service or expense, including Deductibles, Coinsurance or copayments, that is covered in full or in part by any of the plans covering the person, except as described below, or where a statute requires a different definition. This means that an expense or service or a portion of an expense or service that is not covered by any of the plans is not an Allowable Expense. Examples of what is not an Allowable Expense:

- the difference between the cost of a semi-private room in the hospital and a private room;
- when both plans use Usual and Customary (U&C) fees, any amount in excess of the highest of the U&C fee for a specific benefit;
- when both plans use negotiated fees, any amount in excess of the highest negotiated fee is not an Allowable Expense (with the exception of Medicare negotiated fees, which will always take precedence); and
- when one plan uses U&C fees and another plan uses negotiated fees, the secondary plan's payment arrangement is not the Allowable Expense.

NOTE: If the Spouse or Domestic Partner of a primary PEBP Participant is eligible for health insurance coverage from their employer, that Spouse or Domestic Partner is not eligible for PEBP coverage whether they have enrolled in their employer sponsored health insurance or not. This includes Spouses or Domestic Partners who are eligible for PEBP coverage.

## **Which Plan Pays First: Order of Benefit Determination Rules**

### **The Overriding Rules**

Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform order of benefit determination rules in a specific sequence. PEBP uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC), and which are commonly used by insured and self-insured plans. Any group plan that does not use these same rules always pays its benefits first.

When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan (pays first) and which is the secondary plan (pays second). If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

### **Rule 1 Non-Dependent/Dependent**

The plan that covers a person other than as a dependent, for example as an employee, retiree, member or subscriber, is primary and the plan that covers the person as a dependent is secondary. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:

- secondary to the plan covering the person as a dependent;

- primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee);
- then the order of benefits is reversed, so that the plan covering the person as a dependent pays first; and the plan covering the person other than as a dependent (that is, as a retired employee) pays second.

This rule applies when both spouses are employed and cover each other as dependents under their respective plans. The plan covering the person as an employee pays first, and the plan covering the same person as a dependent pays benefits second.

### **Rule 2: Dependent Child Covered Under More Than One Plan**

The plan that covers the parent whose birthday falls earlier in the calendar year pays first; the plan that covers the parent whose birthday falls later in the calendar year pays second, if:

- the parents are married;
- the parents are not separated (whether or not they ever have been married); or
- a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.
- if both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first, and the plan that has covered the other parent for the shorter period of time pays second.
- the word "birthday" refers only to the month and day in a calendar year; not the year in which the person was born.

If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any Plan Year during which any Benefits were actually paid or provided before the Plan had actual knowledge of the specific terms of that court decree.

If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

- The plan of the custodial parent pays first; and
- The plan of the spouse of the custodial parent pays second; and
- The plan of the non-custodial parent pays third; and
- The plan of the spouse of the non-custodial parent pays last.

### **Rule 3: Active/Laid-Off or Retired Employee**

The plan that covers a person, as an active employee (that is, an employee who is neither laid-off nor retired) or as an active employee's dependent pays first; the plan that covers the same person as a laid-off/retired employee or as a laid-off/retired employee's dependent pays second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.



If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

**Rule 4: Continuation Coverage**

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing Continuation Coverage to that same person pays second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of Continuation Coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

**Rule 5: Longer/Shorter Length of Coverage**

If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

**Administration of COB**

To administer COB, the Plan reserves the right to:

- exchange information with other plans involved in paying claims;
- require that You or Your Health Care Provider furnish any necessary information;
- reimburse any plan that made payments this Plan should have made; or
- recover any overpayment from Your hospital, physician, Dentist, other Health Care Provider, other insurance company, You or Your dependent.

If this Plan should have paid Benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount the Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be Benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

To obtain all the Benefits available to You, You should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims Benefits under this Plan must provide all the information the Plan needs to apply COB.

This Plan follows the customary Coordination of Benefits rule that the medical program coordinates with only other medical plans or programs (and not with any dental plan or program), and the Dental program coordinates only with other dental plans or programs (and not with any other medical plan or program). Therefore, when this Plan is secondary, it will pay secondary medical Benefits only when the coordinating primary plan provides medical benefits, and it will pay secondary Dental Benefits only when the primary plan provides Dental Benefits.

If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the Allowable Expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the prevailing rates for such services in the community in which the services were provided.

If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained Out-of-Network, Benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary plan.

If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the Benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Plan Participant may have against the other plan, and the Plan Participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

This Plan does not coordinate Pharmacy Benefits when PEBP is the secondary or tertiary payor.

### **Coordination with Medicare**

Coordination with Medicare is not applicable for Participants and their dependents who are eligible for Medicare Parts A and B; and who are required to transition to the Medicare Exchange. Refer to the Enrollment and Eligibility Master Plan Document for more information regarding enrollment in the Medicare Exchange.

### **Coverage Under Medicare and This Plan When You Have End-Stage Renal Disease**

If, while You are actively employed, You or any of Your covered dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins, or the first month in which the individual receives a kidney transplant. Then, starting with the 31<sup>st</sup> month after the start of Medicare coverage or the first month after the individual receives a kidney transplant, Medicare pays first and this Plan pays second. If You are under age 65 years and are receiving Medicare ESRD benefits You will not be required to transition to PEBP's Medicare Exchange program. When You reach age 65 years You will be transitioned to the Medicare Exchange in accordance with PEBP's eligibility requirements as stated in the Enrollment and Eligibility Master Plan Document.

### **How Much This Plan Pays When It Is Secondary to Medicare**

When the Plan Participant is covered by Medicare Parts A and B and this Plan is secondary to Medicare, this Plan pays as secondary to Medicare, with the Medicare negotiated allowable fee taking precedence. If a service is not covered under Medicare but is covered under this Plan, this Plan will pay as Primary with the Plan's allowable fee for the service taking precedence.

When the Retiree or their Retired Spouse is eligible for Medicare Part B: This Plan will always be secondary to Medicare Part B, whether or not You have enrolled. This Plan will estimate Medicare's benefit. This Plan will always be secondary to Medicare Part B, whether or not You have enrolled. This Plan will assume that Medicare has paid 80% of Medicare Part B eligible expenses. This Plan will only consider the remaining 20% of Medicare Part B expenses.

When the Plan Participant Enters Into a Medicare Private Contract: a Medicare Participant is entitled to enter into a Medicare private contract with certain Health Care Practitioners under which he or she agrees that NO claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare Participant enters into such a contract this Plan will NOT pay any Benefits for any health care services and/or supplies the Medicare Participant receives pursuant to it.

## **Coordination with Other Government Programs**

### **Medicaid**

If a covered individual is covered by both this Plan and Medicaid, this Plan pays first and Medicaid pays second.

### **Tricare**

If a Participant or their covered dependent is covered by both this Plan and Tricare (the program that provides health care services to active or retired armed services personnel and their eligible dependents), this Plan pays first and Tricare pays second. For an Employee called to active duty for more than 30 days, Tricare is primary and this Plan is secondary.

### **Veterans Affairs Facility Services**

If a Participant receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related illness or injury, Benefits are not payable by the Plan. If a covered individual receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related illness or injury, Benefits are payable by the Plan at the In-Network Benefit level at the Usual and Customary Charge, only to the extent those services are Medically Necessary and are not Excluded by the Plan.

### **Worker's Compensation**

This Plan does not provide Benefits if the expenses are covered by workers' compensation or occupational disease law. If a Participant contests the application of workers' compensation law for the Illness or Injury for which expenses are incurred, this Plan will pay Benefits, subject to its right to recover those payments if and when it is determined that they are covered under a Workers' Compensation or occupational disease law. However, before such payment will be made, You and/or Your covered dependent must execute a Subrogation and reimbursement agreement (described in the Third Party Liability section of this document) that is acceptable to the Plan Administrator or its designee.

## **Third Party Liability**

### **Subrogation and Third Party Recovery**

Subrogation applies to situations where the Participant or their covered dependent is injured and another party is responsible for payment of health care expenses he or she incurs because of the injury. The other party may be an individual, insurance company or some other public or private entity. Automobile Accident injuries or personal injury on another's property are examples of cases frequently subject to Subrogation.

The Subrogation provision allows for the right of recovery for certain payments. Any payments made for injuries under the Plan may be recovered from the other party. Any payments made to the Participant or their covered dependent for an injury may be recovered from any judgment or settlement of his or her claims against the other party or parties.

By accepting coverage under the Plan, the Participant and their covered dependent automatically assigns to the Plan any rights they may have to recover all or part of any payments made by the Plan from any other party, including an insurer or another group health program. Therefore, the Plan Administrator may act as the substitute for the Participant or their covered dependent in the event any payment made by this Plan for health care Benefits, including any payment for a known pre-existing condition, that may be the responsibility of another party. Such payments shall be referred to as Reimbursable Payments. This assignment allows the Plan to pursue any claim that the Participant or their covered dependent may have, whether or not they choose to pursue that claim.

The Participant or their covered dependent must cooperate fully and provide all information needed by the Plan to recover payments, execute any papers necessary for such recovery, and do whatever else is necessary to secure recovery rights to the Plan. The Plan has the right to sue the other party in order to recover the payments made for the Participant or their covered dependent under the Plan.

### **Right of Reimbursement and Recovery**

By accepting Coverage under the Plan the Participant or their covered dependent agrees that if they receive any recovery in the form of a judgment, settlement, payment or compensation (regardless of who was at fault, who was negligent or who committed the offense), the Plan has the right to recover Reimbursable Payments from:

- (1) a Tortfeasor,
- (2) a liability insurer for a Tortfeasor, or
- (3) any other source, including but not limited to any form of insured or underinsured motorist coverage, any medical payments, no-fault or school insurance coverages, workers' compensation coverage, premises liability coverage, any medical malpractice recovery, or any other form of insurance coverage.

The Plan will place a lien against the Recovery rights of the Participant or their covered dependent and has the right to be paid from any such Recovery any and all monies.

- PEBP has the right to subrogate on a first-dollar basis, that is, PEBP has priority over rights such as attorney fees or costs incurred by the Participant or their covered dependent in the collection of damages. However, PEBP has the right to consider reducing the subrogated amount (lien) by any attorney's fees or costs incurred (e.g. Deductible and co-insurance) by the Participant or their covered dependent in the collection of damages.
- The Plan (PEBP) has the discretionary authority to seek any other equitable remedy against any party possessing or controlling such monies or properties. PEBP may instruct the Claims Administrator to reduce any future eligible medical or Dental expenses otherwise available to the Participant or their covered dependent under the Plan by any amount up to the total amount of subrogated amount (lien). All rights of recovery will be limited to the amount of payments made under this Plan.

The Plan may, in its sole discretion, require the Participant or their covered dependent, as a pre-condition to receiving Benefit payments, to sign a Subrogation agreement and to agree in writing to assist the Plan to secure the Plan's right to payment of the Subrogation amount from the other party. In the event that the Plan does not receive payment of the subrogated amount, the Plan may, in its sole discretion, bring legal action against the Participant or their covered dependent or reduce or set-off the unpaid subrogated amount against any future Benefit payments to the Participant or their covered dependent. If the Plan takes legal action to enforce its Subrogation rights, the Plan shall be entitled to recover its attorneys' fees and costs from the Participant or their covered dependent.

The following provisions apply to the Plan's right of Subrogation, reimbursement, and creation of a lien:

1. **"Pay and Pursue."** The Plan Administrator has elected the "pay and pursue" option in connection with the Subrogation, reimbursement and lien rights for claims involving eligible expenses. Pursuant to the election of "pay and pursue," Benefit payments will be made **prior** to applying the Subrogation, reimbursement and lien rights under the Plan.
2. **Scope of Subrogation, Reimbursement and Lien Rights.** The Subrogation, reimbursement and lien rights apply to any Benefits paid by the Plan on behalf of the Participant or their covered dependent as a result of the injuries sustained, including, but not limited to:
  - a. Any no-fault insurance;
  - b. Medical benefits coverage under any automobile liability plan. This includes the Participant's or their covered dependent's insurance plan or any third party's policy under which they are entitled to benefits;
  - c. Under-insured and uninsured motorist coverage;
  - d. Any automobile medical payments and personal injury protection benefits;
  - e. Any third party's liability insurance;
  - f. Any premises/guest medical payments coverage;
  - g. Any medical malpractice recovery;
  - h. Workers' compensation benefits. The right of Subrogation, reimbursement and lien attach to any right to payment for workers' compensation, whether by judgment or settlement, where the Plan has paid benefits for eligible expenses prior to a determination that the

eligible expenses arose out of and in the course of employment.

- i. Any other governmental agency reimbursement (i.e., state medical malpractice compensation funds).
3. **Reimbursable Payments.** Refers to any Benefit payments made by the Plan that are eligible for recovery from any other party, including an insurer or another group health program.
4. **“Make Whole” and “Common Fund” Rules Do Not Apply.** The provisions of the Plan concerning Subrogation, reimbursement, liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines and/or state laws commonly referred to as the “make whole” rule and the “common fund” rule.

## Life Insurance

This section provides a brief summary of the fully insured group Basic Life Insurance available from PEBP. Since this is only a summary, for complete information You must refer to the Certificate of Coverage Booklet available from the insurance company who insures this Benefit. Their name and contact information is listed in the Participant Contact Guide section of this document.

### Eligibility for Life Insurance

To be eligible for the Life insurance, You must be covered under the PEBP sponsored medical plan, and be in one of the following classes:

- Class 1: Full-time Employees of the State of Nevada (or any non-State agency approved by the PEBP board), professional full-time Employees of the Nevada System of Higher Education (under annual contract), and members of the Nevada Senate or Assembly are all eligible for this Benefit. A full-time Employee is one who works at least 80 hours per month, before reduction due to mandatory furloughs. Your employer pays the full cost of Basic Life Insurance.
- Class 2: Retirees of the State of Nevada receiving PERS, TIAA or CREF or judge retirement Benefits and legislators qualifying under Chapter 242 of the Sessions Law of the sixty-third Session of the Nevada State Legislature (or NRS 287.045) are eligible for this Benefit. Retirees pay a contribution toward the cost of Basic Life Insurance.

Outstanding premium payment and/or medical, Pharmacy or Dental claim overpayment of a deceased Retiree or Employee: Life insurance Benefits (if any) may be suspended on any Retiree or Employee account in which there is an outstanding premium payment and/or medical, Pharmacy or Dental claim overpayment due to PEBP until the outstanding balance has been paid in full.

### Coverage

Life insurance Benefits are as follows:

	Class 1 (Employee) Benefit Amount	Class 2 (Retiree) Benefit Amount
Life Insurance amount	\$25,000	\$12,500

## **Long-Term Disability (LTD) Insurance**

Long-Term Disability (LTD) Insurance is provided to active Employees who are enrolled in a PEBP-sponsored medical Plan. If You are a person with a disability for an extended period due to an illness or injury and are under the regular care of a physician, long-term disability (LTD) Benefits help You financially while Your ability to work is limited. The LTD Benefits are insured through an insurance company whose name and address are listed on the Participant Contact Guide. Questions about Your LTD Benefits should be directed to the insurance company whose name and contact information is located in the Participant Contact Guide section of this document.

### **Premium Payment**

Your employer pays the full cost of Your LTD insurance.

### **How the LTD Benefit Works**

LTD Benefits are designed to be a source of income if Your ability to work is limited due to a disability. You should notify the LTD insurance company as soon as possible so that a claim decision can be made in a timely manner. You must send the LTD insurance company proof of Your claim no later than 90 days after the Benefit waiting period ends. If it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is required.

Since the information provided in this document is only a summary of Benefits, for complete information You must refer to the Certificate of Coverage Booklet available from the insurance company who insures this Benefit. Their name and contact information is listed in the Participant Contact Guide section of this document.

NOTE: This insurance does not replace or affect the requirements for coverage by any Workers' Compensation insurance.



## 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 PPO Dental 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 guided 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 has a total disability, 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 this document).

## 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

### **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.

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 7<sup>th</sup> 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.

### **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.

### **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](http://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 employers 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](http://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](http://www.eeoc.gov/ada).

#### **Paul Wellstone & Pete Domenici Mental Health Parity & Addiction Equity Act**

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](http://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 at: [www.genome.gov/10002328](http://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 a Participant and individuals who are eligible to participate in the Program.

NAC 287.135 - Definition of a retired officer or Employee and who is eligible to participate in the Program.

NAC 287.317 - Notification timeframe and enrollment requirements for participating agencies to notify PEBP of the appointment of eligible employees and the termination of employees.

NAC 287.320 - Eligibility and the re-enrollment rights and limitations for certain retired officers of participating and non-participating local governmental agency.

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; coverage upon return to work.

NAC 287.530 - Coverage of retired person, Spouse, Domestic Partner or surviving dependent: 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:
  - (a) Retired before July 1, 2004;
  - (b) Is enrolled in the Program as a surviving dependent; and
  - (c) 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:
  - (a) 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
  - (b) 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 reenrolling in the Program; and
    - Enrolls or reenrolls, as appropriate, in the Program.
- Continued coverage provided to a surviving dependent who reenrolls 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 reenroll 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 reenrolls 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 his intent to continue coverage in the Program. If the

Participant reenrolls in the Program, the Participant will have uninterrupted Benefits and is not subject to any waiting period. Upon reenrollment, 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 reenrolls 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
  - Reenrolls in the Program, will have uninterrupted Benefits and is not subject to any waiting period.
  - Upon reenrollment, 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 reenrolls 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

- Reenrolls 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 reenrollment, 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 nonparticipating 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 reenroll 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.

Please refer to the Enrollment and Eligibility MPD for more information about newly born and adopted children.

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.

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.

## 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.

**Accident:** A sudden and unforeseen event that is not work-related, resulting from an external or extrinsic source.

**Adverse Benefit Determination:** A determination that an admission, availability of care, continued stay or other health care service that is a covered Benefit has been reviewed, and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

**Allowable Expense:** A health care service or expense, including Deductibles or Coinsurance, that is covered in full or in part by any of the Plans covering a Plan Participant (see also the COB section of this document), except as otherwise provided by the terms of this Plan or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the Plans is not an Allowable Expense.

**Ancillary Services:** Services provided by a hospital or other health care facility other than room and board, including (but not limited to) use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

**Anesthesia:** The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g., general Anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g., regional or local Anesthesia). Anesthetics are commonly administered by injection or inhalation.

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

**Appliance (Dental):** A device to provide or restore function or provide a therapeutic (healing) effect.

**Appropriate:** See the definition of Medically Necessary for the definition of appropriate as it applies to medical services that are Medically Necessary.

**Average Wholesale Price (AWP):** the average price at which drugs are purchased at the wholesale level.

**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.

**Benefit, Benefit Payment, Plan Benefit:** The amount of money payable for a claim, based on the Usual and Customary Charge, after calculation of all Deductibles, Coinsurance and copayments, and after determination of the Plan’s Exclusions, limitations and maximums.

**Bitewing X-Rays (Dental):** Dental x-rays showing the coronal (Crown) halves of the upper and lower teeth when the mouth is closed.

**Bridge, Bridgework (Dental) Fixed:** A Prosthesis that replaces one or more teeth and is cemented in place to existing abutment teeth. It consists of one or more Pontics and one or more retainers (Crowns or Inlays). The patient cannot remove the Prosthesis.

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

**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.

**Coinsurance:** That portion of eligible medical expenses for which the covered person has financial responsibility. In most instances, the covered individual is responsible for paying a percentage of covered medical expenses in excess of the Plan’s Deductible. The Coinsurance varies depending on whether In-Network or Out-of-Network Providers are used.

**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).

**Cosmetic Surgery or Treatment:** Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes (but is not limited to) removal of tattoos, breast augmentation, or other medical, Dental or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

**Cost-Efficient:** See the definition of Medically Necessary for the definition of Cost-Efficient as it applies to dental services that are Medically Necessary.

**Course of Treatment (Dental):** The planned program of one or more services or supplies, provided by one or more Dentists, to treat a Dental condition diagnosed by the attending Dentist as a result of an oral examination. The Course of Treatment begins when a Dentist first renders a service to correct or treat the diagnosed Dental condition.

**Covered Dental Expenses:** See the definition of Eligible Dental Expenses.



**Crown (Dental):** The portion of a tooth covered by enamel. An artificial Crown is a Dental Prosthesis used to return a tooth to proper occlusion, contact and contour, as used as a Restoration or an abutment for a fixed Prosthesis.

**Customary Charge:** See the definition of Usual and Customary Charge.

**Deductible:** The amount of Eligible Dental Expenses You are responsible for paying before the Plan begins to pay Benefits. The amount of Deductibles is discussed in the Dental Expense Coverage section of this document.

**Dental:** As used in this document, Dental refers to any services performed by (or under the supervision of) a Dentist, or supplies (including Dental Prosthetics). Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat: teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the Temporomandibular joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection. Dental services and supplies are covered under the Dental expense coverage plan, and are not covered under the medical expense coverage of the Plan unless the medical Plan specifically indicates otherwise in the Schedule of Medical Benefits.

**Dental Care Provider:** A Dentist, Dental Hygienist nurse, or other Health Care Practitioner (as those terms are specifically defined in this section of the document) who is legally licensed and who is a Dentist or performs services under the direction of a licensed Dentist; and acts within the scope of his or her license; and is not the patient or the parent, Spouse, sibling (by birth or marriage) or child of the patient.

**Dental Subspecialty Areas:**

Subspecialty Area	Services related to the diagnosis, treatment or prevention of diseases
Endodontics	the Dental pulp and its surrounding tissues.
Implantology	attachment of permanent artificial replacement of teeth directly to the jaw using artificial root structures.
Oral Surgery	extractions and surgical procedures of the mouth.
Orthodontics	abnormally positioned or aligned teeth.
Pedodontics	treatment of Dental problems of children.
Periodontics	structures that support the teeth (gingivae, alveolar bone, Periodontal membrane or ligament, cementum).
Prosthodontics	construction of artificial Appliances for the mouth (Bridges, Dentures, Crowns, implants).

**Dental Hygienist:** A person who is trained, legally licensed and authorized to perform Dental hygiene services (such as Prophylaxis, or cleaning of teeth), under the direction of a licensed Dentist; and who acts within the scope of his or her license; and is neither the patient, the parent, spouse, sibling (by birth or marriage) nor child of the patient.

**Dental Implant:** A Dental Implant is an artificial tooth root that is placed into Your jaw to hold a replacement tooth or Bridge.

**Dentist:** A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice all branches of dentistry under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

**Denture:** A device replacing missing teeth.

**Domestic Partner:** The Participant's lawful Domestic Partner (opposite sex or same sex) as determined by the laws of the State of Nevada. The Plan will require proof of legal domestic partnership.

**Eligible Dental Expenses:** Expenses for Dental services or supplies, but only to the extent that they are Medically Necessary, as defined in this Definitions section; and the charges for them are Usual and Customary, as defined in this Definitions section; and coverage for the services or supplies is not excluded, as provided in the Dental Exclusions section of this document and the Plan Year Maximum Dental Benefits for those services or supplies has not been reached.

**Emergency:** See Medical Emergency.

**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.

**Exclusions:** Specific conditions, circumstances, and limitations, as set forth in the Exclusions section for which the Plan does not provide Plan Benefits.

**Explanation of Benefits (EOB):** When a claim is processed by the Claims Administrator You will be sent a form called an Explanation of Benefits, or EOB. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to Your Deductible, if Your Out-of-Pocket Maximum has been reached, if certain services were denied and why, amounts You need to pay to the Provider, etc.

**Fixed Appliance:** A device that is cemented to the teeth or attached by adhesive materials.

**Fluoride:** A solution applied to the surface of teeth, or a Prescription Drug (usually in pill form) to prevent Dental decay.

**Food and Drug Administration (FDA):** The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain Prescription Drugs and other medical services and supplies to be lawfully marketed.

**Health Care Practitioner:** A physician, behavioral health practitioner, chiropractor, Dentist, nurse, Nurse Practitioner, Physician Assistant, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist, Master's prepared audiologist, optometrist, optician for Vision Plan Benefits, oriental medicine doctor for acupuncture or Christian Science Practitioner, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice.

**Health Care Provider:** A Health Care Practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this Definitions section).

**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 coverage and when there is an adoption, placement for adoption, birth, or marriage.

**Impression:** A negative reproduction of the teeth and gums from which models of the jaws are made. These models are used to study certain conditions and to make Dental Appliances and Prostheses.

**Injury to Sound and Natural Teeth (ISNT):** An injury to the teeth caused by trauma from an external source. This does not include an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for Injury to Sound and Natural Teeth are payable under the medical plan (see also the definition of Sound and Natural Teeth).

**Inlay:** A Restoration made to fit a prepared tooth cavity and then cemented into place (see the definition of Restoration).

**In-Network Services:** Services provided by a Health Care Provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from Out-of-Network Services that are provided by a Health Care Provider that is not a member of the PPO network.

**In-Network Contracted Rate:** The negotiated amount determined by the PPO network to be the maximum amount charged by the PPO Provider for a covered service. In some cases, the In-Network contracted amount may be applied to Out-of-Network Provider charges.

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**Medically Necessary:** A medical or Dental service or supply will be determined to be “Medically Necessary” by the Plan Administrator or its designee if it:

- is provided by or under the direction of a physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it (or Dentist if a Dental service or supply is involved); and
- is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and Dental standards; and
- is determined by the Plan Administrator or its designee to meet all of the following requirements:
  - It is consistent with the symptoms or diagnosis and treatment of the Illness or Injury; and
  - It is not provided solely for the convenience of the patient, physician, Dentist, hospital, Health Care Provider, or health care facility; and
  - It is an “appropriate” service or supply given the patient’s circumstances and condition; and
  - It is a “Cost-Efficient” supply or level of service that can be safely provided to the patient; and
  - It is safe and effective for the illness or injury for which it is used.
- A medical or Dental service or supply will be considered to be “appropriate” if:
  - It is a diagnostic procedure that is called for by the health status of the patient, and is: as likely to result in information that could affect the Course of Treatment as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient’s overall health condition.
  - It is care or treatment that is: as likely to produce a significant positive outcome as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient’s overall health condition.

A medical or Dental service or supply will be considered to be “Cost-Efficient” if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply. The fact that Your physician or Dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical or Dental coverage provided by the Plan.

A hospitalization or confinement to a health care facility will not be considered to be Medically Necessary if the patient’s illness or injury could safely and appropriately be diagnosed or treated while not confined.

A medical or Dental service or supply that can safely and appropriately be furnished in a physician’s or Dentist’s office or other less costly facility will not be considered to be Medically Necessary if it is furnished in a hospital or health care facility or other more costly facility.

- The non-availability of a bed in another health care facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is Medically Necessary.
- A medical or Dental service or supply will not be considered to be Medically Necessary if it does not require the technical skills of a Dental or Health Care Practitioner or if it is furnished

mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Dental or Health Care Practitioner, hospital or health care facility.

**Non-Network:** See Out-of-Network Services.

**Non-Participating Provider:** A Health Care Provider who does not participate in the Plan's Preferred Provider Organization (PPO).

**Office Visit:** A direct personal contact between a Dentist or other Dental care practitioner and a patient in the Dental care practitioner's office for diagnosis or treatment associated with the use of the appropriate Office Visit code in the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirement of such CDT coding.

**Onlay:** An Inlay Restoration that is extended to cover the biting surface of the tooth, but not the entire tooth. It is often used to restore lost and weakened tooth structure.

**Oral Surgery:** The specialty of dentistry concerned with surgical procedures in and about the mouth and jaw.

**Orthodontics, Orthodontia:** The science of the movement of teeth in order to correct a malocclusion or "crooked teeth."

**Orthognathic Services:** Services dealing with the cause and treatment of malposition of the bones of the jaw, such as Prognathism, Retrognathism or TMJ Syndrome. See the definitions of Prognathism, Retrognathism and TMJ.

**Out-of-Network, Out-of-Network Services (Non-Network):** Services provided by a Health Care Provider that is not a member of the Plan's Preferred Provider Organization (PPO), as distinguished from In-Network Services that are provided by a Health Care Provider that is a member of the PPO. Greater expense could be incurred by the Participant when using Out-of-Network Providers.

**Outpatient Services:** Services provided either outside of a hospital or health care facility setting or at a hospital or health care facility when room and board charges are not incurred.

**Partial Denture:** A Prosthesis that replaces one or more, but less than all, of the natural teeth and associated structures. The Denture may be Removable or fixed.

**Participating Provider:** A Health Care Provider who participates in the Plan's Preferred Provider Organization (PPO).

**Periodontal Disease:** Means bacterial gum infections that destroy gum tissue and supporting bone that hold teeth in place.

**Pharmacy:** A licensed establishment where covered Prescription Drugs are filled and dispensed by a Pharmacist licensed under the laws of the state where he or she practices.

**Pharmacist:** A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, Compound and dispense drugs and medicines, and who acts within the scope of his or her license.

**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 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.

**Plan Year Deductible:** The amount You must pay each Plan Year before the Plan pays Benefits.

**Plan Year Maximum Benefits:** The maximum amount of Benefits payable each Plan Year for certain Dental expenses incurred by any covered Plan Participant (or any covered family member of the Plan Participant) under this Plan.

**Plan Participant; Participant:** The Employee or Retiree or their enrolled Spouse or Domestic Partner or Dependent Child(ren) or a surviving Spouse of a Retiree.

**Pontic:** The part of a fixed Bridge that is suspended between two abutments and replaces a missing tooth.

**Post-Service Claim:** Means any Claim for Benefits under a Health Benefit Plan regarding payment of Benefits that is not considered a Pre-Service Claim or an Urgent Care Claim.

**Preferred Provider Organization (PPO):** A group or network of Health Care Providers (*e.g.*, hospitals, physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted/reduced rates.

**Pre-Service/Dental Pre-Estimate:** Means any estimate for Benefits under a Health Benefit Plan with respect to which the terms of the Plan condition receipt of the Benefit, in whole or in part, on approval of the Benefit in advance of obtaining Dental care.

**Prescribed for a Medically Necessary Indication:** The term medically accepted indication means any use of a covered Outpatient drug which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the following compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, the DRUGDEX Information System or American Medical Association Drug Evaluations.

**Prescription Drugs:** For the purposes of this Plan, Prescription Drugs include:

1. **Federal Legend Drugs:** Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
2. **Other Prescription Drugs:** Drugs that require a prescription under state law but not under federal law.
3. **Compound Drugs:** Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

**Prognathism:** The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

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

**Prophylaxis:** The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth is performed by a Dentist or Dental Hygienist.

**Prosthesis (Dental):** An artificial replacement of one or more natural teeth and/or associated structures.

**Prosthetic Appliance (Dental):** A Removable device that replaces a missing tooth or teeth.

**Provider:** See the definition of Health Care Provider.

**Removable:** A Prosthesis that replaces one or more teeth and which are held in place by clasps. The patient can remove the Prosthesis.

**Restoration:** A broad term applied to any filling, Crown, Bridge, Partial Denture or complete Denture that restores or replaces loss of tooth structure, teeth or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape and function of part or all of the tooth or teeth.

**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.

**Retrognathism:** The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face.

**Root Canal (Endodontic) Therapy:** Treatment of a tooth having damaged pulp. The treatment is usually performed by completely removing the pulp, sterilizing the pulp chamber and Root Canals, and filling these spaces with a sealing material.

**Root Planning and Scaling:** Also known as conventional periodontal therapy, non-surgical periodontal therapy, or deep cleaning, is the process of removing or eliminating Dental plaque and calculus, which cause inflammation.

**Service Area:** The geographic area serviced by the In-Network Health Care or Dental Providers who have agreements with the Plan's PPO networks. Refer to the Participant contact guide for additional information regarding the PPO networks.

**Sound and Natural Teeth:** Natural Teeth (not Dentures, Bridges, Pontics or artificial teeth) that are free of active or chronic clinical decay; and have at least 50% bony support; and are functional in the arch; and have not been excessively weakened by previous Dental procedures.

**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.

**Subrogation:** This is a technical legal term for the right of one party to be substituted in place of another party in a lawsuit. See the Third Party Liability section of this document for an explanation of how the Plan may use the right of Subrogation to be substituted in place of a covered individual in that person's claim against a third party who wrongfully caused that person's injury or illness, so that the Plan may recover medical Benefits paid if the covered individual recovers any amount from the third party either by way of a settlement or judgment in a lawsuit.

**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.

**Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome:** The Temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ dysfunction or Syndrome refers to a variety of symptoms where the cause is not clearly established, including (but not limited to) masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking); myofascial pain, headaches, earaches, limitation of the joint, clicking sounds during chewing; tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such



as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting Dentures, or internal derangement of the TMJ.

**Topical:** Painting the surface of teeth, as in a Fluoride treatment or application of a cream-like anesthetic formula to the surface of the gum.

**Tortfeasor:** Means an individual or entity who commits a wrongful act, either intentionally or through negligence, that injures another and for which the law provides a legal right through a civil case for the injured person to seek relief.

**Usual and Customary Charge (U&C):** While Your medical or Dental Care Provider may charge whatever he feels his services are worth, the Plan has the right to determine what it will allow as the Usual and Customary Charge, sometimes referred to as Usual and Customary fee or allowable fee or prevailing fee. The Usual and Customary Charge for Medically Necessary services or supplies will be determined by the Claims Administrator or Plan Administrator and will be the lowest of:

- With respect to a PPO (In-Network) participating medical health care or Dental Care Provider, the fee set forth in the agreement between the PPO Network or the Claims Administrator or the Plan Administrator and the participating medical health care or Dental Care Provider. or
- The medical health care or Dental Care Provider's actual charge; or
- The usual charge by the medical health care or Dental Care Provider for the same or similar service or supply.
- For Out-of-Network medical or Dental services, no more than the 70<sup>th</sup> percentile of Fair Health. Fair Health is a national schedule of prevailing health care charges that is updated twice per year. Information regarding Fair Health is located on the PEBP website.
- For services provided by an Out-of-Network medical or Dental Care Provider that are not addressed by Fair Health, the Claims Administrator or the Plan Administrator may refer to the PPO (In-Network) fee schedule of the nearest (geographically) or the most prevalently used PPO Provider of the nearest (geographically) for the same or similar service when determining the Usual and Customary Charge by the Out-of-Network Provider.

The "prevailing charge" of most other health care or Dental Care Providers in the same or similar geographic area for the same or similar health care service or supply will be determined by the Claims Administrator using proprietary data that is provided by a reputable company or entity and is updated no less frequently than annually. The Plan will not always pay Benefits equal to or based on the health care or Dental Care Provider's actual charge for health care services or supplies, even after You have paid the applicable Deductible and Coinsurance. This is because the Plan covers only the Usual and Customary Charge for health care services or supplies. Any amount in excess of the Usual and Customary Charge does not count toward the Plan Year's Out-of-Pocket Maximum. The Usual and Customary Charge is sometimes referred to as the U & C Charge, the Reasonable and Customary Charge, the R & C Charge, the Usual, Customary and Reasonable Charge, or the UCR Charge. Note: to obtain the most current Usual and Customary amount, please contact PEBP's Claims Administrator, listed in the Participant Contact Guide in this document. You must provide the Claims Administrator with the specific procedure code,

Provider name and the zip code for the location where the procedure will take place. This service is only available to PEBP Plan Participants.

**NOTE:** The Claim Administrator has the discretionary authority to determine the Usual and Customary Charge based upon standards set forth by the Plan Administrator.

**Visit:** See the definition of Office Visit.

**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.