Introduction to Employee Benefits

Plan Year 2017

STATE OF NEVADA

***P**ublic* ***E**mployees'* ***B**enefits* ***P**rogram*

Plan Year 2017

- *Medical*
- *Dental*
- *Prescription Drug*
- *Vision*
- *Basic Life Insurance*
- *Long-term Disability Insurance*
- *Premium Rates*
- *Voluntary Products*

901 S. Stewart St., Suite 1001
Carson City, NV 89701
(775) 684-7000 or (800) 326-5496
Fax: (775) 684-7028
www.pebp.state.nv.us
mservices@peb.state.nv.us

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

State of Nevada

Public Employees' Benefits Program

Table of Contents

Welcome 1
Completing Enrollment 1
Start of Coverage 2
Dependent Eligibility 3
Summary of Supporting Eligibility Documents 4
Summary of Employee Benefit Options 5
New Hire Resources 6
Medical Plan Comparison 7
Pharmacy Plan Comparison 8
Consumer Driven Health Plan (CDHP) 9
Consumer Driven Health Plan Pharmacy Benefits 11
Diabetes Care Management Program 13
Obesity and Overweight Care Management Program 15
Health Savings Account (HSA) 18
Health Reimbursement Arrangement (HRA) 20
Hometown Health HMO Plan 21
Health Plan of Nevada 26
Dental Plan 32
Group Life and Long-Term Disability Insurance 33
Group Life Insurance Portability Conversion Options 35
State Active Rates 36
Non-State Active Rates, State Legislature and Military Leave Rates 38
State and Non-State COBRA Rates 39
Completing the Employee Benefit Enrollment and Change Form 40
Group Basic Life Insurance Beneficiary Designation 41
Voluntary Flexible Spending Accounts 42
Voluntary Life Insurance & Short Term Disability (STD) 44
Important Information About Your Coverage 45
PEBP Initial COBRA Notice—COBRA Notification Rights 47
Group Life and Long Term Portability.. 54
Contact List 55

This document is for informational purposes only. Any discrepancies between the information contained herein and the *Plan Year 2017 Master Plan Document/HMO Evidence of Coverage Certificates* shall be superseded by the plans' official documents.

Revised 12-13-2016

Welcome

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). PEBP provides a comprehensive benefit package to eligible employees offering medical, prescription drug, dental, vision, $25,000 basic life, and long-term disability insurance. In addition to these core benefits, employees enrolled in a PEBP medical plan are eligible to purchase voluntary products such as supplemental life insurance, short-term disability, long-term care and auto/homeowners' insurance. State employees may also enroll in Medical, Limited Purpose and Dependent Care Flexible Spending accounts.

The information contained herein is intended to provide a summary of the main features of the benefits available to eligible employees. For a detailed description of benefits, visit the PEBP website at www.pebp.state.nv.us.

Every effort has been made to ensure the accuracy of the information contained in this document. In the event of any discrepancies between the information in this document and the Master Plan Document or Evidence of Coverage applicable to each plan, the plan documents will govern. Should you have any questions regarding your benefits and/or eligibility contact the PEBP office at (775) 684-7000 or (800) 326-5496.

Completing Enrollment

As a new benefits-eligible employee you must enroll or decline coverage and submit any required supporting documents (if adding dependents) within 15 days after the first day of employment or no later than the last day of the month that coverage is scheduled to become effective.

Default Enrollment

Failure to enroll or decline coverage within the specified timeframe will result in your coverage being defaulted to the Consumer Driven Health Plan (CDHP) with a Health Reimbursement Arrangement (HRA) and self-only coverage. Employees enrolled in the CDHP will pay a monthly premium for that coverage.

Complete your enrollment by doing one of the following:

- **Enroll online**
  Go to www.pebp.state.nv.us and click on the "**Login**" button highlighted in orange at the top right of the webpage. After creating your User ID and Password, follow the instructions to complete your enrollment.

- **Complete the Employee Benefit Enrollment and Change Form (BECF)**
  If you do not have internet access, please contact PEBP to request the Employee Benefit Enrollment and Change Form at (775) 684-7000 or (800) 326-5496. Mail the completed BECF to the following address:

Public Employees' Benefits Program
901 South Stewart Street, Suite 1001
Carson City, NV 89701
Forms must be original. No copies or facsimiles accepted.

Start of Coverage

Employees working in a full-time position for a state agency or a participating non-state agency are eligible for benefits on:

- The first day of full-time employment, if that date is the first day of the month; or
- The first day of the month immediately following the first day of full-time employment, if the date of hire is not on the first day of the month.

Professional employees of the Nevada System of Higher Education (NSHE) who have annual employment contracts are eligible for benefits on:

- The effective date of an employee's respective employment contract, if that date is on the first day of a month; or
- The first day of the month immediately following the effective date of an employee's respective employment contract, if that date is not on the first day of a month.

Examples of Enrollment Requirements

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

Failure to Enroll When Eligible

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

New Hire Employee enrolled as a dependent child of a PEBP Participant

A dependent child of a PEBP primary participant who becomes eligible for PEBP benefits as a new hire may decline coverage as an "active employee" and retain coverage as a "dependent child" of a PEBP primary participant. If the new hire elects coverage as an employee rather than a dependent child, the employee shall be deleted as a dependent.

By declining coverage as an employee, you are also declining all PEBP-sponsored benefits including Long-Term Disability and Basic Life Insurance benefits.

Note: A spouse or domestic partner who becomes eligible for PEBP coverage as an employee must enroll as an employee and cannot be covered as a dependent of another PEBP primary participant.

Dependent Eligibility

A dependent of two PEBP participants cannot be covered under more than one PEBP medical plan at the same time.

A child that is covered as a dependent under a PEBP participant who becomes eligible for PEBP coverage as a primary participant may enroll as a primary participant or waive primary participant coverage and remain as a dependent of another PEBP primary participant's plan.

Child to age 26

Children may be covered from birth through the last day of the month in which the child reaches age 26 (regardless of the child's marital status).

For eligibility purposes, children are defined as a participant's biological child, step-child, child of a registered domestic partner, legally adopted child, and a child for whom the participant has assumed a legal obligation for total or partial support in *anticipation* of adoption.

Legal guardianship

An unmarried child who is under age 19 and under a permanent legal guardianship may be enrolled as a dependent. To continue coverage after age 19 (to age 26), the child must be unmarried, either reside with the participant or is enrolled as a full-time student at an accredited institution and satisfy the following conditions:

1. Is eligible to be claimed as a dependent on the federal income tax return of the participant or his spouse/domestic partner for the preceding calendar year; and
2. Dependent is a grandchild, brother, sister, step-brother, step-sister, or descendent of such relative.

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

Disabled child

A child of any age with a disability, mental illness or intellectual, or other developmental disability who is incapable of self-support, provided such condition occurs before age 26. The participant must provide evidence of the disability and evidence that the condition occurred before age 26.

Spouse or domestic partner

A spouse or domestic partner who is eligible for other employer-group health coverage is not eligible for coverage under this plan.

Exceptions may apply if the employer-group health coverage is determined to be significantly inferior. Significantly inferior plans offer limited benefits such as a mini-med plan or a catastrophic plan with a $5,000 or greater individual deductible and the plan is not coupled with a HSA or HRA.

The above is only a summary of the eligibility requirements for dependents. For complete details, view the Master Plan Document for the PEBP Enrollment and Eligibility available at www.pebp.state.nv.us.

Summary of Supporting Eligibility Documents

Dependent Type	Social Security Number	Marriage Certificate	Birth Certificate	Hospital Birth Confirmation	Adoption Decree	Nevada Certification of Domestic Partnership	Legal Permanent Guardianship Signed by a Judge	Physician's Disability Certification
Newborn Child	√		√	√				
Child - Birth to age 26	√		√					
Adopted Child	√		√		√			
Permanent Legal Guardianship of a Child	√		√				√	
Stepchild	√	√	√					
Domestic Partner's Child	√		√			√		
Domestic Partner's Adopted Child	√		√		√	√		
Disabled Child	√		√					√
Disabled Stepchild	√	√	√					√
Domestic Partner's Disabled Child	√		√			√		√
Spouse*	√	√						
Domestic Partner*	√					√		

*If you are adding a spouse/domestic partner who is eligible for employer group health care coverage through their own employer, you must provide the other plan's Summary Plan Document indicating that the other plan offers significantly inferior coverage e.g., limited benefits (mini-med) plan or a catastrophic plan with a $5,000 or greater individual deductible and the plan is not coupled with a Health Savings Account or Health Reimbursement Arrangement.

All foreign documents must be translated to English.

The list above is not exhaustive. To view a complete list of supporting document requirements, refer to the PEBP Enrollment and Eligibility Master Plan Document available at www.pebp.state.nv.us. Note: PEBP reserves the right to request additional documentation as required to establish dependent eligibility.

Summary of Employee Benefit Options

	State Employee	Non-State Employee	Active Legislator
Medical Plan Options			
Consumer Driven Health Plan (CDHP) with HSA or HRA	√	√	√
Health Plan of Nevada (Southern Nevada HMO) available in Clark, Esmeralda and Nye Counties	√	√	√
Hometown Health Plan (Northern Nevada HMO)	√	√	√
Dental Benefits			
Dental Plan	√	√	√
Voluntary Insurance Options			
Short-term Disability Insurance	√	√	√
Home and Auto Insurance	√	√	√
Health Care Flexible Spending	√		√
Dependent Care Flexible Spending	√		√
Voluntary Life Insurance	√	√	√
Voluntary Long-Term Care Insurance	√	√	√

Summary of Benefits and Coverage Document (SBC)

The SBC provides a summary of the key features of the benefits of each health plan option such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

To view the SBC for the Consumer Driven Health Plan, Hometown Health Plan or Health Plan of Nevada visit www.pebp.state.nv.us or contact PEBP for a hardcopy at (775) 684-7000 or (800) 326-5496 or by email at mservices@peb.state.nv.us.

New Hire Resources

www.pebp.state.nv.us

To learn more about your medical, pharmacy, dental and voluntary benefits, visit the PEBP website at www.pebp.state.nv.us	
Plan Documents	• Consumer Driven Health Plan • Health Plan of Nevada • Hometown Health Plan • Enrollment and Eligibility • Wellness Benefits Summary • Summary of Benefits and Coverage - Individual and Family • Flexible Spending Account Summary Plan Description • PPO Dental Plan • Glossary of Medical Terms • Basic Life, Long Term Disability, Voluntary Life and Short Term Disability Insurance
Providers	• Statewide PPO Network (Consumer Driven Health Plan) • First Health National Network (Consumer Driven Health Plan • Express-Scripts (Pharmacy Benefit Manager - Consumer Driven Health Plan • Health Plan of Nevada • Hometown Health Plan • Diversified Dental (PPO Dental Network)
Resources	• FAQs • How-To Information • New Hire Resources • Forms • Newsletters • Publications

Medical Plan Comparison

Benefit Category	Consumer Driven Health Plan	Health Plan of Nevada	Hometown Health Plan
	Amount You Pay In-Network	**Amount You Pay In-Network**	**Amount You Pay In-Network**
Medical Deductible	$1,500 Individual Deductible $3,000 Family Deductible • $2,600 Individual Family Member Deductible	No Deductible	No Deductible
Annual Out-of-pocket Maximum	$3,900 Individual $7,800 Family • $6,850 Individual Family Member Out-of-Pocket Maximum (per plan year)	$6,000 Individual $12,000 Family (per calendar year)	$6,600 Individual $13,200 Family (per plan year)
Hospital Inpatient	20% Coinsurance after Deductible	$300 Copayment per admission	$500 Copayment per admission
Outpatient Same Day Surgery	20% Coinsurance after Deductible	$50 Copayment per admission	$350 Copayment per admission
Primary Care Visit	20% Coinsurance after Deductible	$15 Copayment	$25 Copayment
Specialist Visit	20% Coinsurance after Deductible	$25 Copayment	$45 Copayment
Urgent Care Visit	20% Coinsurance after Deductible	$30 Copayment	$50 Copayment
Emergency Room Visit	20% Coinsurance after Deductible	$150 Copayment	$300 Copayment
Laboratory Services *Performed at independent facility*	20% Coinsurance after Deductible	$0 Copayment	$0 Copayment
Chiropractic Services	20% Coinsurance after Deductible	$25 Copayment	$45 Copayment
Wellness/Prevention	No charge for eligible wellness benefits provided in-network	No charge	No charge
Vision Exam*	Covered at 100% of U&C, $120 allowance (one exam per plan year)*	$10 Copayment every 12 months	$15 Copayment every 12 months
Hardware (frames, lenses, contacts)	No Benefit	$10 Copayment for glasses ($100 allowance) or contacts in lieu of glasses ($115 allowance)	Frames:35% off retail price standard plastic lenses: $50 to $135 Copayment depending on lens type; conventional contact lenses: 15% off retail

*PEBP does not maintain a network specific to vision care. Out-of-network providers will be paid at Usual and Customary (U&C). One annual vision exam, maximum annual benefit $120 per plan year.

Usual and Customary Charge (U&C): The charge for medically necessary services or supplies as determined by HealthSCOPE Benefits to be the prevailing charge of most other health care providers in the same or similar geographic area for the same or similar health care service or supply.

For Plan Limitations and Exclusions, refer to the CDHP Master Plan Document or the HMO Evidence of Coverage Certificates available at www.pebp.state.nv.us.

Pharmacy Plan Comparison

Benefit Category	Consumer Driven Health Plan	Health Plan of Nevada	Hometown Health Plan
	Amount You Pay In-Network	**Amount You Pay In-Network**	**Amount You Pay In-Network**
Plan Deductible (applies to both medical and pharmacy benefits)	$1,500 Individual $3,000 Family • $2,600 Individual Family Member Deductible	No Deductible	No Deductible
Annual Out-Of-Pocket (OOP) Maximum* (applies to both medical and pharmacy benefits)	$3,900 Individual $7,800 Family • $6,850 Individual Family Member Out-of-Pocket Maximum (per plan year)	$6,000 Individual $12,000 Family (per calendar year)	$6,600 Individual $13,200 Family (per plan year)
Retail Pharmacy - 30 day supply			
Formulary Preferred Generic	20% after Deductible	$7 Copayment	$7 Copayment
Formulary Preferred Brand	20% after Deductible	$35 Copayment	$40 Copayment
Non-Formulary	100% of contracted price (non-formulary will drugs will not apply to Deductible or Out-of-Pocket Maximum)	$55 Copayment	$75 Copayment or 40% whichever is greater
Mail Order - 90 day supply			
Formulary Preferred Generic	20% after Deductible	$17.50 Copayment	$14 Copayment
Formulary Preferred Brand	20% after Deductible	$87.50 Copayment	$80 Copayment
Non-Formulary	100% of contracted price (non-formulary will drugs will not apply to Deductible or Out-of-Pocket Maximum)	$137.50 Copayment	Greater of $150 Copayment per script or 40% Coinsurance

Specialty Medications Mail Order - 30 day supply			
Formulary Preferred Generic **Formulary Preferred Brand** **Non-Formulary**	20% after Deductible - available in 30 day supply only through Accredo (Specialty Pharmacy)	Applicable 30 day retail Copay above will apply for Generic, Brand-name and Non-Formulary	30% Coinsurance

Consumer Driven Health Plan
Plan Benefits

Plan Category	Amount You Pay (for eligible health care services when using In-Network providers)
Plan Deductible (medical & pharmacy expenses apply to plan deductible)	$1,500 Individual Deductible $3,000 Family Deductible • $2,600 Individual Family Member Deductible
Annual Out-Of-Pocket (OOP) Maximum (medical & pharmacy expenses apply to annual OOP maximum)	$3,900 Individual $7,800 Family • $6,850 Individual Family Member (per plan year)
Hospital Inpatient Admission	20% Coinsurance after Deductible
Outpatient Same Day Surgery	20% Coinsurance after Deductible
Primary Care Visit	20% Coinsurance after Deductible
Doctor on Demand (video consultation with physicians/psychologists) Medical Visit Psychologist Visit	 $40 Copay per visit $50 Copay for a 25 minute appointment or $95 Copay for a 50 minute appointment
Specialist Visit	20% Coinsurance after Deductible
Urgent Care Visit	20% Coinsurance after Deductible
Emergency Room Visit	20% Coinsurance after Deductible
Laboratory Services	20% Coinsurance after Deductible • Outpatient laboratory services (except for pre-admission testing, urgent care facility or emergency room) performed at an acute care hospital will not be covered unless an exception is warranted and approved by the Plan Administrator. • If an outpatient laboratory facility or draw station is not available to you within 50 miles of your residence, you may use an acute care hospital to receive your outpatient laboratory services.
Chiropractic Services	20% Coinsurance after Deductible
Wellness/Prevention	No charge for eligible wellness benefits provided in-network
Vision Exam *No benefit for hardware (frames, glasses, contacts)	Covered at 100% of U&C, $120 allowance (one exam per plan year)

****Usual and Customary Charge (U&C):** The charge for medically necessary services or supplies as determined by HealthSCOPE Benefits to be the prevailing charge of most other health care providers in the same or similar geographic area for the same or similar health care service or supply.

Note: The CDHP maintains separate deductibles and out-of-pocket maximums for in-network and out-of-network providers. In-and out-of-network deductibles and out-of-pocket maximums are not combined to reach your plan year deductible and out-of-pocket maximum. For Plan information, limitations and exclusions, refer to the CDHP Master Plan Document or the HMO Evidence of Coverage Certificates available at www.pebp.state.nv.us.

Consumer Driven Health Plan
Wellness/Preventive Benefits

The Consumer Driven Health Plan provides wellness/preventive screening tests such as colonoscopies, hearing tests, skin cancer examinations, hypertension evaluation, and more. To receive this benefit, participants must access wellness/preventive care benefits using in-network providers. For a comprehensive list of wellness/preventive care benefits, refer to the Plan Year 2017 Medical, Vision and Prescription Drug Master Plan Document and the Wellness Benefits Document at www.pebp.state.nv.us.

Plan Feature	In-Network (participating provider)	Out-of-Network Benefit
Prevention/Wellness Benefit Examples of Preventive Wellness Screenings: • Physical exam, screening lab, and x-rays • Well child visits and services • HPV Vaccination • Prostate screening • Routine sigmoidoscopy or colonoscopy • Adult immunizations • Screening mammograms (in the absence of a diagnosis) • Pelvic exam and Pap smear lab test • Osteoporosis screening • Hypertension screening • Skin Cancer screening • Routine hearing exam • Medically supervised weight loss • Stress management For an expanded list of covered preventive/wellness services, please refer to the Plan Year 2017 CDHP Wellness Benefits Document available at www.pebp.state.nv.us.	100% - No Deductible	Not covered

Consumer Driven Health
Pharmacy Benefits

Benefit Category	Amount You Pay In-Network
Plan Deductible (medical & pharmacy expenses apply to plan deductible)	$1,500 Individual $3,000 Family • $2,600 Individual Family Member Deductible
Annual Out-Of-Pocket (OOP) Maximum (medical & pharmacy expenses apply to annual OOP maximum)	$3,900 Individual $7,800 Family • $6,850 Individual Family Member (per plan year)
Retail Pharmacy - 30 day supply	
Tier I: Formulary Generic Drug	20% after Deductible
Tier 2: Formulary Brand-name Drug	20% after Deductible
Tier 3: Non-Formulary Drug	100% of contracted price (non-formulary drugs will not apply to Deductible or Out-of-Pocket Maximum unless prior authorization on file with Express Scripts).
Express Scripts Mail Order - 90 day supply	
Tier 1: Formulary Generic Drug	20% after Deductible
Tier 2: Formulary Brand-name Drug	20% after Deductible
Tier 3: Non-Formulary Drug	100% of contracted price (non-formulary drugs will not apply to Deductible or Out-of-Pocket Maximum)

Accredo Specialty Pharmaceuticals - 30 day supply	
Tier 1: Formulary Generic Drug	20% after Deductible
Tier 2: Formulary Brand-name Drug	20% after Deductible
Tier 3: Non-Formulary	100% of contracted price (non-formulary drugs will not apply to Deductible or Out-of-Pocket Maximum unless prior authorization on file with Express Scripts).

Consumer Driven Health Plan
Pharmacy Benefits

Retail Drugs

The prescription drug plan allows you to obtain a 30-day supply at any in-network retail pharmacy. You may also purchase a 90-day supply of maintenance medications at your local in-network retail pharmacy. You can determine the cost of your medication or the location of an in-network pharmacy by calling Express Scripts at (855) 889-7708 or by visiting www.Express-Scripts.com.

Mail Order Prescription Drug Service

The CDHP prescription drug mail order program is administered by Express Scripts Home Delivery. By using this service you will typically pay less when you purchase a 90-day supply of maintenance medications. Maintenance medications include non-emergency, extended use prescriptions such as those used for high blood pressure, lowering cholesterol, controlling diabetes or birth control.

Express Scripts' Home Delivery offers:

- Exclusive 24-hour access to pharmacists.
- Specialist pharmacists who are trained and experienced in the medications used to treat specific conditions.
- Safety alerts if a new prescription may cause harmful interactions with other medications you are taking.
- Automatic refill reminders by email or by mobile app so you never run out.
- Tips to make taking your medicine easier.

To determine whether your medication will cost less when purchased through mail order or through retail, contact Express Scripts at (855) 889-7708 or login to www.Express-Scripts.com.

Specialty Medications

The CDHP Specialty Drug Pharmacy is Accredo. Specialty medications are prescribed for individuals with a chronic or difficult health condition, like multiple sclerosis or rheumatoid arthritis. Specialty drugs typically require special handling, administration or monitoring. Specialty drugs require prior authorization and are limited to a 30-day supply. For information about Specialty Medications or for a list of Specialty Medications, contact Accredo (see Vendor Contact List).

Diabetic Supplies Mail Order Program

The preferred Diabetic Supplies Mail Order Program is for participants enrolled in the CDHP and the Diabetes Care Management Program. The Diabetic Supplies Mail Order Program allows members to receive up to a 90-day supply of diabetic supplies; not subject to deductible or coinsurance requirements. Diabetic supplies include blood glucose monitors, test strips, insulin, syringes, alcohol pads, and lancets. The Diabetes Supplies Mail Order Program is administered by Express Scripts. Diabetic supplies through this program are subject to a $50 copayment for each 90-day supply item. To enroll in this program, contact Express Scripts at (855) 889-7708.

Note: To qualify for this program, you must be enrolled in the Diabetic Care Management Program.

Consumer Driven Health Plan
Diabetes Care Management Program

Opt-In Program - Accompanied with Benefit Enhancements

The Diabetes Care Management Program is a voluntary "opt-in" program. Participants and their covered dependents with diabetes or who receive a diagnosis of diabetes at any time during a plan year are eligible to enroll in this program.

To receive the following benefit enhancements the member must be actively engaged and accept regular telephonic engagement calls with PEBP's Utilization Management Company and maintain a treatment plan as prescribed by your physician to include regular office visits, lab work, blood glucose monitoring, etc.

- Two (annual) physician office visits indicating a primary diagnosis of diabetes will be paid under the wellness benefit; not subject to deductible or coinsurance.
- Two (annual) routine laboratory blood services such as a hemoglobin (A1c) test will be paid under the wellness benefit without deductible or coinsurance.
- Diabetes related medications such as Metformin will be eligible for copayments and not subject to the plan year deductible.

Diabetes Pharmacy Benefit Enhancement

Generic and Preferred Brand drugs are not subject to deductible or coinsurance when using in-network pharmacies; flat copayment amounts will apply. Copayments will not apply to deductible or Out-of-Pocket Maximum.

Tier	Retail 30 day Supply	Mail order 90 day Supply
Tier 1: Generic	$5 Copayment (no deductible)	$15 Copayment (no deductible)
Tier 2: Preferred Brand	$25 Copayment (no deductible)	$75 Copayment (no deductible)
Tier 3: Non-Preferred Brand	100% of the drug cost (deductible credit will not apply)	100% of the drug cost (deductible credit will not apply)

- To view or download the Preferred Drug List (formulary) or locate an in-network pharmacy, visit www.Express-Scripts.com or contact Express Scripts (see Vendor Contact List).
- Express Scripts Prior Authorization (PA) Program is designed to manage the utilization of drugs that are relatively expensive, has significant potential for misuse and/or requires close monitoring because of potentially serious side effects. The PA Program requires approval from Express Scripts' Prior Authorization Team before the drug is covered. PA approval is usually contingent upon documentation of specific diagnosis, dosing regimen, intolerance, and other clinical characteristics that makes the drug medically necessary. The prescribing physician can contact Express Scripts at (855) 889-7708 for more information.

Note: Copayments for Tier 1 and Tier 2 diabetes medications do not apply to the deductible; however, once the annual out-of-pocket maximum has been met, the plan will pay 100% for Tier 1 and Tier 2 diabetes medications.

Consumer Driven Health Plan

Diabetes Care Management Program

Diabetic Supplies Program

Administered by Express Scripts Home Delivery (855) 889-7708

Diabetic Supplies coordinated through Express Scripts Home Delivery (Preferred Mail Order) is focused on helping you achieve appropriate control of your diabetes through consistent blood glucose self-monitoring, support and education.

Program Benefits:

- Convenient affordable home delivery of your diabetic testing supplies by offering a 90-day supply for one copayment for each 90-day supply item; and
- Telephone access to diabetes educators, pharmacists, and dieticians.

Covered Supplies:	• Home Blood Glucose Monitor • Blood Glucose Test Strips • Lancets	• Spring-Powered device for Lancets • Syringes • Alcohol Pads	$50 Copay applies to each 90 day supply item. If the actual cost is less, you pay the actual cost. No cost for the blood glucose monitor.

Diabetic supplies must be filled through the Express Scripts Home Delivery Pharmacy to receive the benefit. To order your supplies, call (855) 889-7708 or visit www.Express-Scripts.com.

When you join the Diabetes Care Management Program, your effective date will be the 1st of the month following your enrollment in the program. The effective date will be determined by PEBP's Utilization Management Company and PEBP.

To learn more or to participate in this program, please contact Hometown Health Providers at (775) 982-3232 or (888) 323-1461.

Consumer Driven Health Plan
Obesity and Overweight Care Management Program

The Obesity and Overweight Care Management Program is a voluntary “opt-in” program open to primary CDHP participants and their covered dependents who have been diagnosed as obese or overweight by a physician.

Obesity and Overweight Care Management is offered as a medically supervised weight loss program for CDHP participants and their covered dependents who meet certain eligibility criteria. The program provides benefits for nutritional counseling, weight-loss medications, and meal replacement therapy with certain restrictions. For eligibility requirements, refer to the Obesity and Overweight Care Management section of the Plan Year 2017 Medical, Vision and Prescription Drug Master Plan Document available at www.pebp.state.nv.us.

Tier	Retail 30 day Supply	Mail order 90 day Supply
Tier 1: Generic	$5 Copayment (no deductible)	$15 Copayment (no deductible)
Tier 2: Preferred Brand	$25 Copayment (no deductible)	$75 Copayment (no deductible)
Tier 3: Non-Preferred Brand	100% of the drug cost (deductible credit will not apply)	100% of the drug cost (deductible credit will not apply)

- Medications for obesity or overweight management will be identified by Express Scripts. Before you begin your medication weight loss treatment, please contact Express Scripts at (855) 889-7708 to make sure the medication your provider has prescribed is covered under this program.

Note: Copayments for Tier 1 and Tier 2 Obesity and Overweight medications are not applied to deductible or annual out-of-pocket maximum

Doctor on Demand

Video consultation with board-certified physicians/psychologists

Telemedicine services include assessment, diagnosis and prescriptions when necessary. With Doctor on Demand, you can receive treatment from a board-certified physician for things like cold and flu, sore throat, UTIs, skin issues and rashes, diarrhea and vomiting, eye issues, sports injuries, travel illness, and smoking cessation. Telemedicine services also include mental health care with psychologists for issues such as depression, anxiety and/or mood changes.

The copay for Doctor on Demand is not subject to deductible. The cost for a medical visit is $40 and the copay for a psychologist visit is $50 for a 25 minute appointment and $95 for a 50 minute appointment. CDHP participants can learn how to download the Doctor on Demand app by visiting: https://pebp.state.nv.us/wp-content/uploads/2016/04/DOD_Registration_Visit_Process_Guide.pdf

Consumer Driven Health Plan

First Health
The First Health preferred provider network is the CDHP's national network for participants residing outside Nevada or Nevada residents who wish to access health care outside Nevada. Providers in the First Health network accept the PPO negotiated amounts in place of their standard charges for covered services. Out-of-pocket costs are lower when medical services or supplies are received from in-network PPO providers. To locate a First Health network, call (800) 226-5116 or search for providers online at www.pebp.state.nv.us.

Wise Provider Network
The Wise Provider Network covers members who use the Wise Network in Utah, Idaho, Arizona, Colorado, Oregon, Nevada and Wyoming.

Pre-certification Review
Pre-certification reviews are completed before certain medical services are provided to assure the services meet medical necessity criteria. For more information regarding the pre-certification provisions, refer to the Plan Year 2017 Medical, Vision and Prescription Drug Master Plan Document at www.pebp.state.nv.us.

Case Management
The process whereby the patient, the patient's family, physician and/or other health care providers, and PEBP work together under the guidance of the plan's independent utilization management company to coordinate a quality, timely and cost-effective treatment plan.

Diabetes Care Management Program
The Diabetes Care Management Program is administered by Hometown Health Providers and is available to all primary CDHP participants and their covered spouses/domestic partners, and children with diabetes. Participants who are diagnosed with diabetes and who are *actively engaged* in the Diabetes Care Management Program are eligible to receive benefit enhancements on diabetes related medications.

CDHP Pharmacy Plan
The pharmacy benefit manager for the CDHP is Express Scripts. The prescription drug benefit is subject to deductible. This means, you will pay 100% of the cost of the in-network discounted amount for prescription drugs listed on the Express Scripts drug formulary until you meet your deductible. For information about the prescription drug program, refer to the Plan Year 2017 Medical, Vision and Prescription Drug Master Plan Document at www.pebp.state.nv.us.

Prior Authorization (PA)
Medications that require prior authorization should be reviewed by Express Scripts prior to purchase to ensure that you do not incur additional expenses in addition to the required copayment or deductible. The prior authorization process may be started by your provider, pharmacist as well as yourself. Express Scripts will fax the prior authorization to your provider. After the form is completed and faxed back by your provider, Express Scripts will review the criteria based on the CDHP's prescription drug benefits. For information regarding prior authorizations, contact Express Scripts at (855) 889-7708.

Consumer Driven Health Plan

Consumer Driven Health Plan (CDHP)

The Consumer Driven Health Plan consists of a PPO network of doctors and health care facilities who agree to provide medical services at discounted rates. Claims are submitted for the services you receive and you pay 100% of the discounted amount until the deductible has been met, then you pay 20% (in-network) for the cost of most services up to the annual out-of-pocket maximum. Participants may access health care services from any provider; however, the out-of-pocket costs are lower when using PPO network providers.

Each year, before the plan begins to pay benefits, you are responsible for paying all of your eligible medical and prescription drug expenses up to the plan year deductible. Eligible medical and prescription drug expenses are applied to the deductibles in the order in which claims are received by the plan. Only eligible medical and prescription drug expenses can be used to satisfy the plan deductible. Deductibles accumulate on a plan year basis and reset to zero at the start of each new plan year beginning July 1st.

Plan Year Deductible

The CDHP features a $1,500 individual (participant only coverage tier) deductible. For participants with family coverage (one or more covered dependents) there is a $3,000 family deductible. The family deductible includes a $2,600 individual family member deductible (IFMD). With the IFMD, the plan will pay benefits for one individual in the family once that person meets the $2,600 IFMD. The balance of the family deductible ($400) may be met by one or more remaining family member(s).

Plan Year Medical Out-of-Pocket Maximum

The annual in-network out-of-pocket maximum is $3,900 for an individual. The annual in-network out-of-pocket maximum for a family is $7,800. (The family out-of-pocket maximum also includes an embedded $6,850 “individual family member” out-of-pocket Maximum.) Note: Premiums paid by the participant are not included in the out-of-pocket maximum.

Once the out-of-pocket maximum has been met (through deductible and coinsurance) the plan will pay 100% of eligible expenses for the remainder of the plan year. Note: A single individual within a family will never pay more than the “individual family member out-of-pocket maximum” for eligible health care expenses provided in-network.

Statewide PPO Network

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

Health Savings Account (HSA)

For Eligible Active Employees Enrolled in the CDHP

Health Savings Accounts (HSA) are similar to Individual Retirement Accounts (IRAs), but for health care. However, unlike an IRA, HSA distributions are tax-exempt when used to pay qualifying health care expenses. The HSA is an interest bearing account and investment options are available for account balances in excess of $2,000. Employees who wish to contribute to their HSA may do so through pre-tax payroll deductions. Election amounts may be modified at any time throughout the year.

- Employee contributions are excluded from gross income, lowering total taxable income.
- The account balance remains with the employee at termination, retirement, declination of coverage, change of coverage to an HMO, and in the event of death may generally be passed to a beneficiary(ies).
- Interest and investment earnings are tax free and amounts used for qualifying health care expenses are also tax free. Note: HSA funds withdrawn for purposes other than qualified health care expenses may be taxable and subject to a 20% excise penalty.
- Employees 55 years or older by December 31st of the current tax year may contribute $1,000 in excess of the regular IRS calendar year limit.
- HSAs must be established as individual accounts; IRS does not allow joint accounts. However, HSAs may be used to pay for qualifying health care expenses for other members of the tax-family, whether or not they are covered on an employee's health plan.
- No administrative fees for eligible employees.
- Investment options for account balances in excess of $2,000.

You must meet certain eligibility requirements to establish and contribute to an HSA.

- You must be an active employee enrolled in the CDHP
- You cannot have secondary coverage unless your secondary coverage is also a high deductible health plan
- You cannot be claimed on another person's tax return (excludes joint returns)
- Your spouse (if applicable) cannot have a Medical FSA or HRA that can be used to pay for your out-of-pocket medical expenses
- You cannot be enrolled in Medicare or COBRA
- If you do not qualify for an HSA at initial enrollment or on the first day of the Plan Year (July 1), you cannot change from an HRA to an HSA mid-year.
- If you are enrolled in Medicare, you cannot establish or contribute to an HSA.

IMPORTANT

Section 326 of the USA PATRIOT Act requires financial institutions to verify the identity of each employee who opens a Health Savings Account (HSA). If an employee's identity cannot be verified, the employee will be required to provide additional documentation to establish their identity. If additional verification is not provided within 14 days of the employee's health coverage effective date, the HSA will not be opened. Failure to comply with the identity verification requirement within the stated timeframe will result in the conversion from an HSA to a Health Reimbursement Arrangement (HRA) for the remainder of the plan year. The next opportunity to establish an HSA will be during the open enrollment period for the subsequent plan year.

Health Savings Account (HSA) Contribution

For Eligible State and Non-State Active Employees Enrolled in the CDHP

Participants enrolled in the CDHP on July 1, 2016 receive the *Base Contribution and a One-Time Supplemental Contribution* as shown below:

Employees Enrolled in the CDHP Effective July 1, 2016	Base Contribution	One-time Supplemental Contribution	Total Contribution
Participant Only	$700	$400	$1,100
Per Dependent (maximum 3 dependents)	$200	$100	$300

Participants and covered dependents enrolled in the CDHP on August 1, 2016 and later receive a pro-rated *Base Contribution* that is determined by the coverage effective date and the remaining months in the plan year.

Calendar Year 2016 HSA Contribution Limits

Calendar Year 2016 Maximum Contribution Allowed by the Internal Revenue Service (IRS)	Individual	Family (two or more family members)
The maximum shown is for eligible HSA individuals with high deductible health coverage through December 31, 2016	$3,350	$6,750

- The total calendar year 2016 contributions (combined employee/employer) cannot exceed the limits shown above.
- To be eligible for the family maximum, the employee and at least one tax dependent must be eligible for the HSA.
- Employees who have Medicare or other secondary coverage that is not considered a high deductible health plan are not eligible to establish or contribute to an HSA.

HSA holders can choose to save up to $3,350 for an individual and $6,750 for a family. (HSA holders 55 and older can save an extra $1,000 which means $4,350 for an individual and $7,750 for a family) - these contributions are 100% tax deductible from gross income.

Health Reimbursement Arrangement (HRA)

For Eligible State and Non-State Active Employees Enrolled in the CDHP

The Health Reimbursement Arrangement (HRA) is an employer-owned account established on behalf of employees enrolled in the CDHP who are not eligible for the HSA.

PEBP contributes funds to the HRA on behalf of eligible employees. HRAs are pass-through accounts and are owned by PEBP; employee contributions are not allowed. HRA funds may be used to pay for qualified healthcare expenses for both the employee and the employee's tax dependents. If the participant is no longer covered under the CDHP (terminates employment, declines coverage or passes away) or converts from an HRA to an HSA, any remaining funds in the HRA are returned to PEBP.

For more information regarding the HRA, please refer to the Plan Year 2017 Medical, Vision and Prescription Drug Master Plan Document located at www.pebp.state.nv.us.

Employees enrolled in the CDHP (who are not eligible for the HSA) receive HRA contributions based upon their coverage effective date as shown below:

Important!

- If you are enrolled in an HRA, you cannot change to an HSA until the annual open enrollment period.
- If you are enrolled in Medicare, please submit a copy of your Medicare card to the PEBP office.

HRA contributions for state employees with coverage effective July 1, 2016:

State Employees with Coverage Effective July 1, 2016	Base Contribution	One-time Supplemental Contribution	Total Contribution
Participant Only	$700	$400	$1,100
Per Dependent (maximum 3 dependents)	$200	$100	$300

State and Non-State employees with a coverage effective date of August 1, 2016 or later receive a prorated HRA contribution based on the employee's coverage effective date and the number of months remaining in the current plan year. Note: One-time supplemental contributions do not apply.

Hometown Health Plan Northern Nevada HMO Plan	
Category	**Member Responsibility**
Deductible	No Deductible
Out-of-Pocket Maximum	$6,600 Individual $13,200 Family (per plan year)
Coinsurance • Special Pharmaceuticals	 30% Coinsurance
Primary Care Visit	$25 Copayment
Specialist Visit	$45 Copayment
Urgent Care Visit	$50 Copayment
Emergency Room Visit	$300 Copayment
Ambulance - Ground & Air	$150/$200 Copayment
Hospital Services (inpatient)	$500 Copayment per admission
Outpatient Surgery	$350 Copayment
Diagnostic Endoscopy	$150 Copayment
Chiropractic Visit	$45 Copayment
General Laboratory Services	No charge
Durable Medical Equipment • $3,500 plan year maximum • Pre-authorization in excess of $150	No charge
Mental Health Visit (outpatient)	$25 Copayment
X-ray & Diagnostic Services	
CT Scan, MRI & Nuclear Medicine	$250 Copayment per service
Pet Scan	$350 Copayment
All other imaging services • Provided in a primary care physician office • Provided in a specialty care physician office • Provided in a hospital outpatient setting • Diagnostic mammography	 $25 Copayment per visit $45 Copayment per visit $75 Copayment per visit $45 Copayment per visit

Hometown Health Plan
Northern Nevada HMO Plan

Category	Member Responsibility	
Wellness Benefit		
Wellness visit, pap smear, PSA, colorectal screening & mammogram	No charge	
EyeMed Vision Plan (844) 261-9033		
Eye Exam every 12 months (EyeMed provider) **Out-of-Network (not an EyeMed provider)**	$15 Copayment every 12 months Your coverage with other providers: Up to $32 every 12 months	
Prescription Glasses Discounts Frames: Standard Plastic Lenses: • Single vision • Bifocal • Trifocal • Standard Progressive Lenses	 35% off retail price (in-network) $50 copay $70 copay $105 copay $135 copay	
Contact Lenses	15% discount off contact lens exam (fitting and evaluation)	
HMO Prescription Benefits - Hometown Rx (844) 373-0970		
Category	**Retail - 30 Day Supply**	**Mail - 90 Day Supply**
Formulary Generic Drug **Formulary Brand Drug** **Non-Formulary Brand Drug**	$7 Copayment $40 Copayment Greater of $75 or 40% coinsurance	$14 Copayment $80 Copayment Greater of $150 or 40% coinsurance
Special Pharmaceuticals	30% coinsurance	30% coinsurance
Diabetic Supplies	$7 Generic $40 Brand	$14 Generic $80 Brand
HTH Diabetic Sense Program (866) 896-7303 Member must enroll in this program to receive benefits	No charge for glucose meter (Bayer HealthCare Ascensia & Roche Diagnostic Accu-Check), test strips, lancets, syringes and alcohol pads	

Hometown Health Plan

Northern Nevada HMO Plan

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

Important Plan Information

Hometown Health Plan is an open access plan. This feature allows members to self-refer to select specialists contracted with Hometown Health Plan without first obtaining a referral from a primary care physician (PCP). However, the following services require a referral from a member's primary care physician or a prior authorization from Hometown Health:

- All out-of-area services
- Any non-contracted provider or service
- Plastic surgery services
- Gastric bypass or lap banding services
- Anesthesiology and psychiatry services including pain management
- Genetic counseling and testing
- Second-opinion services
- All inpatient services in any facility type, including acute and skilled care, mental healthcare, drug and alcohol detoxification, or rehabilitation
- Surgical services
- Home health care
- Durable medical equipment, prosthetic and orthopedic devices over $100
- Transplant services, including the evaluation process
- Medications specified by Hometown Health Plan as Special Pharmaceuticals
- Botox injections

Hometown Health Plan Option

Northern Nevada HMO Plan

Primary Care Physician (PCP)

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

My Hometown Benefits - personalized online access to information

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

- Claims and authorizations
- Benefit status
- Prescription drug benefits
- Obtain directions to one of more than 1,300 providers
- Healthcare related topics, including self help tools for asthma and diabetes

Retail Prescription Drugs

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

Mail-Order Drug Program

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

EyeMedVision Care

Hometown Health Plan offers EyeMed Vision Care Benefits. With EyeMed, you have the freedom to choose an EyeMed network doctor or an out-of-network provider. If you choose an out-of-network provider, your benefit will differ from the coverage you receive with an EyeMed doctor. For information, visit http://stateofnv.hometownhealth.com.

Hometown Health Plan Option

Northern Nevada HMO Plan

Selecting and changing your Primary Care Physician (PCP)

To choose your Primary Care Physician (PCP) follow these steps:

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

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

HMO Reciprocity

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

Health Plan of Nevada (HPN) Southern Nevada HMO Plan	
Category	**Member Responsibility**
Deductible	No Deductible
Out-of-Pocket Maximum	$6,000 Individual $12,000 per Family
Primary Care Visit **Convenient Care Facility** **Telemedicine Services (select providers only)**	$15 Copayment per visit $5 Copayment per visit $5 Copayment per visit
Specialist Visit	$25 Copayment per visit
Urgent Care Facility	$30 Copayment per visit
Emergency Services • Emergency Room • Hospital Admission • Ground Ambulance	 • $150 Copayment per visit • $300 Copayment per admission • No charge
Ambulance Services • Emergency Transport • Non-Emergency - HPN arranged transfers	 $0 per trip $0 per trip
Inpatient Hospital	$300 Copayment per admission
Outpatient Surgery	$50 Copayment per admission
Chiropractic Visit Subject to a maximum of sixty (60) visits per calendar year	$25 Copayment per visit
General Laboratory Services	$0 Copayment per visit
Laboratory Services - Outpatient (performed at an independent facility)	$0 Copayment per visit
Mental Health Services • Inpatient Hospital • Outpatient Treatment	 $300 per admission $15 Copayment per visit
Wellness Services	
Preventative Health Services Services include various exams, immunizations, diagnostic tests and screenings. Refer to HPN Preventive Guidelines at http://stateofnv.healthplanofnevada.com/ or contact the HPN at (702) 242-7300 or (877) 545-7378.	No charge

Health Plan of Nevada (HPN) Southern Nevada HMO Plan	
Category	**Member Responsibility**
Deductible	No Deductible
Out-of-Pocket Maximum	$6,000 Individual $12,000 per Family
Retail Prescription Drug Benefit - Up to a 30 Day Therapeutic Supply	
Tier I: Preferred Generic Covered Drug **Tier II:** Preferred Brand Name Covered Drug* **Tier III:** No-Preferred Generic or Brand Name Covered Drug*	$7 Copayment $35 Copayment $55 Copayment
* If a Generic Covered Drug equivalent is available, Member pays the Tier I Drug copayment plus the difference between the eligible medical expenses of the Generic Drug and the medical expense of the Brand Name Covered Drug to the Plan Pharmacy for each therapeutic supply. For more information regarding HPN's Prescription Drug benefit, contact HPN at (702) 242-7300 or (877) 545-7378.	
Mail Order Plan Pharmacy	
Preferred Maintenance Covered Drugs	The Member pays 2.5x the applicable copayments as outlined above for up to a 90-day Maintenance Supply for Preferred Maintenance Covered Drugs.

Mail Order Program

HPN's mail order program is available for members to get preferred maintenance medications delivered right to their door. HPN's mail order vendor is Optum Rx.

In order to be available through the mail order pharmacy, a drug must be on Tier I or Tier II of the HPN preferred drug list.

The OptumRx Mail Order Program offers:

- A 90-day supply of medication—at a lower cost than a local retail pharmacy
- Access to specialist pharmacists
- Convenient delivery through the mail with standard shipping at no cost
- Advanced quality checks of all your prescriptions

Please refer to the Preferred Drug List for HPN available at www.pebp.state.nv to confirm whether your medication is eligible for the mail order benefit or call HPN at 702-242-7300 or 877-545-7378.

Health Plan of Nevada (HPN)
Southern Nevada HMO Plan

Vision Benefit

Covered Services	Member Pays
Examination One vision examination by a Plan Provider to include complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities will be provided each 12 consecutive calendar month period.	$10 Copayment
Lenses One pair of lenses will be provided during any 12 consecutive calendar month period, without charge, if a prescription change is determined to be medically necessary by a plan provider. Lenses are limited to plastic lenses, including single vision, bifocal, trifocal, lenticular, and other complex Lenses.	$10 Copayment
Frames One pair of Frames will be provided during any 24 consecutive calendar month period from an approved frame selection. Charges for frames in excess of the maximum allowance shall be the responsibility of the member. Discounts may be available through the plan provider for those charges in excess of the maximum allowance.	All charges over $100 maximum allowance
Medically Necessary Contact Lenses One pair of contact lenses will be provided during any 12 consecutive calendar month period when visual acuity cannot be corrected to 20/70 in the better eye except for the use of Contact Lenses. Contact Lenses are limited to single vision spherical lenses. Discounts may be available through the Plan Provider for those charges in excess of the maximum allowance.	All charges over $250 maximum allowance
Elective Contact Lenses One pair of Contact Lenses will be provided in any 12 consecutive month period in lieu of all other benefits except the annual vision examination (as described above).	All charges over $115 maximum allowance

Health Plan of Nevada

Southern Nevada HMO Plan

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

Important Plan Information

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

To select a primary care physician, or to review *HPN's Evidence of Coverage*, visit the PEBP website at www.pebp.state.nv.us, or contact HPN at (702) 242-7300 or (877) 545-7378.

Services Requiring Prior-Authorization

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

- Non-emergency inpatient admissions and extensions of stay in a hospital, skilled nursing facility, or hospice
- Outpatient surgery provided in any setting, including technical and professional services
- Diagnostic and therapeutic services
- Home healthcare services
- Mental health, severe mental illness, and substance abuse services
- All specialist visits or consultations
- Prosthetic devices, orthotic devices, and durable medical equipment
- Courses of treatment, including allergy testing or treatment, angioplasty, home health care services, physiotherapy or manual manipulation, rehabilitation therapy (physical, speech or occupational)

Vision - Eye Med Vision Care

Benefits are only available through participating providers who have agreed to provide services to Health Plan of Nevada members. For a complete list of providers, hours, and locations, contact EyeMed Vision Care at (877) 226-1115.

Health Plan of Nevada

Southern Nevada HMO Plan

We're At Your Service

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

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

HMO Reciprocity

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

Health Plan of Nevada

Southern Nevada HMO Plan

HPN Pharmacy Benefits

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

Mail Order Pharmacy Program

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

Education and Wellness (HEW)

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

Another feature of ***MyHEWOnline*** is the Health Risk Assessment. The health risk assessment is your first step to better health. It is designed to help you identify your health and lifestyle profile. After completing the questionnaire, you will receive a personalized profile with recommendations to help improve your overall health. For more information about HPN's Health Education and Wellness visit HPN's website at www.stateofnvhpnbenefits.com

Dental Plan

All PPO and HMO Eligible Participants

Benefit Category	In-Network	Out-of-Network
Individual Plan Year Maximum	$1,500 per person for Basic and Major services	$1,500 per person for Basic and Major services
Plan Year Deductible (applies to Basic and Major services only)	$100 per person or $300 per family (3 or more)	$100 per person or $300 per family (3 or more)
Preventive Services Four cleanings/plan year, exams, bitewing X-rays (2/plan year) Preventive Services are not subject to the $1,500 Individual Plan Year Maximum	100% of allowable fee schedule, no deductible	80% of allowable fee schedule for the Las Vegas area for participants using an out-of-network provider *within the in-network* service area; or For services received out-of-network, outside of Nevada, the plan will reimburse at the U&C rates
Basic Services Periodontal, fillings, extractions, root canals, full-mouth X-rays	80% of allowable fee schedule, after deductible	50% (after deductible) of allowable fee schedule for the Las Vegas area for participants using an out-of-network provider *within the in-network* service area; or For services received out-of-network, outside of Nevada, the plan will reimburse at the U&C rates
Major Services Bridges, crowns, dentures, tooth implants	50% of allowable fee schedule, after deductible	50% (after deductible) of allowable fee schedule for the Las Vegas area for participants using an out-of-network provider *within the in-network* service area; or For services received out-of-network, outside of Nevada, the plan will reimburse at the U&C rates

- **Family Deductible may be met by any combination of eligible dental expenses of three or more members of the same family coverage tier**. No one single family member would be required to contribute more than the equivalent of the individual deductible toward the family deductible.

- **Under no circumstances will the combination of PPO and Non-PPO benefit payments exceed the plan year maximum benefit of $1,500.**

Group Basic Life and Long Term Disability Insurance Included with all plan options	
Benefit Description	**Benefit Features** **All Eligible Participants**
Group Basic Life Insurance	Employees enrolled in a PEBP-sponsored medical plan receive $25,000 Basic Life Insurance coverage. Refer to the Life Insurance Certificate at https://www.standard.com/mybenefits/nevada/ for more information about this benefit. The Accelerated Benefit for Basic Life is available under certain circumstances. To exercise this option, or to learn more, contact The Standard at (888) 288-1270.
Beneficiary Financial Counseling	The beneficiary of a deceased active employee may be eligible to receive comprehensive and objective financial counseling through an arrangement with Pricewaterhouse Coopers. Services include a beneficiary guide about settling an estate and other important topics, personal financial counseling, financial analysis, 12 months of unlimited toll-free telephone access to financial counselors, a financial web site and newsletter "Your Money, Your Future." See the Beneficiary Counseling Brochure at https://www.standard.com/mybenefits/nevada/ for more information.
Life Services Toolkit (available July 1, 2016)	Employees enrolled in a PEBP-sponsored medical plan have access to a tool to address important life matters via The Standard's Life Services Toolkit: • Estate Planning Assistance: online tools that walk you through the steps to prepare a will and create other documents, such as living wills, powers of attorney and health care agent forms. • Financial Planning: Online services to help you manage debt, calculate mortgage and loan payments, and take care of other financial matters with confidence. • Health and Wellness: Timely articles about nutrition, stress management and wellness. • Identity Theft Prevention: Online tools that provide ways to thwart identity thieves and resolve issues if identity theft occurs. • Funeral Arrangements: Use the website to calculate funeral costs, find funeral-related services and make decisions about funeral arrangements in advance. For more information, visit https://www.standard.com/mybenefits/nevada/.

Group Basic Life and Long Term Disability Insurance
Included with all plan options

Benefit Description	Benefit Features (Provided to employees who are enrolled in a PEBP-sponsored medical plan)
Travel Assistance	Travel Assistance is designed to respond to most medical care situations and many other emergencies you and your family experience when you travel 100 miles or more from your home. Travel Assistance provides a wide range of information, referral, coordination, and assistance services. These services include pre-trip assistance, medical assistance, emergency transportation, travel and technical assistance, legal services, and medical supplies. Assistance is available 24 hours a day, 365 days a year whether you are 100 or 10,000 miles away from home. Simply print and carry the Travel Assistance Card available at https://www.standard.com/mybenefits/nevada/.
Long Term Disability (LTD) Insurance	Long Term Disability Insurance is designed to help protect you against a loss of income in the event you become disabled and are unable to work for an extended period of time. If your LTD claim is approved, benefits become payable at the end of the 180-day Benefit Waiting Period (no benefits are paid during the Benefit Waiting Period). The monthly LTD benefit is based on your earnings from the State of Nevada or participating public agency. Your monthly LTD benefit is 60 percent of the first $12,500 of your monthly earnings, as defined by the group insurance policy, reduced by deductible income. For more information about the LTD benefit, see the LTD Certificate of Insurance at https://www.standard.com/mybenefits/nevada/.

Group Life Insurance Portability and Conversion Options

Benefit Description	Benefit Features All Eligible Participants
Portability of Life Insurance	You may be eligible to buy portable Group Life Insurance if your employment terminates. You must apply in writing and pay the first premium to the Standard within 31 days after the date your employment terminates. To be eligible, you must meet the following requirements: • You must have been continuously insured under your employer's Group Life Insurance plan for at least 12 consecutive months on the date your employment terminates. • You must be able to perform with reasonable continuity the material duties of at least one gainful occupation for which you are reasonably fitted by education, training and experience on the date your employment terminates. • You must be under age 65 on the date your employment terminates. For information regarding Portability of Group Life Insurance, refer to the Group Life Insurance Certificate available at https://www.standard.com/mybenefits/nevada/ or contact The Standard Insurance Company at (888) 288-1270.
Conversion of Group Life Insurance	A conversion right is the right given to an insured person under a group life insurance plan to convert coverage (without evidence of insurability) to an Individual Policy upon termination of the group coverage. To convert coverage, the insured person must apply for conversion by obtaining, completing and returning a conversion application to The Standard Insurance Company within 31 days after the date of employment termination, or the date the insured person and/or his dependents are no longer eligible to participate in group life insurance coverage. For information regarding Conversion of Group Life Insurance, refer to the Group Life Insurance Certificate available at https://www.standard.com/mybenefits/nevada/ or contact The Standard Insurance Company at (888) 288-1270.

State Active Rates

Effective July 1, 2016 - June 30, 2017

State Employee Rates	Statewide PPO Consumer Driven Health Plan		
	Rate	Base Subsidy	***Participant Premium***
Employee Only	598.69	556.78	41.91
Employee + Spouse	1,078.66	907.16	171.50
Employee + Child(ren)	786.88	694.16	92.72
Employee + Family	1,266.01	1,043.92	222.09

State Employee Rates	Statewide HMO Hometown Health Plan and Health Plan of Nevada		
	Rate	Base Subsidy	***Participant Premium***
Employee Only	764.03	595.94	168.09
Employee + Spouse	1,482.28	1,012.53	469.75
Employee + Child(ren)	1,097.74	789.50	308.24
Employee + Family	1,815.99	1,206.08	609.91

State Active Rates

Effective July 1, 2016 - June 30, 2017

State Employee with Domestic Partner Rates	Statewide PPO					
	Consumer Driven Health Plan					
	Rate	Base Subsidy	Taxable Subsidy	***Participant Premium***	Pre-Tax Deduction	Post-Tax Deduction
Employee + DP	1,078.66	556.78	350.38	171.50	41.91	129.59
Employee + DP's Child(ren)	786.88	556.78	137.38	92.72	41.91	50.81
Employee + Children of both	786.88	694.16	—	92.72	92.72	—
Employee + DP + EE's Child(ren)	1,266.01	694.16	349.76	222.09	92.72	129.36
Employee + DP + DP's Child(ren)	1,266.01	556.78	487.14	222.09	41.91	180.17
Employee + DP + Children of both	1,266.01	694.16	349.76	222.09	92.72	129.36

State Employee with Domestic Partner Rates	Statewide HMO					
	Hometown Health Plan and Health Plan of Nevada					
	Rate	Base Subsidy	Taxable Subsidy	***Participant Premium***	Pre-Tax Deduction	Post-Tax Deduction
Employee + DP	1,482.28	595.94	416.59	469.75	168.09	301.66
Employee + DP's Child(ren)	1,097.74	595.94	193.56	308.24	168.09	140.15
Employee + Children of both	1,097.74	789.50	—	308.24	308.24	—
Employee + DP + EE's Child(ren)	1,815.99	789.50	416.58	609.91	308.24	301.67
Employee + DP + DP's Child(ren)	1,815.99	595.94	610.14	609.91	168.09	441.82
Employee + DP + Children of both	1,815.99	789.50	416.58	609.91	308.24	301.67

Non-State Active Rates

Effective July 1, 2016 - June 30, 2017

Non-State Active Employee Rates	Statewide PPO	Statewide HMO
	Consumer Driven Health Plan	**Hometown Health Plan and Health Plan of Nevada**
	Participant Premium	**Participant Premium**
Employee Only	974.97	809.75
Employee + Spouse	1,831.22	1,573.72
Employee + Child(ren)	1,718.44	1,210.92
Employee + Family	2,573.84	1,974.89

State Rates For State Active Legislators, Employees on Leave without Pay, and Employees on Military Leave

Effective July 1, 2016 - June 30, 2017

State Legislators Employees on Leave Without Pay and Employees on Military Leave	Statewide PPO	Statewide HMO
	Consumer Driven Health Plan	**Hometown Health Plan and Health Plan of Nevada**
	Participant Premium	***Participant Premium***
Employee Only	598.69	764.03
Employee + Spouse/DP	1,078.66	1,482.28
Employee + Child(ren)	786.88	1,097.74
Employee + Family	1,266.01	1,815.99

State active legislators, employees on Leave without Pay and Military Leave do not receive a subsidy towards their health insurance premium.

COBRA Rates

State and Non-State Employee

State Employee COBRA	Statewide PPO **Consumer Driven Health Plan**	Statewide HMO **Hometown Health Plan & Health Plan of Nevada**
Employee	**Premium**	**Premium**
Participant	610.67	779.31
Participant + Spouse/DP	1,100.24	1,511.93
Participant + Child(ren)	802.62	1,119.69
Participant + Family	1,291.33	1,852.31
Spouse/DP Only	610.67	779.31
Spouse/DP + Child(ren)	802.62	1,119.69
Retiree		
Participant	592.40	761.04
Participant + Spouse/DP	1,081.97	1,493.66
Participant + Child(ren)	780.94	1,101.43
Participant + Family	1,273.06	1,834.04
Spouse/DP Only	592.40	761.04
Spouse/DP + Child(ren)	780.94	1,101.43

-- COBRA participants do not qualify for Life Insurance and Long-Term Disability.
-- Participants on COBRA do not receive a subsidy.

Non-State Employee COBRA	Statewide PPO **Consumer Driven Health Plan**	Statewide HMO **Hometown Health Plan & Health Plan of Nevada**
Employee	**Premium**	**Premium**
Participant	994.47	825.95
Participant + Spouse/DP	1,867.84	1,605.19
Participant + Child(ren)	1,752.81	1,235.14
Participant + Family	2,625.32	2,014.39
Spouse/DP Only	994.47	825.95
Spouse/DP + Child(ren)	1,752.81	1,235.14
Retiree		
Participant	976.20	807.68
Participant + Spouse/DP	1,849.57	1,586.93
Participant + Child(ren)	1,734.54	1,216.87
Participant + Family	2,607.05	1,996.12
Spouse/DP Only	976.20	807.68
Spouse/DP + Child(ren)	1,734.54	1,216.87

-- COBRA participants do not qualify for Life Insurance and Long-Term Disability.
-- Participants on COBRA do not receive a subsidy.

Completing the

Employee Benefit Enrollment and Change Form (BECF)

Employees *without* access to the Internet can call the PEBP office at (775) 684-7000 or (800) 326-5496 to request the Employee Benefit Enrollment and Change Form (BECF)

Section 1: Select your employee category, e.g., New Hire, Rehire or Reinstatement
Date of Event: Enter the effective date of your coverage

Section 2: Enter Participant information

Section 3: Select your health plan, e.g., Consumer Driven Health Plan, Hometown Health Plan or Health Plan of Nevada. If declining coverage, place a check-mark in the Decline/Waive coverage box.
Note: By declining coverage, you lose your eligibility for all PEBP medical benefits, including Basic Life and Long-Term Disability Insurance.

Section 4: HMO plans only: Enter the Primary Care Physician Code (ID number) (to locate the PCP ID number, visit www.pebp.state.nv.us, select Plan Contacts, then select the applicable HMO plan).

Section 5: Choose your coverage tier

- Participant Only
- Participant + Spouse
- Participant + Participant's Child(ren)
- Participant + Family (employee, spouse and children)
- Participant + Domestic Partner (DP)
- Participant + DP's Child(ren)
- Participant + DP + Participant's Child(ren) + DP's Child(ren)
- Participant + Participant's Child(ren) + DP's Child(ren)
- Participant + DP + DP's Child(ren)
- Participant + DP + Participant's Child(ren)

Section 6: Enter the information for any dependents you are adding. Refer to page 4 for supporting documentation requirements.

Section 7: Read, sign and date the form using black or blue ink

Return the completed BECF and copies of supporting document(s) to:

Public Employees' Benefits Program
901 South Stewart Street, Suite 1001
Carson City, NV 89701

Group Basic Life Insurance Beneficiary Designation

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

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

Mail completed Beneficiary Designation and Change Forms to:

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

Beneficiary Information

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

Designating Beneficiaries:

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

Voluntary Flexible Spending Accounts (FSA)

For State Active Employees Only

Health Care FSA

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

When you enroll in an FSA, you decide how much to contribute to each account for the remaining months in the plan year which ends on June 30th. The amount you elect to contribute is then deducted monthly from your paycheck, pre-tax (before Federal & State income taxes and FICA taxes are deducted). The amount you elect to contribute is deducted in equal amount over the course of the months remaining in the plan year. Eligible expenses that you incur may be paid using the FSA debit card or through the submission of a claim for reimbursement to HealthSCOPE Benefits.

For Plan Year 2017, you may contribute up to the IRS maximum of $2,550. Your election amount is typically fixed for the entire plan year (unless you have a qualifying event).

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

HealthSCOPE Benefits will charge a $3.25 per month administration fee for participating in the Health Care and/or Dependent Care FSA. There is no fee for the FSA debit card.

Who is eligible for Flexible Spending Account (FSA)?

Employees working for a state agency (NDOT, LCB, PERS, etc.), State Boards, and Commissions are eligible to enroll in Flexible Spending. Employees working for a non-state agency and the Nevada System of Higher Education will need to contact their human resources benefits office for information about the availability of Flexible Spending Accounts offered by their employer.

IMPORTANT!

Employees with an HSA are not eligible to contribute to the Health Care FSA, but may contribute to a Limited Scope FSA for eligible dental and vision expenses only. For more information regarding the Limited Scope FSA, contact HealthSCOPE Benefits at (888) 763-8232.

Domestic Partner Eligibility

The health care expenses of a domestic partner are generally not eligible for reimbursement using the Health Care FSA unless the domestic partner qualifies as a dependent under the IRS's definition of a qualifying relative. If you have questions regarding your eligibility to enroll in an FSA, please contact HealthSCOPE Benefits at (888) 763-8232.

Voluntary Flexible Spending Accounts (FSA) *Continued*

Dependent Care FSA

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

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

Flexible Spending enrollment forms are available at www.pebp.state.nv.us. To enroll, complete the form and fax it to HealthSCOPE Benefits within 60 days of your initial coverage effective date.

Auto, Home, RV and Renters' Insurance

Employees have the option of purchasing a variety of insurance products, such as auto, home, renters, condo, boat, RV, etc., at special group discounts. Liberty Mutual offers convenient payment options such as automatic deductions from your checking account, payroll deduction and online payments. To receive an insurance quote or for additional information, contact Liberty Mutual at (800) 637-7026

Long-Term Care Insurance

Long-term care is the assistance received when someone needs help with two or more *Activities of Daily Living* (i.e. dressing, bathing, going to the bathroom, eating, etc.) This care may be provided in the home, in an assisted living or residential care facility, or in a skilled nursing home facility.

New hires have 30 days to enroll to receive *Guarantee Issue* coverage (measured from the date PEBP coverage becomes effective). After the initial enrollment period, employees will be required to complete a medical questionnaire. For information about Long-Term Care, contact UNUM at (800) 227-4165.

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

Voluntary Life Insurance & Short-Term Disability (STD) Insurance

Voluntary Life Insurance

Once you are enrolled in a PEBP medical plan you will receive a basic amount of life insurance to help protect your loved ones in the event of your death. Since everyone's needs are different, the State of Nevada also provides you with the opportunity to apply for Voluntary Life Insurance from Standard Insurance Company — a simple, easy way to further help protect your family. It allows you to apply for the additional coverage you need, with premiums deducted directly from your paycheck.

You can purchase the following Voluntary Life, AD&D and Dependents Life Insurance at group rates. To qualify for guarantee issue, you must apply for Voluntary Life Insurance within 60 days of your coverage effective date (otherwise, you may be required to provide satisfactory proof of evidence of insurability).

Voluntary Life and Accidental Death and Dismemberment (AD&D) Insurance	
Employees	Any multiple of $10,000 to a maximum of $500,000
Spouses/Domestic Partners	Any multiple of $10,000 to a maximum of $250,000
Child(ren)	Any multiple of $2,500 to a maximum of $10,000

Voluntary Short Term Disability (STD)

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

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

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

It's easy to enroll for Voluntary Life and STD Insurance coverage: Simply complete the form available for download at https://www.standard.com/mybenefits/nevada/ and mail to the address indicated on the form. For more information about these voluntary coverage options, contact The Standard at (888) 288-1270.

Important Information About Your Coverage

Dual PEBP Coverage Not Permitted

PEBP participants (employees and/or their dependents) are not permitted to be covered under two PEBP accounts. If a dependent child becomes eligible for coverage as a primary insured, that individual may select primary coverage in lieu of being covered as a dependent of another primary insured.

Moving Outside the Plan's Coverage Area

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

Open Enrollment

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

Pre-Existing Conditions

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

Family Medical Leave of Absence

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

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work, regardless of whether the employee is on paid or unpaid leave. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Employees are eligible for FMLA leave if they have worked for the State of Nevada for 12 months and for 1,250 hours over the previous 12 months. For an overview of FMLA provided by the Department of Administration, Human Resource Management visit http://dop.nv.gov/FMLAOverview.pdf.
Employees working for a participating local government will need to contact their Human Resources office for FMLA eligibility.

Important Information About Your Coverage

Leave Without Pay (LWOP)

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

At the initial start of leave, it is the employee's responsibility to inform PEBP of their coverage preference while on leave. If the employee fails to inform PEBP of his or her coverage preference, PEBP will continue the same medical plan and coverage tier that the employee had in affect prior to taking that leave. An employee who wishes to continue coverage while on LWOP will pay the full cost of premiums for their coverage. An employee on LWOP is not eligible for coverage as a dependent of another PEBP covered participant (spouse/domestic partner, child, etc.).

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

- Employees on active military service (for up to 31 days) may elect to continue health care coverage during that leave period by paying any premium contributions due for that coverage while on leave.

- If the employee goes into active military service for 31 days or more, the employee is eligible to enroll him/herself and family in health care coverage provided by the military the day the employee is activated for military duty. The employee is also eligible to purchase continued health coverage for him/herself and their family for up to 24 months in a manner similar to the provisions of COBRA. When the employee returns from military leave within the required reemployment period, there will be an immediate reinstatement of PEBP-sponsored medical coverage with no waiting period.

Workers' Compensation Leave

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

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

PEBP Initial COBRA Notice - COBRA Continuation Rights

This notice contains important information about your right to continue your health care coverage (called "Continuation Coverage" or COBRA coverage). This notice also contains important information about health coverage alternatives that may be available to you through the Health Insurance Marketplace when coverage under the Public Employees' Benefits Program (PEBP) would otherwise end.
This notice provides a brief overview of your rights and obligations under current law. (Note: the PEBP-sponsored group health plan is referred to as "Plan" in this notice.) The Plan offers no greater COBRA rights than what the COBRA statute requires and this notice should be construed accordingly.

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

Both you (the employee or retiree) and your spouse or domestic partner should read this notice carefully and keep it with your records.

Qualifying Events

If you are the **employee/retiree** and are covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any one of the two "qualifying events":

1. Termination of employment (for reasons other than gross misconduct), or
2. Reduction in the hours of your employment.

If you are the **spouse or the domestic partner** of an employee or retiree covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the four qualifying events:

1. The death of your spouse or domestic partner.
2. A termination of your spouse's or domestic partner's employment (for reasons other than gross misconduct) or reduction in your spouse's or domestic partner's hours of employment with the PEBP participating employer.
3. Divorce from your spouse or the dissolution of your domestic partnership. (Also, if an employee or retiree eliminates coverage for his or her spouse or domestic partner in anticipation of a divorce or the dissolution of domestic partnership, and a divorce or dissolution of domestic partnership later occurs, then the later divorce or dissolution of domestic partnership will be considered a qualifying event even though the ex-spouse or ex-domestic partner lost coverage earlier. If the ex-spouse or ex-domestic partner notifies PEBP within 60 days after the later divorce or dissolution of domestic partnership, then COBRA coverage may be available for the period after the divorce or dissolution of domestic partnership.)

4. Your spouse or domestic partner becomes entitled to Medicare benefits.

In the case of a **dependent child** of an employee or retiree covered by the Plan, the dependent child has the right to elect continuation coverage if group health coverage under the Plan is lost because of any of the following five qualifying events:

1. The death of the employee/retiree.
2. The termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee hours of employment with the employer.
3. Parent's divorce or dissolution of domestic partnership.
4. The employee/retiree becomes entitled to Medicare benefits.
5. The dependent ceases to be a "dependent child" under the Plan.

Your IMPORTANT Notice Obligations

If your spouse/domestic partner or dependent child loses coverage under the Plan because of divorce, dissolution of domestic partnership or the child ceases to be a dependent under the Plan, then you (the employee) or your spouse/domestic partner or dependent has the responsibility to notify PEBP no later than 60 days after the date coverage terminates under the Plan.

If you, your spouse/domestic partner or your dependent fail to notify PEBP during this 60-day notice period, the spouse/domestic partner or dependent child who loses coverage will NOT be offered continuation coverage. Any claims paid by the Plan on behalf of your spouse/domestic partner or dependent child after the coverage termination date must be reimbursed to the Plan.

If PEBP receives timely notification of a divorce/dissolution of domestic partnership or of a child who ceases to be a dependent which results in a loss of coverage, then PEBP will notify the affected family member of the right to elect continuation coverage (but only to the extent that PEBP has been notified in writing of the affected family member's current mailing address).

PEBP will also notify you (the employee or retiree), your spouse/domestic partner and dependent children of the right to elect continuation coverage after it receives notice of the following events that result in a loss of coverage: the employee's termination of employment (other than for gross misconduct), reduction in hours, the death of the employee or retiree, or the employee's or retiree's becoming entitled for Medicare.

Election Procedures

You (the employee or retiree) and/or your spouse/domestic partner and/or dependent children must elect continuation coverage within 60-days after Plan coverage ends or 60 days after PEBP provides you or your family member with the COBRA Continuation Coverage Election Form. If you or your spouse/domestic partner and/or dependent children do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage. A COBRA election that is mailed to PEBP is considered received on the date of the mailing. You and/or your spouse/domestic partner and dependent children may elect continuation coverage for all qualifying family members. You, your spouse/domestic partner and dependent children each have an independent right to elect continuation coverage (spouse/domestic partner or dependent child may elect continuation coverage even if the covered employee does not (or is not deemed to) elect it). You and/or your spouse/domestic partner and dependent children may elect continuation coverage even if covered under another employer-sponsored group health plan or entitled to Medicare.

Type of Coverage

Ordinarily, the continuation coverage that is offered will be the same coverage that you, your spouse/ domestic partner or dependent children had on the day before the qualifying event. An employee or retiree, spouse/domestic partner or dependent child who is not covered under the Plan on the day before the qualifying event generally is not entitled to COBRA coverage except, for example, when there is no coverage because it was *eliminated in anticipation* of a qualifying event such as divorce. If the coverage is modified for similarly situated employees or their spouses/domestic partners or dependent children, then COBRA coverage will be modified in the same way.

If you (employee) are enrolled in a PEBP-sponsored health flexible spending arrangement (health FSA) under which you are reimbursed for medical expenses, you (or your spouse or dependent children) may elect to continue the health FSA coverage under COBRA, but only if there is a positive account balance (*i.e.*, year-to-date contributions exceed year-to-date claims) on the day before the qualifying event (taking into account all claims submitted by that date). COBRA coverage under the health FSA will continue only for the remainder of the Plan year in which the qualifying event occurred.

If there is a negative account balance (*i.e.*, year-to date contributions are less than year-to-date claims), then no qualified beneficiary may elect COBRA coverage under the health FSA.

COBRA Premiums That You Must Pay

The premium payments for the "initial premium months" must be paid for you (the employee) and for any spouse/domestic partner or dependent children by the 45th day after electing continuation of coverage. The initial premium months are the months that end on or before the 45th day after the election of continuation coverage is made.

Once continuation of coverage is elected, the right to continue coverage is subject to timely payment of the required COBRA premiums. Coverage will not be effective for any initial premium month until the month's premium is paid within the 45-day period after the election of continuation of coverage is made.

Paying for COBRA Continuation of Coverage (The Cost of COBRA)

By law, any person who elects COBRA Continuation of Coverage will pay the full cost of the COBRA Continuation of Coverage. PEBP is permitted to charge the full cost of coverage for similarly situated employees/retirees and families (including both PEBP's and employee's /retiree's share), plus an additional 2%. If the 18-month period of COBRA Continuation of Coverage is extended because of disability, the plan may add an additional 50% applicable to the COBRA family unit (but only if the person with a disability is covered) during the 11-month additional COBRA period.

Grace Period

The initial payment for the COBRA Continuation of Coverage is due within 45 days after COBRA Continuation of Coverage is elected. If this payment is not made when due, COBRA Continuation of Coverage will not take effect. After that, payments are due on the first day of each month, but there will be a 30-day grace period to make those payments. If payments are not made within the time indicated in this paragraph, COBRA Continuation of Coverage will be cancelled as of the due date.

A premium payment that is mailed is considered to be received on the date it is postmarked. If full premium payment is not received by the due date or within the 30-day grace period, then COBRA coverage will be canceled retroactively to the first day of the month, with no possibility of reinstatement.

Maximum Coverage Periods

The maximum duration for COBRA coverage is described below. COBRA coverage terminates before the maximum coverage period in certain situations described later under the heading "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

36 Months

If you (the spouse/domestic partner or dependent child) lose group health coverage because of the employee's death, divorce, legal separation, or the employee's becoming entitled to Medicare, or because you lose your status as a dependent child under the Plan, then the maximum coverage period (for spouse/ domestic partner and dependent child) is three years from the date of the qualifying event.

18 Months

If you (the employee, spouse/domestic partner or dependent child) lose group health coverage because of the employee's termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage is 18 months from the date of termination or reduction in hours. There are three exceptions:

1. If an employee or family member is disabled at any time during the first 60 days after the date of termination of employment or reduction in hours, then the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours.

   The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to the Plan Administrator within the 18-month coverage period and 60 days after the date of the determination.

2. If a second qualifying event that gives rise to a 36-month maximum coverage period for the spouse or dependent child (for example, the employee dies or becomes divorced) occurs within an 18-month or 29-month coverage period, then the maximum coverage period (for a spouse or dependent child) becomes three years from the date of the initial termination or reduction in hours. For the 36-month maximum coverage period to apply, notice of the second qualifying event must be provided to the Plan Administrator within 60 days after the date of the event. If no notice is given within the required 60-day period, no extension of COBRA coverage will occur.

3. If the qualifying event occurs within 18 months after the employee becomes entitled to Medicare, then the maximum coverage period (for the spouse and the dependent child) is three years from the date the employee became entitled to Medicare.

Health FSA

If you enroll in a Health FSA and your coverage terminates because of a qualified event, i.e. termination of employment (does not include retirement), you may continue your FSA coverage if you elect COBRA. The maximum COBRA period for a health FSA (if there is a positive account balance including the remaining monthly administrative fee and the 2% COBRA administrative fee as of the date of the qualifying event) ends on the last day of the Plan year in which the qualifying event occurred. If there is a negative balance as of the date of the qualifying event, no COBRA coverage will be offered. If COBRA is elected, it will be available only for the remainder of the applicable plan year. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Employees who have incurred a COBRA qualifying event as a result of no longer being actively employed will be responsible for the monthly administration fee. The monthly administration fee will be paid on an after tax basis.

COBRA FSA benefits will end on the earlier of:

- You cease paying the monthly administration fee;
- Your remaining FSA balance is depleted, or;
- At the end of the applicable plan year.

For more information on continuing your Health FSA, contact your FSA plan administrator within 31 days of your coverage end date.

Children Born to or Placed for Adoption With the Covered Employee During COBRA Period

A child born to, adopted by or placed for adoption with a covered employee during a period of continuation of coverage is considered to be a qualified beneficiary, provided that the covered employee has elected continuation of coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Open Enrollment Rights and HIPAA Special Enrollment Rights

Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly-situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment. In addition, HIPAA's special enrollment rights will apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA certain rights to add coverage for dependents if such person acquires a new dependent (through marriage, registered domestic partnership, birth, adoption or placement for adoption), or if an eligible dependent declines coverage because of other coverage and later loses such coverage due to certain qualifying reasons. Except for certain children described above under "Children born to or Placed for Adoption With the Covered Employee During COBRA Period," dependents who are enrolled in a special enrollment period or open enrollment period do not become qualified beneficiaries and their coverage will end at the same time that coverage ends for the person who elected COBRA and later added them as dependents.

Alternate Recipients Under QMCSOs

A child of yours (the employee's) who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the PEBP during your (the employee's) period of employment with the employer is entitled to the same rights under COBRA as a dependent child of yours, regardless of whether that child would otherwise be considered your dependent.

Termination of COBRA Coverage Before the End of Maximum Coverage Period

Continuation of coverage of the employee, spouse/domestic partner and/or dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following six events occurs.

1. The Employer no longer provides group health coverage to any of its employees.
2. The premium for the qualified beneficiary's COBRA coverage is not timely paid.
3. After electing COBRA, you (the employee, spouse/domestic partner or dependent child) become covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable exclusions or limitations, then your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group health plan. (Note that under HIPAA, an exclusion or limitation of the group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other group health plan.)
4. After electing COBRA coverage, you (the employee, spouse/domestic partner or dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
5. You (the employee, spouse/domestic partner or dependent child) became entitled to a 29-month maximum coverage period due to disability of qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation of coverage will not end until the month that begins more than the 30 days after the determination).
6. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered employees or their spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of federal law.

You Must Notify Us About Address Changes, Marital Status/Domestic Partnership Changes, Dependent Status Changes and Disability Status Changes

If you or your spouse's/domestic partner's address changes, you *must* promptly notify PEBP in writing (PEBP needs up-to-date addresses in order to mail important COBRA notices and other information). Also, if your marital/domestic partnership status changes or if a dependent ceases to be a dependent eligible for coverage under the Plan terms, you or your spouse or your dependent *must* promptly notify PEBP in writing (such notification is necessary to protect COBRA rights for your spouse/domestic partner and dependent children). In addition, you must notify us if a disabled employee or family member is determined to be no longer disabled.

PEBP is the Plan Administrator. All notices and other communications regarding the Plan and regarding COBRA must be directed to PEBP.

Public Employees' Benefits Program

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

COBRA ADDRESS NOTIFICATION FORM

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

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

1. COVERED DEPENDENT ADDRESS INFORMATION

Name of covered dependent:____

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

Street Address:____

City:____________________________State:____________Zip:________

2. COVERED DEPENDENT ADDRESS INFORMATION

Name of covered dependent:____

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

Street Address:____

City:____________________________State:____________Zip:________

3. COVERED DEPENDENT ADDRESS INFORMATION

Name of covered dependent:____

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

Street Address:____

City:____________________________State:____________Zip:________

Group Life and Long-Term Care Portability and Conversion Options

Important Notice regarding the Active Employee Basic Life Insurance and/or Voluntary Life Insurance.

If you terminate your active employment you may have the option to convert or port your Basic and/or Voluntary Life Insurance (if applicable). If you want to maintain coverage for any of the applicable coverages, you must apply directly with the Standard Insurance within 31 days of the date your PEBP-sponsored active employee coverage ends; otherwise, you may lose your right to convert or port these coverages.

Portability of Basic and/or Voluntary Life Insurance

You must apply in writing and pay the first premium to Standard Insurance within 31 days after the date your employment terminates.

To be eligible, you must meet the following requirements:

- You must have been continuously insured under your employer's Group Life Insurance plan for at least 12 consecutive months on the date your employment terminates.
- You must be able to perform with reasonable continuity the material duties of at least one gainful occupation for
  which you are reasonably fitted by education, training and experience on the date your employment terminates.
- You must be *under age 65* on the date your employment terminates.

Conversion of Basic and/or Voluntary Life Insurance
A conversion right is the right given to an insured person under a group life insurance plan to convert coverage *(without evidence of insurability)* to an Individual Policy upon termination of the group coverage.

To convert coverage you must apply for conversion by completing and returning a conversion application to Standard Insurance within 31 days after the date of employment termination.

For information regarding the Portability and Conversion provisions, refer to the Group Life Insurance Certificate available at http://www.standard.com/mybenefits/nevada/ or contact Standard Insurance at (888) 288-1270.

Long-Term Care Insurance Policy #508396

If you have Long-Term Care Insurance through UNUM, you may wish to port or convert your coverage if you terminate your active employment. To convert/port your coverage, you must apply within 31 days following the date your PEBP-sponsored active employee coverage ends. To request the portability/conversion forms contact Karla Decrescenzo at (775) 722-5907 or Nikki Pecorino at (775) 813-5309 or UNUM at (800) 227-4165.

Vendor Contact List

CDHP Medical and PPO Dental Claims Administrator • Claim status inquiries • Plan benefit information • HSA/PPO-HRA Administration • Network Providers • ID cards	**HealthSCOPE Benefits** P.O. Box 91603 Lubbock, TX 79490-1603 Customer Service: 888-7NEVADA (888) 763-8232 Group Number: NVPEB www.healthscopebenefits.com
In-State PPO Medical Network • Network Providers • Provider directory • Additions/deletions of providers	**PEBP Statewide PPO Network** Administered by Hometown Health Partners and Sierra Healthcare Options Customer Service: (800) 336-0123 www.pebp.state.nv.us
National Provider Network For participants who reside outside Nevada or who reside in Nevada and access healthcare services outside of Nevada	**First Health Network** P.O. Box 91603 Lubbock, TX 79490-1603 Customer Service: (800) 226-5116 www.myfirsthealth.com
CDHP Wise Provider Network For participants who reside outside Nevada or who reside in Nevada and access healthcare services outside of Nevada	6995 Union Park Center #250 Cottonwood Heights, UT 84047 Customer Service: (866) 485-5205 www.wiseprovider.net
CDHP Pharmacy Plan Administrator • Prescription drug information • In-network pharmacies • Prior authorization • Non-network retail claims payment • Price and Save Tool • Mail order service and mail order forms • Diabetic supplies mail order program	**Express Scripts, Inc.** PO Box 66566 St. Louis, MO 63166-6566 Customer Service: (855) 889-7708 www.Express-Scripts.com **(available 7/1)** **Price a Medication Tool** www.Express-Scripts.com/NVPEBP **(available for price comparison)** **Specialty Pharmacy** Accredo (800) 803-2523
Hometown Health Providers • Utilization Management and Case Management • Diabetes Care Management for the CDHP Plan	**Hometown Health Providers** Pre-certification and Customer Service (775) 982-3232 (888) 323-1461 www.stateofnv.hometownhealth.com
Dental PPO Network • Statewide dental PPO providers • Dental provider directory	**Diversified Dental Services** Northern Nevada: (866) 270-8326 Southern Nevada: (800) 249-3538 www.ddsppo.com

Vendor Contact List	
Northern HMO Plan • Provider network • Provider directories • Appeals • Benefit Information • Additions/deletions of providers • Pharmacy Benefits	**Hometown Health Plan HMO** Customer Service: (775) 982-3232 or (800) 336-0123 Hometown Rx Retail Pharmacy (844) 373-0970 Mail Order: Postal Prescription Services (PPS) (800) 552-6694 Costco Mail Order Pharmacy (800) 607-6861 www.pharmacy.costco.com
Southern HMO Plan • Provider network • Provider directories • Benefit Information/Appeals • Additions/deletions of providers	**Health Plan of Nevada** Customer Service: (702) 242-7300 (877) 545-7378 www.stateofnvhpnbenefits.com
Life and AD&D Insurance • Life insurance benefits information • Claim filing • Travel assistance • Beneficiary designation forms	**Standard Insurance Company** Customer Service: (888) 288-1270 https://www.standard.com/mybenefits/nevada/
Flexible Spending • Medical • Dependent Care	**HealthSCOPE Benefits** Customer Service: (888) 763-8232 Fax: (877) 240-0135 P.O. Box 3627 Little Rock, AR 72203 Email: pebphsahra@healthscopebenefits.com www.healthscopebenefits.com
Long-Term Care Insurance	**UNUM Long Term Care Policy #584040** In-State Local Customer Service: Karla DeCrescenzo (775) 722-5907 Karla.Descrescenzo@coloniallife.com Nevada System of Higher Education: Nikki Pecorino (775) 813-5309 or Nikki.pecorino@coloniallife.com Nationwide Customer Service for enrollees: (855) 328-8055 all other questions (877) 485-2318 www.unuminfo.com/stateofnevada
Home and Auto Insurance	**Liberty Mutual** Customer Service: (800) 637-7026 gary.bishop@libertymutual.com