Retiree Enrollment Guide

STATE OF NEVADA

Public Employees' Benefits Program

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Plan Year 2017

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

Plan Year 2017 Retiree Benefits Guide

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This document is for informational purposes only. Any discrepancies between the information contained herein and the *Plan Year 2017 Medical, Vision and Prescription Drug Master Plan Document/HMO Evidence of Coverage Certificates, or the 2017 Medicare & You handbook* shall be superseded by the plans' official documents.

Revised 12-13-2016

Introduction

Dear Retiring Employee:

The Public Employees' Benefits Program (PEBP) would like to extend its sincere congratulations to you as you enter into retirement. As an employee retiring from the State of Nevada or a participating local governmental entity, you may have the option to enroll in retiree coverage offered by the Public Employees' Benefits Program.

The information contained in this document is for Plan Year 2017 (July 1, 2016 - June 30, 2017). The benefits and premiums described herein are subject to change beginning July 1 of each plan year. On or about mid-April, you will receive an Open Enrollment letter describing the changes for the next plan year and instructions on where to find additional information. It is important to review the Open Enrollment material to stay informed of any changes that might occur in the future.

After reading this guide in its entirety, you will have an understanding of your retiree plan options, dependent eligibility, enrollment timeframe, years of service subsidy, premium cost, and the steps to enroll. For additional information, contact the PEBP office at (775) 684-7000 or (800) 326-5496 or email: mservices@peb.state.nv.us.

Eligibility for Retiree Insurance

Pursuant to NAC 287.135, retirees with 5 or more years of service credit (or 8 years of service credit for retired Legislators; NRS 287.047) are eligible for retiree coverage if the employee's last employer is participating in PEBP with their active employees. Retirees must also be receiving retirement benefit distributions from one or more of the following:

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

Retired public officers and employees who wish to enroll in coverage at initial retirement must complete enrollment within 60 days following the date of retirement as determined by PERS or NSHE. Failure to enroll **within 60 days** will result in termination of coverage.

Completing Enrollment

Complete the Retiree Benefits Enrollment and Change Form (RBECF)

Complete the Retiree Benefits Enrollment and Change Form in blue or black ink only. In section 1, choose the event (e.g. Retirement or Disabled Retiree), next enter your date of retirement. In Section 2, enter your information, including home phone and email information (if applicable). In Section 3, select your healthcare coverage. Be sure to only mark one box in the section. Continue completing sections 4 through 8 as indicated on the form.

Submit the original Retiree Benefit Enrollment and Change Form 30 - 60 days before retirement or no later than 60 days after the date of retirement.

Years of Service Certification Form

Submit original Years of Service Certification Form 30 - 60 days before retirement or as soon as possible, but no later than 60 days after the date of retirement.

Please note: Retirees and covered dependents aged 65 or older (or under age 65 if approved for Social Security Disability Benefits) who are eligible for premium-free Medicare Part A, must enroll in Part A and purchase Medicare Part B. For more information about PEBP's Medicare enrollment requirements, see the Enrollment section in this guide.

Mail ORIGINAL Forms to the following:

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

Note: Forms must be original, PEBP will not accept copies or facsimiles.

Voluntary Life Insurance Enrollment and Change Form

Retirees who wish to purchase Voluntary Life Insurance coverage from Standard Insurance must complete the Voluntary Life Enrollment and Change Form within 60 days following the date of retirement to the following:

Mail VOLUNTARY Life Insurance Form to the following:

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

Eligibility for Retiree Benefits

Retiree Coverage for Employees Initially Hired On or After January 1, 2010

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

Retiree Coverage for Employees Initially Hired On or After January 1, 2012

Retired employees with an **initial hire date on or after January 1, 2012** may participate in the program at retirement but will not qualify for a premium subsidy or an Exchange HRA contribution upon retirement.

Retiree Coverage for Employees Initially Hired On or Before January 1, 2012

State and non-state participating employees who meet the following requirements qualify for a "Years of Service" premium subsidy or Exchange Health Reimbursement Arrangement (HRA) contribution at initial retirement or re-retirement if the employee:

- Was initially hired by the state or participating non-state entity before January 1, 2012; and
- Is vested with the Public Employees' Retirement System (PERS) or the Nevada System of Higher Education (NSHE) (did not withdraw [cash out] their pension from PERS or NSHE); and
- Returned to work with a state agency or a participating non-state agency on or after January 1, 2012; and
- Upon retirement the last employer is a state or participating non-state entity.

Coverage for Survivors of Active Employees

The covered dependents of a deceased active employee who had 10 or more years of service credit may continue coverage by re-joining the program as a survivor within 60 days of the employee's death. Surviving dependents may include the spouse, domestic partner, and children covered on the employee's medical plan on the date of death. Survivors are not required to receive a survivor's pension benefit.

Coverage for Survivors of Retirees

The covered dependent(s) of a deceased retiree may continue coverage as a surviving dependent by re-joining the program within 60 days of the retiree's death. Surviving dependents may include the spouse, domestic partner, and children covered on the retiree's medical plan on the date of death. Survivors are not required to receive a survivor's pension benefit.

Non-State Retiree Eligibility (NAC 287.542, 287.548)

Non-state employees who retired after November 30, 2008 from a **PEBP participating** local governmental entity are eligible to enroll in PEBP retiree coverage. However, if the local government opts to leave the PEBP in the future, the retirees described above must also leave the program.

Eligibility for Retiree Benefits

Coverage for Survivors of Police Officer or Firefighter Killed in the Line of Duty

The surviving spouse and any child (dependent) of a police officer or firefighter who was employed by a participating public agency, who was killed in the line of duty, may join or continue coverage under PEBP (if the individual was eligible to participate on the date of death). The survivor and/or dependent must submit written notification of intent to enroll within 60 days after the employee's date of death to the agency that employed the police officer or firefighter.

The participating public agency that employed the police officer or firefighter shall pay the entire cost of the premiums or contributions to PEBP for any covered surviving dependent who meets the requirements to enroll. A surviving spouse is eligible to receive coverage for the duration of the surviving spouse's life. A surviving child is eligible to receive coverage until the child reaches age 26.

Disability Retirement

The PERS retirement date for an employee retiring under a long-term disability plan becomes effective on the day immediately following the employee's last day of employment, or the day immediately following the last day of earning creditable service, whichever is later. The timeframe for submitting retiree enrollment paperwork for a disability retirement is 60 days following the date of retirement. PEBP will confirm the retirement date with PERS prior to activating retiree coverage.

Retiree Late Enrollment

Retirees of a state agency, NSHE, participating local government, or the surviving spouse of a deceased retiree may reinstate coverage during any Open Enrollment if he or she did not have more than one period during which he or she was not covered under PEBP on or after October 1, 2011, or on or after the date of retirement, whichever is later. To request an enrollment packet, contact PEBP between April 1 and May 31. Coverage for late enrollees becomes effective July 1st. Late enrollees are not eligible for the Basic Life Insurance benefit.

Note: A person who retires on or after July 1, 2004, and who is eligible to participate in the Program as a primary insured may not elect to be a dependent of his or her spouse or domestic partner who is a primary insured in the Program. (NAC 287.530)

Enrollment

Enrollment Timeframe

Newly retiring employees who wish to enroll in retiree coverage shall have 60 days measured from their date of retirement to complete enrollment through the submission of the Retiree Benefits Enrollment and Change Form (R-BECF) and the Years of Service Certification Form (YOSC) to the PEBP office.

Allowable Coverage Changes for New Retirees

- May select a new medical plan option
- May enroll new dependents or delete existing covered dependent(s)
- May decline retiree coverage

When Retiree (CDHP or HMO) Coverage Starts

Retirees enrolling in the CDHP or HMO plan at retirement shall have their coverage effective on the first day of the month concurrent with or following the date of retirement. For example, for a June 1st retirement date, coverage becomes effective June 1st. However, for a June 2nd retirement date, coverage becomes effective July 1st.

Medicare Enrollment

Retirees aged 65 or older (or under age 65 if approved for Social Security Disability benefits) at initial retirement must enroll in premium-free Medicare Part A (if eligible) and purchase Medicare Part B. Retirees with Medicare Parts A and B will be required to enroll in a medical plan through Towers Watson's OneExchange unless he or she also covers a non-Medicare dependent.

PEBP will also require verification of Medicare Parts A and B enrollment status through the submission of a copy of the Part A card if eligible for premium-free Medicare Part A, or if ineligible for premium-free Medicare Part A, a copy of the denial letter issued by the Social Security Administration. All retirees are required to purchase Medicare Part B at age 65 (or under age 65 if eligible for Medicare due to disability).

For *newly retiring* employees, aged 65 or older, the Part A card (or Part A denial letter) and Part B card must be submitted to the PEBP office before retiree coverage becomes effective, or no later than 60 days following the retirement date. For more information, refer to the PEBP and Medicare Guide available at www.pebp.state.nv.us.

Declining (terminating) Retiree Coverage

Retirees who wish to decline PEBP coverage may do so by submitting a written request to decline all benefits including medical, dental, vision, prescription drug coverage, $12,500 Basic Life Insurance, Voluntary Life Insurance (if applicable), years of service premium subsidy and Exchange-HRA contribution (if applicable).

Termination requests received prior to the requested date of termination will occur on the last day of the month; otherwise, coverage will terminate on the last day of the month following PEBP's receipt of the written request.

Premium Cost, Premium Subsidy Adjustment, and Exchange HRA Contribution

How to Determine Your Monthly Premium Cost for the CDHP and HMO Plans
The monthly insurance premium is determined by the medical plan option, coverage tier (e.g., retiree only, retiree plus spouse/domestic partner, etc.) and the years of service premium subsidy adjustment (see **Years of Service Premium Subsidy for Retirees** below). Note: Purchased months/years of service do not count toward the years of service premium subsidy.

Years of Service Premium Subsidy for Retirees
Retirees who meet the eligibility requirements to receive a Years of Service Premium Subsidy will receive a monthly premium adjustment. The adjustment is based on the date of retirement and total years of earned service credit from all Nevada public employers (purchased service credit does not apply). The minimum subsidy is based on five years of service with incremental increases for each year above five years to a maximum of twenty years of service.

Monthly Premium cost for Medical Plans through Towers Watsons' One Exchange
The monthly cost for medical plans through OneExchange will vary depending on the medical plan selected. To learn about plan options and premium cost through OneExchange, call (888) 598-7545.

Exchange Health Reimbursement Arrangement (Exchange-HRA)
Eligible retirees enrolled in a medical plan through OneExchange receive an Exchange Health Reimbursement Arrangement (Exchange-HRA) contribution. The monthly contribution amount is based on the employee's retirement date and years of service. The Exchange-HRA contribution will commence coincident with the effective date of the medical plan through OneExchange.

Note: Retiree must maintain coverage in a medical plan through OneExchange to receive the Exchange HRA contribution, basic life and dental insurance (if applicable). Exception: Retirees with Tricare for Life and Medicare Parts A and B are not required to enroll in a medical plan through OneExchange to retain their HRA funding. However, they will be required to submit a copy of their Medicare Parts A and B card and retired military ID card to the PEBP office.

Paying for CDHP or HMO Coverage
PEBP will coordinate with PERS to establish monthly premium deductions from the retiree's pension check. Each monthly deduction pays for medical coverage for that month. In the following circumstances, PEBP may bill the retiree directly:

- During the first few months of retirement, pending PEBP's receipt of the years of service audit;
- Retiree's monthly pension check is insufficient to cover the premium cost; or
- NSHE retiree who participates in an alternative retirement plan.

Direct Payers: Payment for the current month's coverage is due on the 20th of the month. Any account past due is subject to termination retroactive to the last day of the month for which payment was received. To pay by credit card, please call (775) 684-7000 or (800) 326-5496.

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 group health care coverage through their own employer, you must provide the other plan's Summary Plan Document indicating the other plan offers significantly inferior coverage. Significantly inferior coverage is generally defined as a plan that offers 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 Health Savings Account or Health Reimbursement Arrangement.
- All foreign documents must be translated to English.
- The list above is not exhaustive. PEBP reserves the right to request additional documentation as required to establish dependent eligibility.

Plan Options

	Retiree plus spouse or domestic partner **both without** Medicare Part A & B	Retiree plus spouse or domestic partner **both with** Medicare Part A & B	Retiree plus spouse or domestic partner, **one with and one without Medicare**	Retiree only, **without** Medicare Part A & B	Retiree only **with** Medicare Part A & B	Survivor **without** Medicare Part A & B	Survivor **with** Medicare Part A & B
Medical Plan Options							
Consumer Driven Health Plan with HRA	√		√	√		√	
Health Plan of Nevada (Southern Nevada HMO) - Clark, Esmeralda, and Nye Counties	√		√	√		√	
Hometown Health Plan (Northern Nevada HMO)	√		√	√		√	
OneExchange with HRA (Retiree)		√	√		√		
OneExchange *without* HRA (Spouse/DP/Survivor w/ Medicare)		√	√				√
Dental Benefits							
Dental Plan	√	√	√	√	√	√	√
Basic Life Insurance							
Basic Life Insurance	√	√	√	√	√		
Voluntary Insurance Options							
Home and Auto Ins.	√	√	√	√	√	√	√
Voluntary Life Ins.	√	√	√	√	√		

- PEBP requires retirees and their covered dependents to enroll in "premium-free" Medicare Part A and purchase Medicare Part B at age 65; or under age 65 for those who have satisfied the 24 month Social Security Disability waiting period.
- Basic Life Insurance is not offered to reinstated retirees, spouses/domestic partners or dependents.
- The PPO Dental Plan is included with all PPO and HMO medical plans.
- PEBP's PPO Dental Plan is available as a voluntary option for retirees enrolled through OneExchange.

Summary of Benefits for Pre-Medicare Retirees

The following benefits are offered to pre-Medicare retirees, retirees with Medicare Part B only (do not qualify for premium-free Medicare Part A) and retirees with Medicare Part A and B who cover pre-Medicare dependent(s). For more detail on these benefits, see the Plan Year 2017 Medical, Vision and Prescription Drug Master Plan Document available at www.pebp.state.nv.us.

Benefits for Pre-Medicare Retirees

Benefit Type	Description
Medical, Pharmacy, Vision Benefits	Plan Options: Consumer Driven Health Plan (CDHP), Health Plan of Nevada (HPN) and Hometown Health Plan (HHP). Availability of the HMO plans are based on the retiree's county of residence in Nevada.
Dental Benefit (included with medical plan)	PPO Dental Plan: $1,500 annual maximum; $100 individual deductible or $300 family deductible. Eligible preventive services (oral examination, routine cleanings, etc.) are not subject to the annual maximum and are paid at 100% (when using in-network providers); Basic services (full-mouth periodontal cleanings, fillings, extractions) are paid at 80% after deductible; Major services (bridges, crowns, dentures, tooth implants) are paid at 50% after deductible.
Basic Life Insurance (included with medical plan, unless the retiree is a late enrollee)	$12,500 Basic Life Insurance Coverage (not available to late enrollees, dependents or surviving spouses/domestic partners).
Health Reimbursement Arrangement (HRA)	Retirees enrolled in the CDHP receive an HRA and a tax-exempt PEBP contribution to pay for qualifying out-of-pocket health care expenses.
State Retiree Years of Service Premium Subsidy	Eligible State retirees receive a premium subsidy when enrolled in the CDHP or HMO plan. Premium subsidy is based upon retirement date and total years of service credit (up to a maximum of 20 years).
Non-State Retiree Years of Service Premium Subsidy	Eligible non-State retirees receive a premium subsidy when enrolled in the CDHP or HMO plan. Premium subsidy is based upon retirement date and total years of service credit (up to a maximum of 20 years).

Summary of Benefits for Retirees with Medicare Parts A and B

The following benefits are offered to retirees with Medicare Parts A and B and covered spouses/domestic partners or surviving spouses/domestic partners with Medicare Parts A and B.

Benefit Options for Retirees with Medicare Parts A and B	
Benefit Type	**Description**
Medical, Prescription Drug, and Vision Benefits	Retirees and covered spouses/domestic partners and surviving spouses/domestic partners with Medicare Parts A and B may select medical, pharmacy, and vision benefits from a variety of plan options, e.g., Medicare Advantage Plan with Prescription Drug Coverage, Medigap (Medicare supplement) and Medicare Part D Prescription Drug plans through OneExchange.
Dental Plan	Option to purchase PEBP's PPO Dental Plan or select a dental plan through OneExchange
Basic Life Insurance	Eligible retirees enrolled in a medical plan through OneExchange receive a $12,500 Basic Life Insurance coverage benefit. Note: Reinstated retirees, spouses/domestic partners, and surviving spouses/domestic partners are not eligible for Basic Life Insurance coverage.
Exchange- Health Reimbursement Arrangement (HRA) with a monthly Years of Service Contribution	Eligible retirees enrolled in a medical plan through OneExchange receive an Exchange-HRA and a monthly tax-exempt contribution based upon the retiree's retirement date and years of service. Note: Medicare retirees who are eligible for the HRA contribution must maintain medical coverage through OneExchange to receive this benefit. Dis-enrolling or enrolling in a medical plan outside of PEBP or OneExchange will terminate all PEBP benefits. Exception: Retirees with Tricare for Life and Medicare Parts A and B are not required to enroll in a medical plan through OneExchange to retain their HRA funding. However, they will be required to submit a copy of their Medicare Parts A and B card and retired military ID card to the PEBP office. Spouses/domestic partners and surviving spouses/ domestic partners, and unsubsidized dependents are not eligible for the Exchange-HRA.

Medical Plan Comparison

Benefit Category	Consumer Driven Health Plan Amount You Pay In-Network	Health Plan of Nevada (Southern HMO) Amount You Pay In-Network	Hometown Health Plan (Northern HMO) 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 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 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
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)	Vision exam 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. 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 (non-participating provider)
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	100% - No Deductible	Not covered

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.

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 (unless prior authorization on file with Express Scripts)

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 of medications 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 you must be actively engaged and accept regular telephonic engagement calls with PEBP's Utilization Management Company. You must also 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 (non-formulary drugs will not apply to Deductible or Out-of-Pocket Maximum)	100% of the drug cost (non-formulary drugs will not apply to Deductible or Out-of-Pocket Maximum)

- To view or download the Preferred Drug List (formulary) or locate an in-network pharmacy, visit www.Express-Scripts.com or contact Express Scripts at 855-889-7708.

- 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 Mail Order (855) 889-7708

Diabetic Supplies coordinated through Express Scripts (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 a $50 copayment for each 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, then you will pay the actual cost. There is no cost to you for the blood glucose monitor.

To qualify for the Diabetic Supplies Mail Order Program you must be enrolled in the Diabetes Care Management Program. For information on this program and its benefits, please call Hometown Health Providers at (775) 982-3232 or (888) 323-1461.

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 and Hometown Health Providers.

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.

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.

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 care medications are not applied to deductible or annual out-of-pocket maximum.

For eligibility requirements for this program, refer to the Plan Year 2017 Medical, Vision and Prescription Drug Master Plan Document available at www.pebp.state.nv.us. For information on how to enroll in this program, contact HealthSCOPE Benefits at (888) 763-8232.

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.

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 is for participants who reside in rural Eastern Nevada near the Utah border and require access to care in Utah.

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.

CDHP Health Reimbursement Arrangement (HRA)
For Eligible Retirees

The Health Reimbursement Arrangement (HRA) is an account that PEBP establishes on behalf of retirees enrolled in the CDHP. Each plan year, PEBP contributes funds to the HRA which may be used tax-free to pay for qualified medical expenses as defined by the IRS (see IRS Publication 502 at www.IRS.gov); including payment of deductibles, coinsurance, dental costs or vision costs.

HRA funds may be used to pay out-of-pocket health care expenses incurred by the retiree, the retiree's spouse and any other dependent claimed on the retiree's tax return. HRA funds may not be used to pay CDHP premiums.

Current plan provisions allow for the HRA funds to carry-over from one plan year to the next plan year (i.e., funds will not be forfeited). However, in future years, PEBP may establish a limit on the balance that can be rolled over from one year to the next. **HRAs are not portable; participants cannot use HRA funds if they are no longer covered by the CDHP. If a retiree terminates CDHP coverage, the remaining balance in the HRA account will revert back to PEBP.**

The following contributions are provided to retirees who are enrolled in the CDHP on July 1, 2016:

State and Non-State Retiree 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

The Base and One-time Supplemental Contribution shown above only applies to retirees/dependents covered under the CDHP on July 1, 2016. Employees who retire August 1, 2016 and later (and who received the Plan Year 2017 HSA or HRA contribution on July 1, 2016) will not receive additional contributions at retirement. Retirees who change from the HMO plan to the CDHP plan on August 1, 2016 and later, receive a prorated HRA contribution determined by the CDHP coverage effective date and the remaining months in the plan year.

Note: Employees enrolled in the CDHP with an HRA who retire after July 1st will retain their HRA funds if they re-enroll in the CDHP at retirement. However, if the retiring employee changes to the HMO plan, any remaining funds in the HRA will revert to PEBP. The retiree will have one year (12 months) from the date the CDHP coverage ends to file a claim for reimbursement from the HRA for eligible claims incurred during the coverage period.

Coverage Options for Medicare Retirees

Coverage options vary for retirees and their covered dependents based on their Medicare status. For example, a retiree who has Medicare Parts A and B without any covered dependents is required to enroll through OneExchange. However, a retiree who has Medicare Parts A and B and who also covers a non-Medicare spouse may retain coverage under the CDHP or HMO plan until the spouse ages into Medicare.

The following describes the coverage options based on the Medicare status of the retiree and his or her covered dependents (if any).

Retiree has Medicare Parts A and B (without any covered dependents)

Retiree must enroll in a medical plan through OneExchange to receive the Exchange-Health Reimbursement Arrangement (Exchange-HRA), PEBP Dental coverage (optional), and Basic Life Insurance benefits (if applicable).

Retiree has Medicare Parts A and B (covering a non-Medicare dependent)

- Retiree may enroll in a medical plan through OneExchange and the non-Medicare dependent may retain coverage as an unsubsidized dependent on the CDHP or HMO plan; or
- Retiree may remain on the CDHP or HMO plan with the non-Medicare dependent until spouse/domestic partner ages into Medicare. In the case of a dependent child, the retiree may stay on the CDHP or HMO plan until the child ceases to be an eligible dependent; or
- Retiree may enroll in a medical plan through One Exchange and remove any covered dependents from his or her plan.

Retiree is not yet eligible for Medicare (covering a dependent who has Medicare Parts A and B)

- The retiree may remain on the CDHP or HMO plan and the dependent who has Medicare Parts A and B may enroll in a medical plan through OneExchange; or
- Both the retiree and the Medicare dependent may remain on the CDHP or HMO coverage until both become eligible for Medicare Parts A and B. In the case of a child, the retiree may retain CDHP or HMO plan coverage until the child ceases to be an eligible dependent.

Retiree with Medicare Parts A and B and Tricare for Life

- Retiree may enroll in a medical plan through OneExchange; or
- Retiree may continue coverage under Medicare Parts A and B and Tricare for Life.

Note: if the retiree is covering a non-Medicare dependent, he or she may retain coverage under the CDHP or HMO plan.

Coverage Options for Medicare Retirees

Retiree is Not Entitled to Premium-free Medicare Part A

Retiree may remain on the CDHP or HMO plan, but must provide proof of Part A ineligibility (by submitting to PEBP a Part A denial letter from the Social Security Administration). Retiree will be required to enroll in Medicare Part B and provide proof of enrollment by submitting a copy of the Medicare Part B card to PEBP.

Note: Retirees who are eligible to retain coverage under the PEBP CDHP or HMO plan receive a Part B premium credit of $104.90. The Part B credit will not apply until the first of the month following PEBP's receipt of the Part B card or the effective date of Part B, whichever occurs later.

Qualifying Events for Medicare Retirees

Any qualifying event (e.g., divorce, marriage, or the spouse/domestic partner of a retiree becomes eligible for Medicare Part A) which creates a situation where the Medicare retiree is no longer covering a pre-Medicare dependent will result in the requirement for the retiree and the Medicare spouse/domestic partner (if applicable) to enroll in a medical plan through OneExchange.

Medicare Part D Coverage and the Consumer Driven Health Plan

Retirees and covered spouses/domestic partners enrolled in the CDHP will lose their CDHP prescription drug coverage ***if*** they enroll in Medicare Part D Prescription Drug coverage. Further, disenrollment in Part D coverage will not reinstate CDHP prescription drug coverage until the next plan year.

Exchange Health Reimbursement Arrangement

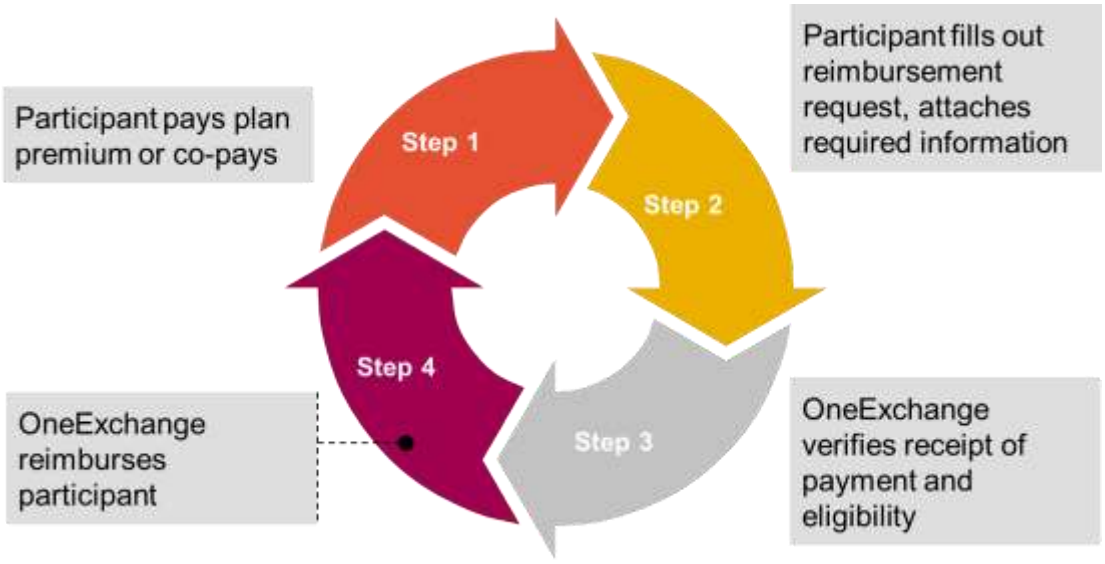
For Medicare Retirees Enrolled in a Medical Plan Through OneExchange

Exchange Health Reimbursement Arrangements or Exchange-HRAs are PEBP owned accounts established on behalf of PEBP retirees enrolled in a medical plan through OneExchange; or who have Medicare Parts A and B and Tricare for Life. Eligible retirees receive a monthly Exchange-HRA contribution based on their date of hire, date of retirement, and total years of service credit earned with each Nevada public employer.

The monthly tax-exempt contribution for Plan Year 2017 is $12 per month per year of service beginning with five years ($60) to a maximum of twenty years of service ($240). Individuals who retired before January 1, 1994, receive a flat $180 per month to the Exchange-HRA. Dependents do not receive an Exchange-HRA and no additional funds are contributed for dependents.

Retirees can use the Exchange-HRA funds to request reimbursement of health care premiums, Medicare Part B premiums, and qualified health care expenses (to the extent that funds are available in the Exchange-HRA). Exchange-HRA funds may also be used to request reimbursement of health care premiums and qualified health care expenses for a spouse or other tax dependent.

Exchange-HRA Plan Administrator
Towers Watson's OneExchange (OneExchange) is the Exchange-HRA plan administrator responsible for processing expense reimbursements. The following describes the reimbursement process:



Establishing the Exchange-HRA

PEBP will automatically establish your Exchange-HRA once you have enrolled in a medical plan through OneExchange. Once established, you will receive the OneExchange-HRA kit with information on how to use the Exchange-HRA and claim forms.

Exchange Health Reimbursement Arrangement

Examples of Eligible Medical Expenses for Exchange-HRA Retirees

An eligible expense is defined as an expense paid for care as described in Section 213 (d) of the Internal Revenue Code. Below are examples of eligible medical expenses that may be reimbursed through the Exchange-HRA.

Please refer to IRS Publication 502 for detailed information about Medical and Dental Expenses. If tax advice is required, you should seek the services of a tax professional.

Examples of qualifying health care expenses:

- Medical insurance premium
- Medicare Part B premium
- Medicare Part D premium
- Dental premium
- Prescription drug copays
- Office visit copays
- Hospital copays/coinsurance
- Prescription eyeglasses
- Prescription contact lenses
- Dental treatment
- Oral surgery
- Hearing aids

365 Day Timely Filing for Claim Submissions

The Exchange-HRA allows for a 12 month (365 day) timely filing period for eligible health care and/or premium expense claim submissions. The 365 days is measured from the date services were incurred. No Exchange-HRA reimbursements will be paid for any claim submitted that exceeds the 365 day timely filing period.

Note: In the event the retiree dies, the Exchange-HRA account of the eligible retiree is immediately forfeited; provided, however, that his or her estate or representatives may submit claims for eligible medical expenses incurred by the eligible retiree and his or her dependents prior to the eligible retiree's death, as long as such claims are submitted within one-hundred eighty (180) days following the retiree's date of death.

Plan provisions allow Exchange-HRA funds to carry-over from one plan year to the next. However, this provision is not guaranteed and changes to the amounts that carry-over from one year to the next could change in the future. The purpose of this account is to assist retirees in paying their current out-of-pocket health care expenses and premiums.

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 test $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 Eye-Med 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 features 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 performed while an inpatient, same day surgery or outpatient office
- 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.

EyeMed Vision Care

Hometown Health Plan offers EyeMed Vision 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 a 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 on the HPN website http://stateofnv.healthplanofnevada.com/ or call 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	$7 Copayment
Tier II: Preferred Brand Name Covered Drug*	$35 Copayment
Tier III: No-Preferred Generic or Brand Name Covered Drug*	$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 pharamcists
- 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. HPN 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 HPN 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 HPN are eligible for expanded statewide provider access. HPN and Hometown Health Plan (northern Nevada HMO plan) have a special network reciprocity agreement that allows HMO members to utilize both networks under certain circumstances. Reciprocity applies when traveling to/from northern/southern Nevada. 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. HPqN'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 HPN's 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 HPN's 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

Voluntary Dental Plan for OneExchange Retirees and Covered Dependents

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 PPO 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 discounted PPO 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 discounted PPO 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: Could 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 $1,500**.

State Retiree and Survivor Rates

Effective July 1, 2016 - June 30, 2017

State Retiree Rates	Statewide PPO **Consumer Driven Health Plan**		
	Rate	Base Subsidy	***Retiree Premium****
Retiree	580.78	371.70	209.08
Retiree + Spouse	1,060.75	582.89	477.86
Retiree + Children	765.62	453.03	312.59
Retiree + Family	1,248.10	665.32	582.78
Surviving/Unsubsidized Spouse	580.78	—	580.78
Retiree/Unsubsidized Spouse + Children	765.62	—	765.62

State Retiree Rates	Statewide HMO **Hometown Health Plan and Health Plan of Nevada**		
	Rate	Base Subsidy	***Retiree Premium****
Retiree	746.12	365.60	380.52
Retiree + Spouse	1,464.37	573.89	890.48
Retiree + Children	1,079.83	462.37	617.46
Retiree + Family	1,798.08	670.67	1,127.41
Surviving/Unsubsidized Spouse	746.12	—	746.12
Surviving/Unsubsidized Spouse + Children	1,079.83	—	1,079.83

The State "Retiree Premiums" above are subsidized rates for those who retired on or before January 1, 1994. If you retired after January 1, 1994, refer to the Retiree Years of Service Subsidy table shown page 42 to determine your final premium.

State Retiree with Domestic Partner Rates

Effective July 1, 2016 - June 30, 2017

State Retiree with Domestic Partner Rates	Statewide PPO			
	Consumer Driven Health Plan			
	Rate	Base Subsidy	Taxable Subsidy	***Retiree Premium***
Retiree + DP	1,060.75	371.70	211.19	477.86
Retiree + DP's Child(ren)	765.62	371.70	81.33	312.59
Retiree + Children of both	765.62	453.03	—	312.59
Retiree + DP + Retiree's Child(ren)	1,248.10	453.03	212.29	582.78
Retiree + DP + DP's Child(ren)	1,248.10	371.70	293.62	582.78
Retiree + DP + Children of both	1,248.10	453.03	212.29	582.78

State Retiree with Domestic Partner Rates	Statewide HMO			
	Hometown Health Plan and Health Plan of Nevada			
	Rate	Base Subsidy	Taxable Subsidy	***Retiree Premium***
Retiree + DP	1,464.37	365.60	208.29	890.48
Retiree + DP's Child(ren)	1,079.83	365.60	96.77	617.46
Retiree + Children of both	1,079.83	462.37	—	617.46
Retiree + DP + Retiree's Child(ren)	1,798.08	462.37	208.30	1,127.41
Retiree + DP + DP's Child(ren)	1,798.08	365.60	305.07	1,127.41
Retiree + DP + Child(ren) of both	1,798.08	462.37	208.30	1,127.41

The State "Retiree Premiums" above are subsidized rates for those who retired on or before January 1, 1994. If you retired after January 1, 1994, refer to the Retiree Years of Service Subsidy table shown on page 42 to determine your final premium.

Non-State Retiree and Survivor Rates

Effective July 1, 2016 - June 30, 2017

Non-State Retiree and Survivor Rates	Statewide PPO		
	Consumer Driven Health Plan		
	Rate	Base Subsidy	***Retiree Premium****
Retiree Only	957.06	612.52	344.54
Retiree + Spouse/DP	1,813.31	989.27	824.04
Retiree + Child(ren)	1,700.53	939.64	760.89
Retiree + Family	2,555.93	1,316.02	1,239.91
Surviving/Unsubsidized Spouse/DP	957.06	—	957.06
Surviving/Unsubsidized Spouse/DP + Child(ren)	1,700.53	—	1,700.53

Non-State Retiree and Survivor Rates	Statewide HMO		
	Hometown Health Plan and Health Plan of Nevada		
	Rate	Base Subsidy	***Retiree Premium****
Retiree Only	791.84	388.00	403.84
Retiree + Spouse/DP	1,555.81	609.55	946.26
Retiree + Child(ren)	1,193.01	504.34	688.67
Retiree + Family	1,956.98	725.89	1,231.09
Surviving/Unsubsidized Spouse/ DP	791.84	—	791.84
Surviving/Unsubsidized Spouse/ DP + Child(ren)	1,193.01	—	1,193.01

*The Non-State "Retiree Premiums" above are subsidized rates for those who retired on or before January 1, 1994. If you retired after January 1, 1994, refer to the Retiree Years of Service Subsidy table shown on page 42.

To determine your Non-State Retiree final premium, turn to page 42.

Retiree Years of Service Subsidy

Effective July 1, 2016 - June 30, 2017

State and Non-State Retiree Years of Service Subsidy for Retirees Enrolled in the CDHP/HMO Plan	
Years of Service	**Subsidy***
5	+322.72
6	+290.45
7	+258.18
8	+225.91
9	+193.63
10	+161.36
11	+129.09
12	+96.82
13	+64.54
14	+32.27
15 (Base)	—
16	-32.27
17	-64.54
18	-96.82
19	-129.09
20	-161.36

- For participants who retired *before* January 1, 1994, the Participant Premium for the selected plan and tier is shown on the applicable State and Non-State Retiree Rate Tables .
- *For participants who retired *on or after* January 1, 1994, *add or subtract* the appropriate subsidy based on the number of years of service *to or from* the Participant Premium for the selected plan and tier shown on pages 39 - 42.
- Those retirees with less than 15 Years of Service, who were initially hired by their last employer *on or after* January 1, 2010 and who are not disabled do not receive a Years of Service Subsidy or Base Subsidy.
- Those retirees who were hired *on or after* January 1, 2012 do not receive a Years of Service Subsidy or Base Subsidy.
- If you are a retiree (or survivor) enrolled in the CDHP or HMO plan and you have submitted proof of your Medicare Part B enrollment to the PEBP office, deduct $104.90 from your premium cost.

State Retiree Rates Without Subsidy

Effective July 1, 2016 - June 30, 2017

State Retirees WITHOUT Subsidy	Statewide PPO	Statewide HMO
	Consumer Driven Health Plan	Hometown Health Plan and Health Plan of Nevada
	Participant Premium	Participant Premium
Retiree only	580.78	746.12
Retiree + Spouse	1,060.75	1,464.37
Retiree + Child(ren)	765.62	1,079.83
Retiree + Family	1,248.10	1,798.08
Surviving/Unsubsidized Dependent	580.78	746.12
Surviving/Unsubsidized Spouse + Child(ren)	765.62	1,079.83

Exchange-HRA Contribution and Optional Dental Coverage

Exchange-HRA Contribution for Medicare Retirees Enrolled in OneExchange	
Years of Service	**Contribution**
5	+60.00
6	+72.00
7	+84.00
8	+96.00
9	+108.00
10	+120.00
11	+132.00
12	+144.00
13	+156.00
14	+168.00
15 (Base)	+180.00
16	+192.00
17	+204.00
18	+216.00
19	+228.00
20	+240.00

- Participants who retired before January 1, 1994 receive the 15-year ($180) base contribution.
- For participants who retired on or after January 1, 1994, the contribution is $12 per month per year of service beginning with 5 years ($60) and a maximum of 20 years ($240).
- Those retirees with less than 15 years of service, who were hired by their last employer *on or after* January 1, 2010, and who are not disabled, do not receive a Years of Service contribution.
- Those retirees who were hired by their last employer on or after January 1, 2012 do not receive a years of service contribution.
- The contribution amounts shown in the table to the left does not include the one-time $2 per month per year of service ($360 for a retiree with 15 Years of Service) contribution for Medicare retirees enrolled in a medical plan through OneExchange on July 1, 2016. Retirees enrolled in OneExchange on or after August 1, 2016 are not eligible for the Plan Year 2017 one-time supplemental contribution.

Voluntary Dental Coverage Option for Medicare Retirees Optional dental coverage for participants enrolled in an OneExchange Medical Plan		
Voluntary Dental Coverage	**State Retiree Rate**	**Non-State Retiree Rate**
Retiree only	36.78	36.84
Retiree + Spouse/DP	73.56	73.68
Surviving/Unsubsidized Spouse/DP	36.78	36.84
To enroll in PEBP dental coverage, select OneExchange with PEBP dental when completing your enrollment form. Note: Retirees paid through PERS will pay their monthly premium through PERS deductions.		

COBRA Rates
State and Non-State Retiree

State Retiree COBRA	Statewide PPO	Statewide HMO
	Consumer Driven Health Plan	**Hometown Health Plan & Health Plan of Nevada**
Retiree	**Premium**	**Premium**
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 Retiree COBRA	Statewide PPO	Statewide HMO
	Consumer Driven Health Plan	**Hometown Health Plan & Health Plan of Nevada**
Retiree	**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
-- COBRA participants do not qualify for Life Insurance and Long-Term Disability. -- Participants on COBRA do not receive a subsidy.		

Retiree Group Basic Life Insurance

For All Plan Options

Benefit Description	Benefit Features All Eligible Participants
Retiree Basic Life Insurance	Retirees enrolled in a PEBP-sponsored medical plan receive $12,500 Basic Life. Refer to the Life Insurance Certificate at www.standard.com/mybenefits/nevada for more information about this benefit.
Beneficiary Financial Counseling	The beneficiary of a deceased retiree may be eligible to receive comprehensive and objective financial counseling through an arrangement with PricewaterhouseCoopers. Services include a beneficiary guide about settling an estate and other important topics, personal financial counseling, financial analysis, 12 months of unlimited toll-free telephone access to financial counselors, a financial web site and newsletter "Your Money, Your Future." See the Beneficiary Counseling Brochure at www.standard.com/mybenefits/nevada for more information.
Medex Travel Assist	Medex Travel Assist is designed to respond to most medical care situations and many other emergencies you and your family experience when you travel 100 miles or more from your home. Medex provides a wide-ranging program of information, referral, coordination, and assistance services. These services include pre-trip assistance, medical assistance, emergency transportation, travel and technical assistance, legal services, and medical supplies. Assistance is available 24 hours a day, 365 days a year whether you are 100 or 10,000 miles away from your home. Simply print out and carry the Medex Travel Assist Card available at www.standard.com/mybenefits/nevada.
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/.

Voluntary Life Insurance

The State of Nevada provides a $12,500 Basic Life Insurance benefit 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 PERS check in most instances for retired participants.

You may also purchase Voluntary Life insurance at group rates. Voluntary Life amounts may be elected to a maximum of $50,000.

Voluntary Life premiums are calculated based on the retiree's age as of each July 1. This means that regardless of the amount of insurance elected, retired participants will pay premiums based on their age and the amount of coverage elected.

Group Life and Long-Term Care Portability and Conversion Options

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

As you leave 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 when you retire. 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.

Years of Service Certification Form (YOSC)

As a retired public employee, you may qualify for a premium subsidy based on each Nevada public employer with whom you earned a service credit. In order to apply for a subsidy toward your retiree health insurance premium, the YOSC form must be received in the PEBP office by the last business day of the month prior to the start of retiree coverage.

Steps to completing the form:

Step 1: Enter social security number, date of birth, gender, last name, first name, and retirement date.

Step 2: List your most recent Nevada public employer on the first line. Employer codes are located on the Employer Code list included in this guide. List each of your former Nevada public employers. *Note: If your former employer cannot be located on the list, write the employer's name without entering a code number.*

Step 3: Enter the years and months you worked for each Nevada public employer; do not round days up to the next month; do not round months up to the next year.

Example: employee worked for the City of Las Vegas from 03-26-82 (Mar 1982) to 03-17-87 (Mar 1987); this is equal to 4 years and 11 months of service.

Step 4: Enter any extra service credit that was purchased on your behalf. Note: do not list repayment of refunded contributions as purchased service credit.

Step 5: Sign and date the form.

Refer to the Years of Service Certification - Employer Code List to identify your former Nevada public employer according to the following:

If you worked for various state agencies within the State of Nevada, enter the total years that you worked for all state agencies on one line.

Note: Various state agencies include employees who worked for a state department, division, board, commission, PERS, LCB, and classified employees working for the Nevada System of Higher Education (contributing to PERS). Enter the following code:

Code 9999 State

If you worked for the Nevada System of Higher Education as a faculty member (under contract) and you are retiring under the Retirement Plan Alternatives program (defined contribution retirement plan) such as TIAA-CREF, VALIC, or Fidelity Investments (non-PERS employee), enter the applicable code below:

9858 University of Nevada, Reno

9859 University of Nevada, Las Vegas

Note: The subsidy or contribution amount is determined using each full year of service credit (12 months) to a maximum of 20 years. Purchased service does not apply to the years of service subsidy or contribution allocation.

Years of Service Certification Form (YOSC)

Employer Code	Employer Name
State Agencies	
9999	Use this code if you worked for a state department, division, board, commission, PERS, LCB, or you are a PERS retiree from the Nevada System of Higher Education
9856	Legislator's Retirement System
9858	Nevada System of Higher Education - North (Non-PERS)
9859	Nevada System of Higher Education - South (Non-PERS)
Cities	
9713	Carson City
9712	City of Boulder
9790	City of Caliente
9785	City of Carlin
9714	City of Elko
9715	City of Ely
9716	City of Fallon
9819	City of Fernley
9860	City of Gabbs
9717	City of Henderson
9718	City of Las Vegas
9818	City of Lovelock
9786	City of Mesquite
9719	City of North Las Vegas
9720	City of Reno
9722	City of Sparks
9816	City of Wells
9724	City of West Wendover
9817	City of Winnemucca
9725	City of Yerington
Counties	
9711	Churchill County
9727	Clark County
9731	Douglas County
9733	Elko County

Years of Service Certification Form (YOSC)	
Employer Code	**Employer Name**
Counties	
9791	Esmeralda County
9737	Eureka County
9740	Humboldt County
9743	Lander County
9746	Lincoln County
9752	Lyon County
9809	Mineral County
9758	Nye County
9763	Pershing County
9771	Storey County
9779	Washoe County
9782	White Pine County
School Districts	
9704	Carson City School District
9709	Churchill County School District
9726	Clark County School District
9729	Douglas County School District
9732	Elko County School District
9735	Esmeralda County School District
9736	Eureka County School District
9739	Humboldt County School District
9742	Lander County School District
9744	Lincoln County School District
9751	Lyon County School District
9753	Mineral County School District
9759	Nye County School District
9761	Pershing County School District
9770	Storey County School District
9777	Washoe County School District
9781	White Pine County School District
Charter Schools	
9791	Esmeralda County
9737	Eureka County

Years of Service Certification Form (YOSC)	
Employer Code	**Employer Name**
Charter Schools	
9874	100 Academy of Excellence
9803	Academy for Career Education
9800	Andre Agassi College Preparatory Academy
9799	Bailey Charter Elementary School
9873	Carson Montessori School
9726	Clark County Team Academy, Clark County
9798	Coral Academy of Science Charter School
9801	Explore Knowledge Academy Charter School
9709	Gateways To Success Charter School, Churchill County
9870	Halima Academy
9804	High Desert Montessori School
9792	I Can Do Anything Charter High School
9875	Innovations Charter
9726	Keystone Academy Charter High School, Clark County
9802	Mariposa Academy of Language And Learning
9777	Nevada Leadership Academy, Washoe County
9872	Nevada State High School
9867	Odyssey Charter School
9876	Rainbow Dreams Academy
9868	Rainshadow Charter School
9871	Sierra Crest Academy
9796	Sierra Nevada Academy
9869	Silver State High School
9777	Team A Washoe Charter School, Washoe County
Police/Fire Protection	
9842	Austin Volunteer Fire Department
9839	Battle Mountain Volunteer Fire Dept.
9700	Central Lyon County Fire Protection District
9710	Churchill County Volunteer Fire Department
9721	City of Reno Firefighters
9723	City of Wells Volunteer Fire Department
9829	Elko Volunteer Fire Department

Years of Service Certification Form (YOSC)	
Employer Code	**Employer Name**
Police/Fire Protection	
9852	Grass Valley Volunteer Fire Department
9749	Las Vegas Metropolitan Police Department
9828	Lovelock Volunteer Fire Department
9755	No. Lake Tahoe Fire Protection District
9901	Mason Valley Fire District
9699	North Lyon County Fire Protection District
9835	Pershing Volunteer Fire Department
9893	Rye Patch Volunteer Fire Department
9885	Sierra Fire Prot District
9773	Tahoe-Douglas Fire Protection District
9840	Winnemucca Rural Volunteer Fire District
9783	Winnemucca Volunteer Fire Department
9902	Mason Valley Fire District
Hospitals/Clinics/Health Districts	
9702	Battle Mountain General Hospital
9705	Carson Tahoe Hospital
9728	Clark County Health District
9738	Grover C. Dils Medical Center
9741	Humboldt General Hospital
9789	Lyon Health Center
9754	Mount Grant General Hospital
9760	Nye Regional Medical Center
9878	Pahrump Medical Center
9764	Pershing General Hospital
9775	University Medical Center of Southern Nevada
9780	Washoe County Hospital
9784	William Bee Ririe Hospital
Utilities/Planning Districts	
9815	Alamo Sewer & Water General Improvement District
9822	Beatty Water & Sanitation District
9703	Caliente Public Utilities
9850	Canyon General Improvement District
9820	Carson Water Sub. District

Years of Service Certification Form (YOSC)	
Employer Code	**Employer Name**
Utilities/Planning Districts	
9706	Carson-Truckee Water Conservancy District
9707	CC Communications
9806	Clark County Water Reclamation District
9899	Clean Water Coalition
9730	Douglas County Sewer District
9879	Ely Water Department
9882	Fernley Town Utilities
9838	Gardnerville-Ranchos General Improvement District
9853	Gerlach General Improvement District
9837	Indian Hills Improvement District
9841	Kingsbury General Improvement District
9813	Lander County Sewer & Water #2
9745	Lincoln County Power District
9788	Lovelock Meadows Water District
9845	McGill-Ruth Consolidated Sewer & Water General Improvement
9827	Minden-Gardnerville Sanitation District
9880	Mineral County Power
9812	Moapa Valley Water District
9889	Northeast NV Develop
9811	Overton Power District #3
9844	Palomino Valley General Improvement District
9762	Pershing County Water Conservation District
9823	Redevelopment Authority of Sparks
9886	Regional Plan Washoe County
9836	Regional Planning Agency of Washoe County
9765	Regional Transportation Commission
9884	Regional Water Planning
9768	Round Hill General Improvement
9894	RTC of Southern Nevada
9883	So Nevada Water Authority
9831	Stagecoach General Improvement
9772	Sun Valley General Improvement District
9887	Tahoe Regional Plan
9825	Tahoe-Douglas District

Years of Service Certification Form (YOSC)	
Employer Code	**Employer Name**
Utilities/Planning Districts	
9881	Tonopah Utilities
9890	Tri-County Development Authority
9836	Truckee Meadows Regional Planning Agency
9848	Truckee Meadows Water Authority
9774	Truckee-Carson Irrigation District
9814	Virgin Valley Water District
9776	Walker River Irrigation District
9778	Washoe County Water Conservation District
Library District	
9862	Boulder City Library District
9849	Henderson District Public Libraries
9750	Las Vegas/Clark County Library District
Convention and Visitor Authorities	
9826	Elko Convention & Visitors Authority
9747	Las Vegas Convention/Visitors Authority
9767	Reno/Sparks Convention/Visitors Authority
9810	White Pine County Tourism & Recreation Board
Housing Authorities	
9748	Clark County Housing Authority
9748	Las Vegas Housing Authority
9833	Mineral County Housing Authority
9757	Nevada Rural Housing Authority
9748	North Las Vegas Housing Authority
9766	Reno Housing Authority
9748	Southern Nevada Regional Housing Authority
Judicial	
9713	Carson City JRS
9718	City of Las Vegas JRS
9720	City of Reno JRS
9722	City of Sparks JRS
9895	Commission on Judicial Discipline
9731	Douglas County JRS
9737	Eureka County JRS
9857	Judicial Retirement System (State)

Years of Service Certification Form (YOSC)	
Employer Code	**Employer Name**
Judicial	
9746	Lincoln County JRS
9752	Lyon County JRS
9701	Airport Authority of Washoe County
9898	Carson City Airport Authority
9846	Central Dispatch Administrative Authority
9832	Churchill Mosquito Abate District
9843	Conservation District of Southern Nevada
9834	East Fork Swimming Pool District
9888	Elko Area Recreation Commission
9866	Elko Co School Lunch Program
9808	Elko County Agricultural Assoc.
9892	Lander Co Fair And Rec
Other	
9891	LV Housing-Force Acct
9830	Nevada Association of Counties
9863	Nevada Employment Security Department
9851	Nevada Tahoe Conservation District
9807	NEVADAWORKS
9713	RSVP
9877	Rural Bi-Co Delinq Prev
9854	Southern Nevada Workforce Investment Board (SNWIB)
9864	Wild Horse Preservation Commission

Informational Resources and Publications

www.pebp.state.nv.us

Plan Year 2017 Medical, Vision and Prescription Drug Master Plan Document Available at www.pebp.state.nv.us or by request by calling PEBP at (775) 684-7000 or (800) 326-5496	The Master Plan Document provides a comprehensive description of the retiree benefits.
Summary of Benefits and Coverage Document (SBC) for the *Consumer Driven Health Plan* Available at www.pebp.state.nv.us or by request by calling PEBP at (775) 684-7000 or (800) 326-5496	The SBC provides a summary of the key features of the Consumer Driven Health Plan such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.
Summary of Benefits and Coverage Document (SBC) for the *Hometown Health Plan* Available at www.pebp.state.nv.us or by request by calling PEBP at (775) 684-7000 or (800) 326-5496	The SBC provides a summary of the key features of the Hometown Health Plan such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.
Summary of Benefits and Coverage Document (SBC) for the *Health Plan of Nevada* Available at www.pebp.state.nv.us or by request by calling PEBP at (775) 684-7000 or (800) 326-5496	The SBC provides a summary of the key features of the Health Plan of Nevada such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.
Retiree Resources www.pebp.state.nv.us	Helpful links that provide information about how to enroll in retiree coverage, retiree eligibility, medical plan options, premium rates, and voluntary product offerings.
Provider Networks www.pebp.state.nv.us	Helpful links to locate providers based upon the plan option selected.
Publications www.pebp.state.nv.us	Links to various PEBP publications including enrollment guides, Health Matters Newsletter, Plan Documents, Presentations and more.
PEBP Board Meetings www.pebp.state.nv.us	Board meeting information such as agendas, board packets and audio recordings of past board meetings.

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 (CDHP members only) **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 (800) 777-1840 www.stateofnvhpnbenefits.com
Life and Long Term Disability Insurance • Life insurance benefits information • Claim filing • MEDEX travel assistance • Beneficiary designation forms	**Standard Insurance Company** Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html
Medicare Exchange Medicare plans Exchange-HRA administrator **PayFlex—Health Reimbursement Arrangement**	**Towers Watson's OneExchange** 10975 Sterling View Drive, Suite A1 South Jordan, UT 84095 Customer Service: (888) 598-7545 www.medicare.oneexchange.com/PEBP **PayFlex** Customer Service: (888) 598-7545 General Fax: (402) 231-4300 Claims Fax: (402) 231-4310

Voluntary Product Contacts

Life Insurance • Voluntary Life Insurance • Voluntary Short-Term Disability Insurance	**Standard Insurance Company** Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html or www.pebp.state.nv.us
Long-Term Care Insurance	**UNUM** Customer Service: (877) 485-2318 www.pebp.state.nv.us
Home and Auto Insurance	**Liberty Mutual** Customer Service: (800) 637-7026 gary.bishop@libertymutual.com