State of Nevada
Public Employees’ Benefits Program

Master Plan Document for the
PEBP Enrollment and Eligibility

Plan Year 2018
July 1, 2017 – June 30, 2018

www.pebp.state.nv.us
(775) 684-7000 or (800) 326-5496
Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.
Welcome PEBP Participant

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

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

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

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

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

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

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

Sincerely,

Public Employees’ Benefits Program

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

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

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

- This PEBP Plan is governed by the State of Nevada.
- This document is intended to comply with the Nevada Revised Statutes (NRS) Chapter 287, and the Nevada Administrative Code 287 as amended and certain provisions of NRS 695G and NRS 689B.
- This Plan is administered in accordance with regulations of Section 125 of the Internal Revenue Code. For information regarding Section 125, please see the Section 125 Health and Welfare Benefits Plan Document available at www.pebp.state.nv.us.

The policies described in this document are effective July 1, 2017, and unless stated differently replace all other Eligibility and Enrollment policies outlined in documents/summary plan descriptions previously provided to You.

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

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

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

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

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

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

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

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

Rescissions

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

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

- Review the Table of Contents. The Table of Contents provides You with an outline of the sections.

- Become familiar with PEBP vendors and the services they provide by reviewing the Participant Contact Guide.

- Review the Participant Rights and Responsibilities section located in the Introduction section of this document.

- The Definitions section explains many technical and legal terms that appear in the text.

- Review the Enrollment and Eligibility provisions. These describe the Enrollment and Eligibility rules in detail. There are examples, charts and tables to help clarify key provisions and details in regards to PEBP Enrollment and Eligibility.

- Refer to the General Provisions and Notices section for information regarding Your rights and general provisions of the Plan.
Participant Rights and Responsibilities

You have the right to:

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

You have the responsibility to:

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

• Provide PEBP with accurate and complete information needed to administer Your health benefit plan, including if You or a covered Dependent has other health benefit coverage.

• Retain copies of the documents provided to You from PEBP and PEBP’s vendors. These documents include but are not limited to:
  o Copies of the Explanation of Benefits (EOB) from PEBP’s third party Claims Administrator. **Duplicates of Your EOB’s may not be available to you.** It is important that You store these documents with Your other important paperwork.
  o Copies of Your Enrollment forms submitted to PEBP.
  o Copies of Your medical, vision and dental bills.
  o Copies of Your HSA contributions, distributions and tax forms.

The Plan is committed to:

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

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<td>Public Employees’ Benefits Program (PEBP) 901 S. Stewart Street, Suite 1001 Carson City, NV 89701 Customer Service: (775) 684-7000 or (800) 326-5496 Fax: (775) 684-7028 <a href="http://www.pebp.state.nv.us">www.pebp.state.nv.us</a></td>
<td>Plan Administrator  • Enrollment and change of status  • Certificate of Creditable Coverage  • COBRA information and premium payments  • Level 2 claim appeals  • External Review coordination</td>
</tr>
<tr>
<td><strong>Office for Consumer Health Assistance</strong> 555 E. Washington Avenue, Suite 4800 Las Vegas, NV 89101 Customer Service: (702) 486-3587 or (888) 333-1597 <a href="http://www.govcha.state.nv.us">www.govcha.state.nv.us</a></td>
<td>Consumer Health Assistance  • Concerns and problems related to coverage  • Provider billing issues  • External Review information</td>
</tr>
<tr>
<td><strong>Nevada Secretary of State Office</strong>  The Living Will Lockbox c/o Nevada Secretary of State 101 North Carson St., Ste. 3 Carson City NV 89701 Phone: (775) 684-5708 Fax: (775) 684-7177 <a href="http://www.livingwilllockbox.com">www.livingwilllockbox.com</a></td>
<td>Living Will Information  • Declaration governing the withholding or withdrawal of life-sustaining treatment  • Durable power of attorney for health care decisions  • Do not resuscitate order</td>
</tr>
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<td><strong>Consumer Driven Health Plan Medical, Vision and Dental Contacts</strong></td>
<td><strong>Service</strong></td>
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<td><strong>PEBP Statewide PPO Network</strong> Administered by Hometown Health Providers and Sierra Health Care Options Customer Service: (800) 336-0123 <a href="http://www.pebp.state.nv.us">www.pebp.state.nv.us</a></td>
<td>In-state PPO Medical Network  • Network Providers  • Provider directory  • Additions/deletions of Providers</td>
</tr>
<tr>
<td><strong>Aetna Signature Administrators PPO Network</strong> For assistance locating a provider, contact HealthSCOPE Benefits at (888) 763-8232</td>
<td>National Medical Network/Outside of Nevada  • Network Providers  • Provider directory (website only)  • Additions/deletions of Providers  The National Medical Network is available to CDHP Participants who reside outside of Nevada or who live in Nevada but choose to seek health care outside of Nevada.</td>
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<td><strong>Diversified Dental Services</strong></td>
<td><strong>Self-funded Dental PPO Network</strong></td>
</tr>
<tr>
<td>P O Box 36100</td>
<td>• General information on statewide dental PPO Providers</td>
</tr>
<tr>
<td>Las Vegas, NV 89133-6100</td>
<td>• General information on national dental PPO Providers</td>
</tr>
<tr>
<td>Customer Service:</td>
<td>• Dental Provider directory</td>
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<tr>
<td>Northern Nevada: (866) 270-8326</td>
<td></td>
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<tr>
<td>Southern Nevada: (800) 249-3538</td>
<td></td>
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<tr>
<td><a href="http://www.ddsppo.com">www.ddsppo.com</a></td>
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<td>HealthSCOPE Benefits</td>
<td>• Claim status inquiries</td>
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<td>P O Box 91603</td>
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<td>Lubbock, TX 79490-1603</td>
<td>• Verification of eligibility</td>
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<tr>
<td>P O Box 2860</td>
<td>• Health Savings Account (HSA) Administrator</td>
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<tr>
<td>Little Rock, AR 72203</td>
<td>• Health Reimbursement Arrangement (HRA) Administrator</td>
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<tr>
<td>Group Number: NVPEB</td>
<td>• In-network pricing tool</td>
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<tr>
<td>Customer Service: (888) 763-8232</td>
<td>• Disease Management for Diabetes</td>
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<tr>
<td><a href="http://www.healthscopebenefits.com">www.healthscopebenefits.com</a></td>
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<td><strong>Mail:</strong> HealthSCOPE Benefits</td>
<td>• Pre-certification, for example:</td>
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<tr>
<td>27 Corporate Hill Drive</td>
<td>o Inpatient and outpatient admissions performed in a surgery</td>
</tr>
<tr>
<td>Little Rock, AR 77205</td>
<td>center or outpatient setting hospital admissions</td>
</tr>
<tr>
<td>Fax: 800-458-0701</td>
<td>o All spinal surgeries</td>
</tr>
<tr>
<td>Email: <a href="mailto:diabetes@healthscopebenefits.com">diabetes@healthscopebenefits.com</a></td>
<td>o All bariatric (weight loss) surgeries</td>
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<td></td>
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<td><strong>Customer Service:</strong></td>
<td>• Prescription Drug information</td>
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<tr>
<td>(775) 982-3232 or (888) 323-1461</td>
<td>• Retail Network Pharmacies</td>
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<tr>
<td><a href="http://www.stateofnv.hometownhealth.com">www.stateofnv.hometownhealth.com</a></td>
<td>• Prior authorization</td>
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<td><strong>Customer Service and Prior Authorization</strong></td>
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</tr>
<tr>
<td>(855) 889-7708</td>
<td></td>
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<tr>
<td>Formulary, forms, online ordering:</td>
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<tr>
<td><a href="http://www.Express-Scripts.com">www.Express-Scripts.com</a></td>
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| Plan Year 2018 Master Plan Document Enrollment and Eligibility |                                   |
## Consumer Driven Health Plan Medical, Vision and Dental Contacts

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<td>PO Box 66566</td>
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<tr>
<td>St. Louis, MO 63166-6566</td>
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<tr>
<td>Customer Service: (855) 889-7708</td>
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<tr>
<td>Accredo Specialty Pharmacy</td>
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<tr>
<td>Customer Service: (855) 809-7708</td>
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<tr>
<td>Department</td>
</tr>
<tr>
<td>PO Box 66587</td>
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<tr>
<td>St. Louis, MO 63166-6587</td>
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<tr>
<td>Express Scripts Clinical Appeals Department</td>
</tr>
<tr>
<td>PO Box 66588 St. Louis, MO 63166-6588</td>
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<tr>
<td>Phone: 800-753-2851</td>
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<tr>
<td>Fax: 877-852-4070</td>
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<tr>
<td>MCMC LLC</td>
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<tr>
<td>Attn: Express Scripts Appeal Program</td>
</tr>
<tr>
<td>300 Crown Colony Dr. Suite 203</td>
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<td>Quincy, MA 02169-0929</td>
</tr>
<tr>
<td>Phone: 617-375-7700 ext. 28253</td>
</tr>
<tr>
<td>Fax: 617-375-7683</td>
</tr>
</tbody>
</table>

## Fully Insured Product Contacts

<table>
<thead>
<tr>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Standard Insurance Company</td>
</tr>
<tr>
<td>920 SW Sixth Avenue</td>
</tr>
<tr>
<td>Portland, OR 97204</td>
</tr>
<tr>
<td>Customer Service: (888) 288-1270</td>
</tr>
<tr>
<td>The Standard Insurance Company</td>
</tr>
<tr>
<td>920 SW Sixth Avenue</td>
</tr>
<tr>
<td>Portland, OR 97204</td>
</tr>
<tr>
<td>Customer Service: (888) 288-1270</td>
</tr>
<tr>
<td>Hometown Health Plan HMO</td>
</tr>
<tr>
<td>Customer Service: (775) 982-3232 or (800) 336-0123</td>
</tr>
<tr>
<td><a href="http://www.stateofnv.hometownhealth.com">www.stateofnv.hometownhealth.com</a></td>
</tr>
<tr>
<td>Northern Nevada Health Maintenance Organization (HMO)</td>
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<td>Medical claims</td>
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<td>Pre-authorization</td>
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<tr>
<td>Provider network</td>
</tr>
<tr>
<td>Fully Insured Product Contacts</td>
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<tr>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Health Plan of Nevada HMO</strong></td>
</tr>
<tr>
<td>Customer Service: (702) 242-7300 or (877) 545-7378</td>
</tr>
<tr>
<td><a href="http://www.stateofnv.healthplanofnevada.com">www.stateofnv.healthplanofnevada.com</a></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Towers Watson’s One Exchange</strong></td>
</tr>
<tr>
<td>10975 Sterling View Drive, Suite A1 South Jordan, UT 84095</td>
</tr>
<tr>
<td>Customer Service: (888) 598-7545 TTY: (866) 508-5123</td>
</tr>
<tr>
<td><a href="http://www.ExtendHealth.com/PEBP">www.ExtendHealth.com/PEBP</a></td>
</tr>
<tr>
<td><strong>PayFlex</strong></td>
</tr>
<tr>
<td>P.O. Box 3039  Omaha, NE 68103-3039</td>
</tr>
<tr>
<td>Customer Service: (888) 598-7545</td>
</tr>
<tr>
<td>General Fax: (402) 231-4300</td>
</tr>
<tr>
<td>Claims Fax: (402) 231-4310</td>
</tr>
<tr>
<td><a href="http://www.payflex.com">www.payflex.com</a></td>
</tr>
<tr>
<td>Voluntary Product Contacts</td>
</tr>
<tr>
<td>---------------------------------</td>
</tr>
<tr>
<td>The Standard Insurance Company</td>
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<tr>
<td>920 SW Sixth Avenue</td>
</tr>
<tr>
<td>Portland, OR  97204</td>
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<tr>
<td>Customer Service: (888) 288-1270</td>
</tr>
<tr>
<td>Liberty Mutual</td>
</tr>
<tr>
<td>Customer Service: (800) 637-7026</td>
</tr>
<tr>
<td><a href="mailto:Gary.bishop@libertymutual.com">Gary.bishop@libertymutual.com</a></td>
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<tr>
<td>HealthSCOPE Benefits</td>
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<tr>
<td>Claims Submission:</td>
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<td>HealthSCOPE Benefits</td>
</tr>
<tr>
<td>P.O. Box 3627</td>
</tr>
<tr>
<td>Little Rock, AR  72203</td>
</tr>
<tr>
<td>Customer Service: (888) 763-8232</td>
</tr>
<tr>
<td>Fax: (877) 240-0135</td>
</tr>
<tr>
<td>Email:  <a href="mailto:pebphsahra@healthscopebenefits.com">pebphsahra@healthscopebenefits.com</a></td>
</tr>
<tr>
<td>Online Claims Submission:</td>
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<tr>
<td><a href="http://www.healthscopebenefits.com">www.healthscopebenefits.com</a></td>
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<tr>
<td>Click Member</td>
</tr>
<tr>
<td>Type PEBP as the company name</td>
</tr>
<tr>
<td>Click Flexible Spending Account (FSA) Status</td>
</tr>
<tr>
<td>Login to Your Member Dashboard</td>
</tr>
<tr>
<td>UNUM Provident</td>
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<tr>
<td>Customer Service: (800) 227-4165 Option #4</td>
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## Summary of Benefit Options

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<thead>
<tr>
<th>Medical Options</th>
<th>Full-Time Employees</th>
<th>Retirees (non-Medicare)</th>
<th>Survivors of Retirees (non-Medicare)</th>
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<tr>
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<td>State</td>
<td>Non-State</td>
<td>NSHE</td>
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<td>Consumer Driven Health Plan</td>
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<td>Hometown Health Plans (HHP) HMO</td>
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<td>Health Plan of Nevada (HPN) HMO</td>
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<td>Other Options</td>
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<td>Self-funded PPO Dental</td>
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<td>Basic Life</td>
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<td>Long-Term Disability (LTD)</td>
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<td>✓</td>
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<tr>
<td>Retirees eligible for Medicare Parts A and B</td>
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<tr>
<td>Survivors of Retirees</td>
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<tr>
<td>Medicare Exchange for Medicare eligible Retirees and their covered Medicare Eligible Dependents</td>
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<td>Voluntary Products</td>
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<tr>
<td>Short-Term Disability</td>
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<tr>
<td>Long-Term Care</td>
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<td>Home and Auto</td>
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<td>Flex Plan (Section 125 pre-tax)</td>
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</tr>
<tr>
<td>Additional Life</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tbody>
</table>
Identification Cards

Medical and Pharmacy and Dental Benefits

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

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

Consumer Driven Health Plan (CDHP) - Benefits ID Card
Issued to CDHP Participants residing in Nevada.

Consumer Driven Health Plan (CDHP) - Benefits ID Card
Issued to CDHP Participants residing outside Nevada.
PPO Dental Benefits ID card
Issued to Retirees covered under the Medicare Exchange who elect the PEBP Self-Funded PPO Dental Plan and to Participants enrolled in a PEBP-sponsored HMO Plan.
Enrollment Processes

Enrollment Options

Enrollment Online

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

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

Enrollment must include without limitation:

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

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

Paper Form Enrollment

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

Initial Enrollment

Initial Enrollment for Active Employees

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

Enrollment Requirement Example:

<table>
<thead>
<tr>
<th>Date of Hire/Contract Date</th>
<th>Coverage Effective Date</th>
<th>Date Enrollment Must Be Completed</th>
<th>Date Supporting Documents Must be Submitted (if any)</th>
<th>Default Coverage Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>June 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>June 30&lt;sup&gt;th&lt;/sup&gt;</td>
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<tr>
<td>June 2&lt;sup&gt;nd&lt;/sup&gt; – 30&lt;sup&gt;th&lt;/sup&gt;</td>
<td>July 1&lt;sup&gt;st&lt;/sup&gt;</td>
<td>July 31&lt;sup&gt;st&lt;/sup&gt;</td>
<td>July 31&lt;sup&gt;st&lt;/sup&gt;</td>
<td>July 1&lt;sup&gt;st&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
Default Coverage – Failure to Enroll When Eligible

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

Initial Enrollment for Retirees

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

Initial Enrollment for Survivors

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

Initial Enrollment for COBRA

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

Open Enrollment

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

During this time active Employees and Retirees may:

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

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

Retiree Late Enrollment

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

HIPAA Special Enrollment Notice
If you are declining enrollment for yourself or your Dependents (including your Spouse or Domestic Partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your Dependents’ other coverage). However, you must request enrollment within 60 days after you or your Dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If You or Your Dependents experience a loss of eligibility for Medicaid or a state Children’s Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If You or Your Dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this Plan and you request disenrollment within 60 days after the determination of eligibility for such assistance.

Special enrollment rights are subject to certain circumstances. If you are a State or non-State Retiree, special enrollment does not apply to you but it does apply to your Dependents if you are covered under the Plan. If you are a Surviving Spouse or Surviving Domestic Partner, special enrollment does not apply to you or your Dependents.

To request special enrollment or to obtain more information, contact PEBP at 775-684-7000 or 800-326-5496 or email mservices@peb.state.nv.us.
Eligibility for Coverage

Summary of PEBP Eligibility and Enrollment Requirements

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

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

Eligibility Determinations

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

Note: A retroactive rescission of coverage may be appealed except when the coverage termination is due to non-payment of premium or fraud.

Eligibility for Active Employees

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

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

Eligibility for Retirees

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

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

**Eligibility for Dependents**

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

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

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

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

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

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

- the day the Participant becomes eligible for coverage, or
- the day the Participant acquires the Eligible Dependent by birth, adoption or Placement for Adoption, or
- the first day of the month concurrent with or following the date of the Participant’s marriage or certification of Domestic Partnership, or
- the first day of the month concurrent with or following the loss of coverage through an Employer Group Health Plan.

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

Dependent Children are automatically terminated from coverage on:

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

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

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

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

Your Newborn Child(ren)

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

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

Your Adopted Dependent Children

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

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

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

Legal Guardianship

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

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

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

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

Children under a temporary guardianship are not eligible for coverage as a Dependent under the PEBP Plan.
Disabled Dependent Child
To cover a Dependent Child with a Disability and who is 26 years old or older requires that the Dependent has maintained continuous medical coverage with no break in service and the completion of the Certification of Disabled Dependent Child Form by the Participant and the Child’s physician. To be eligible for coverage, the physician must diagnose the Child as having a mental or physical impairment causing incapability of self-sustaining employment and depending chiefly on the Participant and/or Participant’s Spouse for support and maintenance. Evidence of Disability must be provided within 30 days after the Child reaches age 26 years (NAC 287.312(1)(d)). The Plan will require proof of support and maintenance through the submission of a copy of the preceding year’s income tax return showing the Child was claimed as a tax Dependent in compliance with the IRS Code 152 (a) without regard to the gross income test.

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

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

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

Foster children
Foster Children are not eligible for Dependent coverage.

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

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

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

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

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

**Survivors of Retirees**

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

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

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

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

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

A surviving Spouse is eligible to receive coverage pursuant to this section for the duration of the life of the surviving Spouse. A surviving Child is eligible to receive coverage pursuant to this section until the Child reaches age 26 years. (A surviving Child under permanent guardianship of deceased police officer or firefighter or voluntary firefighter killed in the line of duty is eligible for coverage to age 19 years.)
Unsubsidized Dependents Covered under a PEBP Plan
An unsubsidized Dependent is an otherwise eligible Spouse/Domestic Partner or Dependent Child who remains covered under PEBP while the primary Plan Participant transitions medical coverage to the Medicare Exchange.

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

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

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

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

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

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

If Tricare and Medicare cards are not received within this timeframe, the only other time to apply for Tricare coverage is during the Open Enrollment period with an effective date of July 1.
When Coverage Begins

Active Employees

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

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

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

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

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

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

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

Retiree Years of Service Premium Subsidy or Exchange HRA Contribution for Employees Initially Hired with a PEBP Participating Agency on or after January 1, 2012
- Employees of a State agency, Judges, professional (contracted) Employees of the Nevada System for Higher Education, Legislators and Employees of participating local government entities with an initial date of hire on or after January 1, 2012, may participate in the program, but will not be eligible for a years of service premium subsidy or Medicare Exchange HRA contribution upon retirement.
Eligibility for a subsidy at retirement is based on the initial date of hire as defined by NAC 287.059 as the first date on which service credit is earned by a Participant during the Participant’s last period of continuous employment with a public Employer (as determined by PERS or NSHE). Continuous employment (defined by NAC 287.021) includes a break in employment of less than 1 year; and does not include a break in employment of 1 year or more.

Pursuant to NRS 287.046 (8), this section does not apply to a person who was employed by the State on or before January 1, 2012, who has a break in service and returns to work for the State at the same or another participating State agency after that date, regardless of the length of the break in service, so long as the person did not withdraw from and was eligible to participate in the Public Employees’ Retirement System (PERS) or the Retirement Plan Alternative for the Nevada System of Higher Education (NSHE) before or during the break in service.

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

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

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

Eligible Dependents may be Enrolled as long as:
- benefit coverage is in effect for the active Employee or Retiree on that day;
- any required supporting documents are received in the PEBP office within 60 days of the Qualifying Event (for example: birth certificate, marriage certificate, etc.); or
- within 30 days following the last day of Open Enrollment; or
- within 15 days after the first day of employment; and
- any required contribution for coverage of the Dependent(s) is paid.
Covered Dependents must be Enrolled in the same medical Plan option as the Employee or Retiree except as described in the Coverage Options for Individuals with Medicare section. Eligible Dependents include a Spouse, Domestic Partner, and/or Dependent Child(ren) (as defined in the Definitions section of this document). Anyone who does not qualify as a Spouse, Domestic Partner, or Dependent Child has no right to any benefits or services under this Plan. Any Retiree covered through the Medicare Exchange will have the option to Enroll in the CDHP or HMO Plan when a non-Medicare Eligible Dependent is Enrolled, subject to the rules described in the Coverage Options for Individuals with Medicare section and the rules of the plan chosen through the Medicare Exchange.
When Coverage Ends

In Case of Death

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

Active Employees

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

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

Retirees

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

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

Dependents

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

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

Surviving Spouse/Domestic Partner of a Retiree

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

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

Unsubsidized Dependent

Coverage for an unsubsidized Dependent ends on the last day of the month in which:
• the covered Dependent no longer meets the definition of Dependent as provided in the Definitions section of this document;
• premium payment for the primary Plan Participant or the covered Dependent was last received;
• PEBP is notified of declination of coverage; or
• the Plan is discontinued.

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

Coverage for Dependent Children of a surviving Spouse or Domestic Partner of a Retiree ends on the last day of the month in which:
• the covered Dependent Child(ren) no longer meets the definition of Dependent Child(ren) as provided in the Definitions section of this document;
• premium payment was last received (see Termination for Non-payment); or
• the Plan is discontinued.

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

An Employee, Spouse/Domestic Partner, or any Dependent Child(ren) must notify the Plan no later than 60 days after the date:
• of a divorce or dissolution of a Domestic Partnership;
• on which a Dependent Child ceases to meet the definition of Dependent as defined in the Definitions section of this document; or
• on which a Dependent Child over age 26 years ceases to have a physical or mental impairment where the Child no longer has a Disability.

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

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

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

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

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

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

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

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

1. Notify the issuing authority with respect to the Child whether coverage of the Child is available under the terms of the Plan and, if so:
   a. Whether the Child is covered under the Plan; and
   b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

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

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

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

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

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

If a QMCSO/NMSN is rescinded the Participant has the option to continue coverage for the Dependent(s) or remove the Dependent(s). If the Participant would like to remove the
Dependent(s), coverage will end at the end of the month of receipt of the order. The primary Participant must continue coverage under the same medical Plan until the next Open Enrollment period.

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

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

1. If health care coverage was provided to the Employee and their Eligible Dependents under the CDHP, coverage will be restored retroactively to the date specified by the Hearing Officer. Any retroactive health insurance subsidy due from the agency will be paid to PEBP. Any retroactive health insurance premiums due from the Employee will be paid by the Employee to PEBP within 60 days of the Hearing Officer’s decision. The amount due to PEBP will be determined by PEBP.
   a. Restoration of coverage will be in compliance with NRS 287, NAC 287 and this Master Plan Document.
   b. Upon restoration of coverage, PEBP will notify its third party administrator, Pharmacy Benefits Manager, Life Insurance vendor and any other applicable vendors of the restoration of coverage.
   c. If the Employee and/or their eligible covered Dependents incurred medical, dental, vision or prescription drug expenses, PEBP will assist the Employee with obtaining reimbursement for the eligible health care expenses.

2. If health care coverage was provided to the Employee and their Eligible Dependents under one of the PEBP-sponsored Health Maintenance Organizations (HMOs), coverage will be restored retroactive to a date not to exceed six (6) months prior to PEBP’s receipt of the notice from the Hearing Officer. Any retroactive health insurance subsidy amounts due to PEBP by the Employee’s agency will be paid to PEBP by the agency. Any retroactive health insurance premiums due to PEBP by the Employee will be paid by the Employee to PEBP within 60 days of the Hearing Officer’s decision. The amount due to PEBP will be determined by PEBP.

3. If an Employee chooses not to proceed with a retroactive effective date for health insurance coverage, coverage shall be reinstated on the first day of the month following the Hearing Officer’s decision.

4. Coverage will be restored to the same coverage that was in place before the suspension of benefits. If a new Plan Year intervenes, the Employee will be allowed to indicate the desired coverage retroactive to the beginning of the new Plan Year.

5. Any premiums associated with Voluntary Insurance products are the Employee’s responsibility.
PEBP and Medicare

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

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

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

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

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

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

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

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

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

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

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

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

**Medicare Part B**

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

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

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

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

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

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

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

Medicare Retirees Covered through the Medicare Exchange

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

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

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

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

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

Medicare Retirees Not Eligible for Premium Free Medicare Part A

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

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

Medicare Part B Premium Credit

Retirees who are covered under the PEBP CDHP or HMO Plan and who have Medicare Part B will receive a premium credit in an amount determined by PEBP. Dependents are not eligible for the Part B premium credit.
The premium credit will apply concurrent with the Medicare Part B effective date or the first of the month concurrent with or following PEBP’s receipt of the Retiree’s Medicare Part B card, whichever is later.

**Medicare Part D Coverage**

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

**Medicare Exchange HRA Contribution Eligibility**

To receive the PEBP HRA contribution, an Eligible Retiree must obtain and maintain an individual medical insurance policy through the PEBP sponsored Medicare Exchange. In other words, to receive the PEBP HRA contribution amount, the Eligible Retiree must Enroll in and maintain a medical insurance policy through the PEBP sponsored Medicare Exchange. If the Eligible Retiree does not Enroll and maintain medical coverage as described, the Eligible Retiree will NOT receive the PEBP HRA contribution amount and will lose their PEBP sponsored benefits entirely, including but not limited to life insurance and dental insurance. This policy also applies to Eligible Retirees who are covered under their Spouse’s employer sponsored health Plan. For more information on Retiree Years of Service HRA Contribution, please refer to the *PEBP and Medicare Guide* and the Health Reimbursement Arrangement (HRA) Summary Plan Description available at [www.pebp.state.nv.us](http://www.pebp.state.nv.us). For re-enrollment eligibility and information, please see the Retiree Late Enrollment section for re-Enrollment rights.

**Tricare for Life and Medicare Parts A and B**

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

Years of Service Eligibility

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

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

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

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

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

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

Years of Service Premium Subsidy

Retired public Employees Enrolled in the CDHP or HMO Plan may qualify for a premium subsidy based on the date of hire, date of retirement, and total years of service credit earned with each Nevada public Employee. For more information on Retiree Years of Service Premium Subsidy, refer to the Retiree Enrollment Guide available at www.pebp.state.nv.us.

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

Retired public Employees Enrolled in a medical plan through Medicare Exchange may qualify for an HRA contribution based on the date of hire, date of retirement, and total years of service credit earned with each Nevada public Employer. For more information on Retiree Years of Service HRA Contribution, please refer to the PEBP and Medicare Guide and the Health Reimbursement Arrangement (HRA) Summary Plan Description available at www.pebp.state.nv.us.
Health Reimbursement Arrangement for Retirees Covered Through the Medicare Exchange

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

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

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

**Medicare Exchange HRA Contribution Eligibility:** To receive the PEBP HRA contribution, an Eligible Retiree must Enroll in and maintain coverage in an individual medical insurance policy through the PEBP sponsored Individual Market Medicare Exchange. If the Eligible Retiree does not Enroll and maintain medical coverage as described above, the Eligible Retiree will NOT receive the PEBP HRA contribution amount and will lose their PEBP sponsored benefits entirely. For re-enrollment eligibility and information, please see the Retiree Late Enrollment section for re-Enrollment rights.

**NOTE:** This policy does not apply to Eligible Retirees or their (PEBP retired) Spouses/Domestic Partners who have health coverage under TRICARE for Life and Medicare. These individuals must submit a copy of their military ID card(s) to PEBP. PEBP will coordinate their Enrollment with the HRA administrator.
<table>
<thead>
<tr>
<th>Dependent Type</th>
<th>Social Security Number</th>
<th>Marriage Certificate</th>
<th>Birth Certificate</th>
<th>Hospital Birth Confirmation</th>
<th>Adoption Decree</th>
<th>Nevada Certification of Domestic Partnership</th>
<th>Legal Permanent guardianship signed by a judge</th>
<th>Physician’s Disability Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn Child</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child: Birth-Age 26 Yrs</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adopted Child</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent Legal Guardianship (child)</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Stepchild</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Partner’s Child</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Partner’s Adopted child</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disabled Child</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Disabled Stepchild</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Partner’s Disabled Child</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Partner</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- When adding a Dependent, other Dependents cannot be dropped for the same qualifying event. Enrollment of a newly acquired Spouse, Domestic Partner, and/or Dependent Child(ren) must occur no later than 60 days after the date of the qualifying event. In all cases, required supporting documentation must be submitted to PEBP within the same timeframe.
- Employees in declined coverage status and who experience a change in number of Dependents may opt to Enroll for coverage mid-year if adding a newly acquired Dependent.
- All foreign documents must be translated to English.
<table>
<thead>
<tr>
<th>Event Type</th>
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</tr>
</thead>
</table>
| Disabled Child age 26 years or older | Within 31 days of the Dependent Child turning age 26 years | • Certification of Disabled Dependent Child (completed by primary Participant and Child’s physician)  
• SSN of Child  
• If not the Participant’s Child, copy of the marriage or Nevada Domestic Partner certificate  
• Verification that the Child has had continuous health insurance since the age of 26 years; and proof of support and maintenance through the submission of a copy of the Participant’s preceding year’s income tax returns showing the Child is a tax Dependent. The Plan will thereafter require proof of the Child’s continuing incapacity and dependency not more than once a year beginning 2 years after the Child attains age 26 NRS 689B.035. | • If already covered under PEBP, coverage will continue  
• If new to PEBP Plan, coverage becomes effective on the first day of the month concurrent with or following the qualifying event | Not applicable |
| Permanent Guardianship of a Child to age 19 | Within 60 days of the event date | • Copy of legal guardianship papers (signed by a judge)  
• SSN of Child  
• Copy of birth certificate  
• If not the primary insured’s Child, a copy of the marriage certificate or Nevada Domestic Partnership certificate | • Coverage effective on the first day of the month concurrent with or following the legal guardianship papers signed by a judge  
• Coverage is provided only up to age 19 years | May add the Child(ren) to age 19 years and other Eligible Dependent(s) in the Family Unit |
<table>
<thead>
<tr>
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</thead>
</table>
| Permanent Guardianship of Unmarried Child age 19 to age 26 currently Enrolled in a PEBP Plan | Within 60 days of the event date | Completion of the Legal Guardianship Certification Form and any required supporting documents listed in the certification | • Coverage continues to age 26 assuming Child continues to meet eligibility requirements as set forth in Legal Guardianship Certification Form  
• Coverage ends the last day of the month Child turns age 19 or last day of the month PEBP determines the Child is no longer eligible | Not applicable |
| Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) | Within 60 days of issuance of QMCSO or Release of QMCSO | Copy of QMCSO appropriately signed | • QMCSO: First of the month concurrent with or following the date PEBP receives the QMCSO  
• Release of QMCSO: Coverage terminates on the last day of the month concurrent with or following the date PEBP receives the Release of QMCSO. | • Must add Dependent(s) as stated in the QMCSO  
• May add other Eligible Dependent(s) in the Family Unit |
<table>
<thead>
<tr>
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</thead>
</table>
| Dependent Loses Coverage   | Within 60 days of the event date | - Creditable Coverage Certificate(s) from other employer group coverage stating the insurance end date and identity of Covered Individual(s) for each Dependent being added to Your coverage  
- SSN for all Dependent(s) being added  
- Copy of marriage certificate or Nevada Domestic Partnership certification  
- If adding Dependent Child(ren), a copy of the Child(ren)’s birth certificates | Coverage effective on the first day of the month concurrent with or following the date of the loss of coverage | May add the Spouse or Domestic Partner and all other Eligible Dependent(s) in the Family Unit who experienced a loss of coverage |
### Enrollment and Eligibility Events Quick Reference Tables

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Dependent Gains Coverage</strong> Spouse/ Domestic Partner or Eligible Dependent experiences a change of status resulting in a gain of eligibility from another Employer Group Health Plan</td>
<td>Within 60 days of the event date</td>
<td>Confirmation of coverage letter from other employer group coverage stating the insurance effective date and identity of Covered Individual(s) for each Dependent being deleted from Your coverage</td>
<td>Coverage terminates on the last day of the month the event occurs</td>
<td>Must delete Spouse or Domestic Partner if coverage is employer based; and may delete any Dependent(s) that are being added to the Employer Group Health Plan</td>
</tr>
</tbody>
</table>
| **Establish Domestic Partnership** | Within 60 days of the event date | • SSN for Domestic Partner and/or covered Child(ren)  
• Copy of the Nevada Domestic Partnership certificate  
• If adding Dependent Child(ren), a copy of the Child(ren)’s birth certificates | Coverage effective on the first day of the month concurrent with or following the date of registration of Domestic Partnership with the Nevada Secretary of State’s office | May add Domestic Partner and other Eligible Dependent(s) in the Family Unit |
## Enrollment and Eligibility Events Quick Reference Tables

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<tr>
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</tr>
</thead>
</table>
| **Marriage**                          | Within 60 days of the event date                                                    | • SSN for the Spouse and/or covered Child(ren)  
• Copy of the certified marriage certificate  
• If adding Dependent Child(ren), a copy of the Child(ren)’s birth certificates | Coverage effective on the first day of the month concurrent with or following the date of marriage                                                                 | May add Spouse and other Eligible Dependent(s) in the Family Unit                                                                                        |
| **Divorce, Annulment or Termination of Domestic Partnership** | Within 60 days of the event date                                                    | • Copy of the divorce/ annulment decree signed by the judge (all pages)  
• Copy of the termination of Domestic Partnership filed with the Nevada Secretary of State’s office | • Coverage terminates on the last day of the month in which divorce decree is signed by the judge or termination of Domestic Partnership is filed with the Secretary of State’s office  
• If the divorce decree/ termination of Domestic Partnership is received more than 60 days after the divorce, coverage ends at the end of the month of receipt of the divorce decree/termination of Domestic Partnership | Must delete ex-Spouse or ex-Domestic Partner and all other Ineligible Dependent(s)                                                                          |
<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| Employer of Spouse/ Domestic Partner Offers an Open Enrollment Period | Within 60 days of the event date            | • Proof of Open Enrollment from the employer  
• Confirmation of coverage letter from the insurance carrier stating the effective date of new coverage and the identity(ies) of the newly Covered Individual(s) | • If deleting Dependent Child(ren) from that other employer’s Group Health Plan and Enrolling them in PEBP coverage, the effective date is the first day of the month concurrent with or following the coverage end date  
• If declining PEBP coverage, the coverage terminates on the last day of the month prior to the month the other coverage becomes effective | • Participant and any covered Dependents may decline PEBP coverage to newly Enroll in the other employer’s coverage; or  
• Participant and Eligible Dependent in declined status with PEBP may re-Enroll in PEBP coverage if the other employer coverage is terminated |
### Enrollment and Eligibility Events Quick Reference Tables

<table>
<thead>
<tr>
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<th>Allowable Changes Based on Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Participant Moves Outside HMO Plan Coverage Area</td>
<td>Within 30 days after moving outside HMO coverage area</td>
<td>Complete a change of address online using the E-PEBP Benefits Portal or via Benefit Enrollment and Change Form.</td>
<td>Coverage under the new CDHP or HMO plan will begin on the first day of the month concurrent with or following the date PEBP is notified of the address change</td>
<td>May change health plan options. Note: Moving outside the HMO coverage area is not a qualifying event to add or delete dependents. For exceptions, see Qualified Medical Child Support Orders (QMCSO) or National Medical Support Notice (NMSN)</td>
</tr>
</tbody>
</table>
| PEBP’s Open Enrollment Period           | Typically May 1- May 31 of each year                     | • If adding a dependent, refer to the Summary of Supporting Eligibility Documents provided in this document  
• Required supporting documents are due by June 15 | Coverage effective date is July 1 immediately following Open Enrollment Period                       | May add or delete Dependents, change Plan options or decline coverage                         |
## Enrollment and Eligibility Events Quick Reference Tables

<table>
<thead>
<tr>
<th>Event Type</th>
<th>Notification Period</th>
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</tr>
</thead>
</table>
| Participant death* | Within 60 days of the event date | Copy of certified death certificate | • Participant coverage terminates on the date of death; and  
• Coverage for any covered Dependent terminates on the last day of the month concurrent with the Participant’s date of death | Covered Dependents may qualify for re-Enrollment in Survivor’s coverage if he/she meets the eligibility requirements as stated in this document |
| Dependent Death*  | Within 60 days of the event date | Copy of certified death certificate | Coverage for the deceased Dependent terminates on the date of death | Must delete the deceased Dependent from coverage and any Ineligible Dependent(s) (e.g. Children of Domestic Partner or stepchildren) |

*Late Notification of Death
Adjustments in premiums resulting from the death of a covered Participant or Dependent will be refunded if notification of death is received within 60 days of the Participant’s or Dependent’s date of death. Notification of death beyond the 60 day period will not be refunded.
<table>
<thead>
<tr>
<th>Event Type</th>
<th>Notification Period</th>
<th>Required Supporting Documents</th>
<th>When Coverage Begins or Ends</th>
<th>Allowable Changes Based on Event</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dependent Child(ren) Enrolls in Medicare</strong></td>
<td>Within 60 days of Medicare effective date</td>
<td>Copy of Medicare card</td>
<td>Coverage terminates on the last day of the month preceding the Medicare coverage effective date</td>
<td>May delete the Dependent who enrolls in Medicare</td>
</tr>
<tr>
<td><strong>Dependent Child(ren) Enrolls in CHIP, Medicaid or Nevada Check Up</strong></td>
<td>Within 60 days of CHIP, Medicaid or Nevada Check Up effective date</td>
<td>Creditable Coverage letter indicating the name of the Dependent Child(ren) and coverage end date</td>
<td>PEBP coverage terminates the last day of the month preceding coverage effective under CHIP/Medicaid or Nevada Check Up coverage effective date</td>
<td>Covered Dependent Child(ren) may decline coverage due to Enrollment in CHIP/Medicaid or Nevada Check Up</td>
</tr>
<tr>
<td><strong>Dependent Child(ren) loses coverage under CHIP, Medicaid or Nevada Check Up</strong></td>
<td>Within 60 days of CHIP, Medicaid or Nevada Check Up termination date</td>
<td>• Creditable Coverage letter indicating the name of the Dependent Child(ren) and coverage end date • Copy of birth certificate(s) for each Dependent Child(ren) being added to the Plan</td>
<td>Coverage for Dependent Child(ren) will become effective on the first day of the month following PEBP’s receipt of loss of coverage from Medicaid and/or Nevada Check Up</td>
<td>Eligible Dependent Child(ren) may be added to the Employee/Retiree’s health Plan</td>
</tr>
</tbody>
</table>
## Enrollment and Eligibility Events Quick Reference Tables

<table>
<thead>
<tr>
<th>Event Type</th>
<th>Notification Period</th>
<th>Required Supporting Documents</th>
<th>When Coverage Begins or Ends</th>
<th>Allowable Changes Based on Event</th>
</tr>
</thead>
</table>
| Declination of Coverage due to Marriage or Establishment of Domestic Partnership (DP) and Enrollment in Spouse’s/DP’s Employer Group Health Plan | Within 60 days of the date of marriage or establishment of Domestic Partnership | • Copy of certified marriage certificate or domestic partnership certificate issued by the Nevada Secretary of State  
• Creditable Coverage letter from the Spouse’s/DP’s Employer or Group Health Plan stating the effective date of new coverage and the identity(ies) of the newly Covered Individual(s). | Coverage for the primary participant and any covered dependents will terminate on the last day of the month of marriage or establishment of domestic partnership. | Primary Participant may decline coverage |
| Medicare Part B Premium Credit | End of the month prior to the Part B effective date | • Copy of Medicare Part B card; or  
• Copy of the Medicare Part B award letter | Part B premium credit will be applied on the first of the month Part B becomes effective or on the first day of the month following PEBP’s receipt of required supporting document | Premium credit will only apply to primary Retirees covered under the Consumer Driven Health Plan or an HMO Plan |
<table>
<thead>
<tr>
<th>Event Type</th>
<th>Notification Period</th>
<th>Required Supporting Documents</th>
<th>When Coverage Begins or Ends</th>
<th>Allowable Changes Based on Event</th>
</tr>
</thead>
</table>
| Survivor of Police/ Firefighter   | Within 60 days of the police officer’s or firefighter’s date of death | • RBECF  
• Written notification to employer of the Survivor’s intent to Enroll in Survivor’s coverage  
• Copy of death certificate  
• SSN and copy of marriage certificate  
• If adding Dependent(s), a copy of Child(ren)’s birth certificate(s) | Coverage for eligible survivors is effective on the first of the month following the police officer’s or firefighter’s date of death | May qualify for Survivor’s coverage if the Dependent meets the Survivor’s eligibility requirements |
<p>| Surviving Dependent Enrollment    | Within 60 days of the primary Participant’s date of death |                                                                                             | Coverage for eligible survivors is effective on the first day of the month following the primary Participant’s date of death | May qualify for Survivor’s coverage if the Dependent meets the Survivor’s eligibility requirements as shown in the Initial Enrollment Section |</p>
<table>
<thead>
<tr>
<th>Event Type</th>
<th>Notification Period</th>
<th>Required Supporting Documents</th>
<th>When Coverage Begins or Ends</th>
<th>Allowable Changes Based on Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Settlement Agreement</td>
<td>Within 60 days of Settlement Agreement</td>
<td>Copy of Hearing Officer’s decision</td>
<td>• Retroactive to date established by the Hearing Officer decision under the CDHP; or</td>
<td>• Employee may re-enroll in coverage; or</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Not more than 6 months prior to PEBP’s receipt of the Hearing Officer’s decision for the HMO; or</td>
<td>• Decline coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• The first month after the decision is received by PEBP if the Employee chooses not to pay back premiums</td>
<td></td>
</tr>
</tbody>
</table>


Qualifying Events

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

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

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

Dependent Loses Other Employer Group Health Care Coverage

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

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

However, if an Employee or Dependent lost other health care coverage as a result of the individual’s voluntary cancellation of coverage, termination of coverage through the state health exchange (Affordable Care Act (ACA)), failure to pay premiums, reduction or elimination of
employer financial payment of premiums, or for cause, such as making a fraudulent claim, that individual does not have Enrollment rights.

**Gain of Other Employer Group Health Care Coverage**

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

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

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

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

**Open Enrollment for Employer of Spouse or Domestic Partner**

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

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

**Change of Residence**

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

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

Declining Active Employee Coverage
An Employee may decline coverage at initial Enrollment, during PEBP’s Open Enrollment, during the Spouse’s/Domestic Partner’s Open Enrollment period or marriage (see Open Enrollment for Employer of Spouse or Domestic Partner section). An Employee will not receive a financial incentive or compensation when in declined coverage status and will not be eligible for Basic Life and Long Term Disability insurance or any voluntary products. Note: Enrollment in Medicare Part A and/or Part B or Medicaid is not a qualifying event to decline coverage.

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

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

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

The PEBP Board has defined Significantly Inferior Coverage as either:

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

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

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

Family and Medical Leave Act (FMLA)

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

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

Employees are eligible for FMLA leave if they have worked for the State of Nevada for 12 months and for 1,250 hours over the previous 12 months. For an overview of FMLA provided by the Department of Administration, Human Resource Management visit https://www.dol.gov/general/topic/benefits-leave/fmla.

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

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

Any changes in the Plan’s terms, rules or practices that went into effect while an Employee is away on leave will apply to the Employee and any Dependents in the same way they apply to all other Employees and their Dependents. Employees should contact their Agency Representative to find out more about their entitlement to family or medical leave as required by Federal and/or State law, and the terms on which it may be entitled.
Leave Without Pay (LWOP)

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

An Employee who is on approved LWOP may pay the full cost of premiums for their coverage and insurance to PEBP. An Employee on LWOP is not eligible for coverage as a Dependent of another PEBP covered Participant (Spouse/Domestic Partner, Child, etc.).

At the initial start of leave, it is the Employee’s responsibility to inform PEBP of their coverage preference while on leave. If the Employee fails to inform PEBP of his or her coverage preference while on leave, PEBP will continue the same medical Plan and Coverage Tier that the Employee had in effect prior to taking that leave.

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

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

State Employees who go into active military service for 31 days or more are eligible to Enroll in health care coverage provided by the military the day the Employee is activated for military duty. This coverage is also available to Dependents. The Employee is also eligible to purchase continued health care coverage through PEBP for up to 24 months in a manner similar to the provisions of COBRA. When the Employee returns from military leave within the required reemployment period, there will be an immediate reinstatement of PEBP-sponsored medical coverage with no waiting period. Questions regarding entitlement to this leave and to the continuation of health care coverage should be referred to PEBP. Questions regarding reemployment rights should be addressed with the Employer.

Worker’s Compensation Leave

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

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

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

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

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

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

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

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

Participants will be billed via premium invoice and will be required to pay the following directly to PEBP:
- contributions resulting from retroactive coverage changes; or
- claims incurred by the Participant or their Dependents who access the Plan during a period when they are ineligible for coverage.
Premium overpayments due to lack of proper notification by the Participant will not be refunded. Participants who fail to pay their premiums or ineligible claims may be reported to the State Controller’s office or to a private collection agency for collection of past due amounts. Collection costs may also be assessed to the Participant.

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

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

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

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

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

**Change to Years of Service Re-Audit Results for Retirees**
Years of service premium subsidy and years of service Exchange HRA contribution are effective upon the date of retirement, based on the audit from either the Public Employees’ Retirement System (PERS) or the Nevada System of Higher Education (NSHE). Changes to the years of service premium subsidy and years of service Exchange HRA contribution resulting from a future audit will occur on the first (1st) day of the month concurrent with or following the date PEBP receives the audit results from the PERS or NSHE. (NAC 287.485)
COBRA Continuation of Medical Coverage

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

Entitlement to COBRA Continuation Coverage

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

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

Qualified Beneficiary

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

Qualifying Event

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

Maximum Period of COBRA Continuation Coverage

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

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

**Certificates of Creditable Coverage**

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

**Health Insurance Marketplace Coverage Options**

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

General Provisions

Name of the Plan
Public Employees’ Benefits Program (PEBP)

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

Tax Identification Number (TIN)
88-0378065

Type of Plan
Group Health Plan including medical expense benefits.

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

Agent for Service of Legal Process
For disputes arising under the Plan, service of legal process may be made on the Plan Administrator, and must comply with the Nevada Revised Statute 41.031, in care of:
Public Employees’ Benefits Program (PEBP)
901 South Stewart Street, Suite 1001
Carson City, NV 89701
Phone: (775) 684-7000 or (800) 326-5496

Plan Year
The Plan’s CDHP and Self-Funded Dental PPO Plan benefits are administered on a Plan Year typically beginning July 1 and ending June 30. PEBP has the authority to revise the benefits and premium rates if necessary each Plan Year. For medical, dental, vision and pharmacy benefits, all deductibles, out-of-pocket maximums and Plan Year maximum benefits are determined based on the Plan Year. Fiscal records are kept on a 12-month period basis beginning on July 1 and ending on June 30.
Plan Amendments or Termination of Plan
PEBP reserves the right to amend or terminate these Plans, or any parts of them at any time. Amendments may occur on the approval of its Board, or on such other date as may be specified in the document amending the Plan. These Plans or any coverage under them may be terminated by its Board, and new coverages may be added by its Board.

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

No Liability for Practice of Medicine
The Plan Administrator and its designees are not engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to You by any health care Provider. Neither the Plan Administrator nor any of its designees will have any liability whatsoever for any loss or injury caused to You by any health care Provider by reason of negligence, by failure to provide care or treatment, or otherwise.

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

When You Must Repay Plan Benefits
If it is found that Plan benefits paid by the Plan are too much because:

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

The Plan will be entitled to a refund from You (or Your health care Provider) of the difference between the amount actually paid by the Plan for those expenses, and the amount that should have been paid by the Plan for those expenses, based on the actual facts (see also the Subrogation section of the Coordination of Benefits section of the PEBP Consumer Driven Health Plan for Medical, Vision and Prescription Drug Benefits Master Plan Document or HMO Evidence of Coverage Certificate).
Disclosure and Access to Medical Information

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

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

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

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

Privacy Notice Definitions

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

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

Uses and Disclosures of Your Protected Health Information

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.
Uses and Disclosures with Your Permission - We will not use or disclose your medical information for any other purposes unless you give us your written authorization to do so. For example, in general and subject to specific conditions, we will not use or disclose your psychotherapy notes, will not use or disclose your protected health information for marketing, or fundraising, unless you give us a written authorization. If you give us written authorization to use or disclose your medical information for a purpose that is not described in this notice, in most cases, you may revoke it in writing at any time. Your revocation will be effective for your medical information we maintain, except where we have already taken action in reliance on your prior authorization.

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

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

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

Business Associates – At times we use outside persons or organizations to help us provide you with the benefits of your Group Health Plan. Examples of these outside persons and organizations might include vendors that help us process and manage your healthcare claims such as Third Party Administrators, Pharmacy Benefit managers, health plan auditors and health maintenance organizations. At times it may be necessary for us to provide certain components of your PHI to one or more of these outside persons or organizations, additionally, one of these outside organizations may disclose your PHI to PEBP.

Other Products and Services – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use and disclose your PHI for the purpose of communicating to you about our health insurance products that could enhance or substitute for existing Group Health Plan coverage, and about health-related products and services that may add value to your Group Health Plan or provide other health care component benefits such as voluntary health flexible spending accounts.

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

- We may use or disclose your PHI for any purpose required by law. For example, we may be required by law to use or disclose your PHI to respond to a court order.
We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.

We may disclose your PHI to the proper authorities if we suspect Child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.

We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.

We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).

We may disclose your PHI to the proper authorities for law enforcement purposes.

We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.

We may use or disclose your PHI for cadaveric organ, eye or tissue donation.

We may use or disclose your PHI for research purposes, but only as permitted by law.

We may use or disclose your PHI to avert a serious threat to health or safety.

We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.

We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.

We will, if required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.

We may disclose your PHI to report adverse reactions to medications.

We may disclose your PHI to assist with certain product recalls.

**Plan Sponsors** - PEBP may use or disclose protected health information to the plan sponsor of a group health plan, if applicable, provided that any such plan sponsor certifies the information provided will be maintained in a confidential manner and not used for employment related decisions or for other employee benefit determinations or in any other manner not permitted by law.

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

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

**Rights That You Have**

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

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

**Accounting for Disclosures of Your PHI** – You have the right to receive an accounting of certain disclosures, or our business associates, have made by us of your PHI. In the six years prior to the date of your request. We are not required to account for disclosures we made before April 14, 2003, or disclosures to you, your personal representative or in accordance with your authorization or permission; for treatment, payment and other health care operations activities; as part of a limited data set; incidental to an allowable disclosure; or for national security or intelligence purposes; or to law enforcement or correctional institutions regarding persons in lawful custody. To be considered, your account request must be in writing and signed by you or your representative. You are entitled to one free accounting every 12 months. We reserve the right to charge you a reasonable fee for each additional accounting you request during the same 12-month period. You are entitled to one free accounting every 12 months. We reserve the right to charge you a reasonable fee for each additional accounting you request during the same 12-month period.

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

**Restrictions on Use of Genetic Information** - We will not use your genetic information that is PHI for underwriting purposes.

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

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


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

**For Further Information**

If you have questions or need further assistance regarding this Notice, you may contact PEBP’s Privacy Officer at the address or telephone number provided below.

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

**Effective Date**

This Notice of Privacy Practices for PEBP is effective July 1, 2017, and replaces all other privacy notices that have been in effect since April 14, 2003.

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

The Plan Sponsor certifies that this Master Plan Document incorporates the provisions set forth in 45 CFR 164.504(f)(2)(ii) and the Plan Sponsor agrees to such provisions in accordance with 45 CFR 164.504(f)(2)(ii)

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

Office of Civil Rights  
Dept. of Health & Human Services  
907 7th St., Ste. 4-100  
San Francisco CA  94103  
(800) 368-1019 Phone  
(415) 437-8329 Fax  
TDD (800) 537-7697  
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

By law, PEBP is required to follow the terms in this privacy notice. PEBP has the right to change the way your personal medical information is used and given out. If PEBP makes any changes to the way your personal medical information is used and given out, PEBP will post the notice of changes on its website within 60 days of the change. You can request a copy of the PEBP privacy notice anytime by contacting PEBP.
PEBP Security Practices

By law, PEBP is required to:

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

National Defense Authorization Act (NDAA)
On January 28, 2008, President Bush signed into law H.R. 4986, the National Defense Authorization Act (NDAA). Section 585 of the NDAA amends the Family and Medical Leave Act of 1993 (FMLA) to permit a “Spouse/ Domestic Partner, son, daughter, parent, or next of kin” to take up to 26 workweeks of leave to care for a “member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary Disability retired list, for a serious injury or illness.”
The NDAA also permits an Employee to take FMLA leave for “any qualifying exigency (as the Secretary [of Labor] shall, by regulation, determine) arising out of the fact that the Spouse/ Domestic Partner, or a son, daughter, or parent of the Employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.”
You can read more about the National Defense Authorization Act by going to the US Department of Labor website at: www.dol.gov.

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

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

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

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 is effective for PEBP on July 1, 2010. This legislation requires that full parity be established between mental health/ substance abuse benefits and other surgical and medical benefits offered

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) was enacted May 21, 2008. Title I (regarding genetic nondiscrimination in Group Health Plans) is effective for Plan Years beginning after May 21, 2009. Title II (regarding genetic nondiscrimination in employment) becomes effective November 21, 2009. GINA amends ERISA, the Code and Public Health Service Act to prevent Group Health Plans and health insurance companies from basing Enrollment decisions, premium costs, or Participant contributions on genetic information. Group Health Plans and group insurers will be prohibited from requiring that individuals undergo genetic testing. Employers are preventing conditioning of hiring or firing decisions on the basis of genetic information. Lastly, GINA will extend medical privacy and confidentiality rules to the disclosure of genetic information. Currently, PEBP and the State of Nevada do not use genetic information in regards to either employment or the determination of benefits. Genetic testing is a Plan exclusion.

You can read more about GINA by visiting www.genome.gov/10002328.

Michelle’s Law

Under the Public Employees’ Benefits Program (“PEBP”), most dependent children are eligible for health coverage until age 26. However, dependent children under a legal guardianship who are unmarried are generally eligible for health coverage until age 19. Eligibility for dependent children under a legal guardianship may be extended beyond age 19 to age 26 if the child satisfies all of the following conditions:

1) Remains unmarried;
2) Is either enrolled as a full-time student at an accredited institution or resides with the Participant;
3) Is eligible to be claimed as a dependent on the Participant’s or his/her Spouse’s or Domestic Partner’s federal income tax return for the preceding calendar year; and
4) Is a grandchild, brother, sister, step-brother, step-sister, or descendent of such relative.

Because eligibility may be conditioned on maintaining full-time student status, Michelle’s Law applies only to the extended eligibility for dependent children under a legal guardianship from ages 19-26 who meet the conditions above.

Should a dependent child under a legal guardianship (as described above) take a medically necessary leave of absence for a serious illness or injury that causes loss of full-time student status, his or her coverage cannot be terminated before the date that is the earlier of - (1) one year after the first day of the medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the PEBP. A written certification stating that the dependent child is suffering from a serious illness or injury and that the leave of absence is medically necessary must be provided by a treating physician of the dependent child to PEBP in order for eligibility and coverage to continue.

For more details or to notify PEBP of a medically necessary leave of absence, please contact PEBP at (775) 684-7000 or (800) 326-5496.
NAC and NRS Regarding the PEBP Plan and Your Coverage

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

NAC 287.095 – Participant defined.

NAC 287.095 - Participant defined.

NAC 287.135 - Retired officer or employee defined.

NAC 287.312 - Dependents: Eligibility of a child of a participant, spouse or domestic partner.

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

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

NAC 287.357 - Application to leave Program

NAC 287.440 - Payment of premiums or contributions by retired officers and employees.

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

NAC 287.530 - Coverage of retired person, spouse, domestic partner or surviving dependent.

NAC 287.540 - Coverage of participating employee of State who reenrolls upon retirement or total disability; coverage of nonparticipating employee of State.

NAC 287.542 - Coverage of participating employee of local governmental agency who retires on or before September 1, 2008, and reenrolls upon retirement or total disability.

NAC 287.546 - Coverage of participating employee of local governmental agency who retires after September 1, 2008, and reenrolls upon retirement or total disability.

NAC 287.548 - Coverage of nonparticipating employee of local governmental agency who retires after September 1, 2008.

NAC 287.680 - Appeal of decision of appeals manager: Requirements; duties of Executive Officer or designee.

NRS 287.023 - Option of retired officer or employee or Dependent to cancel or continue group insurance, plan of benefits, medical and Hospital service, or coverage under Public Employees’ Benefits Program; notice of selection of option; payment of costs for coverage.
NRS 287.0406 – Program is defined as the Public Employees’ Benefits Program established pursuant to subsection 1 of NRS 287.043.

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

NRS 287.0435 - Creation; investment; disbursements; administration by State Treasurer; checking account for payment of claims.

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

NRS 287.046 - Department of Administration will to establish assessment to pay portion of premiums or contributions for participating retirees with state service; amounts assessed to be deposited in Retirees’ Fund; adjustments to portion paid to Program by Retirees’ Fund.

NRS 287.047 - Retention by certain retired State officers and employees and Dependents’ of membership in coverage under Program.

NRS 287.0475 - Reinstatement of insurance by retired public officer or employee or surviving spouse.

NRS 689B.020 - Group health insurance defined; eligible groups and benefits.

NRS 689B.033 - Required provision concerning coverage for newly born and adopted children and children placed for adoption.

NRS 689B.287 - Insurer prohibited from denying coverage solely because insured was intoxicated or under influence of controlled substance; exceptions.

NRS 695G.164 - Required provision concerning coverage for continued medical treatment.

NRS 695G.1665 - Required provision concerning coverage for prescription drugs irregularly dispensed for purpose of the synchronization of chronic medications.

NRS 695G.170 - Required provision concerning coverage for medically necessary emergency services; prohibitions.

NRS 695G.172 - Required provision concerning coverage for early refills of topical ophthalmic products.
Plan Definitions

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

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

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

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

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

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

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

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

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

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

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

**Creditable Coverage:** Prior continuous health coverage and includes prior coverage under:

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

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

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

Dependent Coverage Ends: Coverage of a Dependent Child ends at the end of the month in which that Child:
- reaches his or her 26th birthday,
- enters the military.

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

Domestic Partner/Domestic Partnership: As defined by NRS 122A.030. The Plan will require the Participant to provide a copy of the Domestic Partner certification from the Nevada Secretary
of State. The Participant must also provide a statement acknowledging the Participant’s responsibility for any federal income tax consequences resulting from the Enrollment of the Domestic Partner in the Plan. A Domestic Partner is not eligible for coverage as a Dependent after termination of the Domestic Partnership.

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

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

**Employer:** Unless specifically indicated otherwise when used in this document, Employer refers to an agency or entity that participates in the PEBP Program, including (but not limited to) most State agencies, as well as some county and city agencies and organizations.

**Employer Group Health Plan:** Any Employer who sponsors a health plan for their active Employees.

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

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

**Full-Time Employment:** Employees working 80 hours a month.

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

**Health Reimbursement Arrangement:** A Health Reimbursement Arrangement (HRA) is an Employee-funded spending account that can be used to pay qualified medical expenses. The HRA is 100% funded by the Employer. The terms of these arrangements can provide first dollar medical coverage until the funds are exhausted or insurance coverage kicks in. The contribution amount per Employee is set by the Employer, and the Employer determines what the funds can be used to cover and if the dollars can be rolled over to the next year. In most cases, if the Employee leaves the Employer, they can't take remaining HRA funds with them.
Health Care Provider: A health care practitioner, hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility.

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


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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Provider: See the definition of Health Care Provider.

Qualified Medical Child Support Order (QMCSO)/National Medical Support Notice (NMSN): A court order that complies with requirements of federal law requiring an Employee to provide health care coverage for a Dependent Child, and requiring that benefits payable on account of that Dependent Child be paid directly to the Health Care Provider who rendered the services.
Rescission: A cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance is not a Rescission if the cancellation or discontinuance of coverage has only a prospective effect, or the cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay premium or costs of coverage.

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

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

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

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

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

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

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

The PEBP CDHP complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The PEBP CDHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide free services to people with disabilities to communicate effectively with us, such as:
Qualified sign language interpreters
Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provide free language services to people whose primary language is not English, such as:
  Qualified interpreters
- Information written in other languages

If you need these services, contact PEBP at 775-684-7000 or 800-326-5496.

If you believe that the PEBP CDHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Civil Rights Coordinator, 901 South Stewart Street, Suite 1001, Carson City, NV 89701 or 775-684-7000 (TTY: 1-800-545-8279), Fax 775-684-7028, email: memberservices@peb.state.nv.us.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)


ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-326-5496 (TTY: 1-800-545-8279)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-326-5496 (TTY: 1-800-545-8279)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-326-5496 (TTY: 1-800-545-8279)。
Enrollment and Eligibility Nondiscrimination Notice

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-326-5496 (TTY: 1-800-545-8279) 번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có cạc dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-326-5496 (TTY: 1-800-545-8279).

주의: 일본어를 사용하시는 경우, 한국어로의 번역을 이용하실 수 있습니다. 1-800-326-5496 (TTY: 1-800-545-8279).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-326-5496 (TTY: 1-800-545-8279).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-326-5496 (TTY: 1-800-545-8279).