



SUMMARY PLAN DESCRIPTION

FOR

RETIREE-ONLY HEALTH REIMBURSEMENT ARRANGEMENT FOR MEDICARE EXCHANGE ENROLLEES

ADMINISTERED BY:

OneExchange™
from Towers Watson



PLAN YEAR 2018

July 1, 2017 – June 30, 2018

Introduction

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

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

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

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

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

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Medicare Exchange Retiree-Only Health Reimbursement Arrangement Plan

Plan Information

Name of Plan (The Plan): Public Employees' Benefits Program Medicare Exchange Health Reimbursement Arrangement Plan (Medicare Exchange HRA Plan)

Plan Sponsor: State of Nevada Public Employees' Benefits Program (PEBP)

Plan Administrator: State of Nevada Public Employees' Benefits Program (PEBP)

Contact: Quality Control Officer

Address: 901 South Stewart Street, Suite 1001
Carson City, NV 89701

E-mail Address: memberservices@peb.state.nv.us

Telephone Number: (775) 684-7000 or (800) 326-5496

Tax Identification Number: 88-0378065

Third Party Administrator for Medical Plan selection & coverage questions:

Towers Watson's OneExchange
Address: 10975 Sterling View Drive, Suite A1
South Jordan, UT 84095

Telephone Number: (888) 598-7545

Website Address: www.medicare.oneExchange.com/PEBP

Third Party Administrator for the Medicare Exchange Retiree-Only HRA:

PayFlex
Address: P.O. Box 891155
El Paso, TX 79998-1155

Telephone Number: (888) 598-7545

General Fax Number: (855) 321-2605

Claims Fax Number: (855) 321-2604

Website Address: www.payflex.com

Plan Number: EXCHANGE HRA

Effective Date: July 1, 2011

Definition of Terms

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

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

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

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

Eligible Dependent¹: A dependent who is:

- A. A Spouse or other dependent of an Eligible Retiree as defined in Internal Revenue Code (IRC) Section 152 (26 USC § 152).
- B. A Spouse or other dependent of an Eligible Retiree as defined in PEBP's Master Plan Document.
- C. HRA funds may not be used for a person who does not meet the IRS definition of dependent as defined in IRC section 26 USC § 152, including many domestic partners, children of domestic partners and older children who cannot be claimed on the participant's tax return, regardless of whether PEBP provides coverage for the dependent.

Eligible Expenses: Eligible Expenses that do not exceed the balance in your HRA can be reimbursed from your HRA if the expenses are incurred during the time you participate in the HRA. Expenses are eligible only to the extent that they are not paid for by your health care coverage. Eligible Expenses are the costs associated with the diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. These expenses include payments for eligible medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include the costs of medical equipment, supplies, and diagnostic services.

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

Eligible Expenses include the premiums you pay for insurance that covers the expenses of medical care and the amounts you pay for transportation to get medical care. Medical expenses also include amounts paid for qualified long-term care services and limited amounts paid for any qualified long-term care insurance contract.

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

Below are examples of Eligible Expenses. For a list of expenses eligible for reimbursement under the HRA refer to the Internal Revenue Service (IRS) Publication 502, available by calling 1-800-TAX-FORM (829-3676) or by logging on to the IRS website at <http://www.IRS.gov>. Publication 502 provides a list of Eligible Expenses and any applicable limitations.

- Acupuncture
- Chiropractic
- Contact Lenses
- Durable Medical Equipment
- Hearing Aids
- Certain Insurance Premiums (Health, Long Term Care, etc.)

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

Eligible Retiree¹: An Eligible Retiree is a retiree who:

- A. is eligible to be covered under PEBP pursuant to:
 - 1) Nevada Revised Statutes Chapter 287;
 - 2) Nevada Administrative Code Chapter 287, and
 - 3) The Master Plan Document for the PEBP Enrollment and Eligibility
- B. is eligible for and enrolled in premium-free Medicare Part A;
- C. is eligible for and enrolled in Medicare Part B; and
- D. elects medical coverage through the Individual Medicare Exchange sponsored by PEBP;
or
- E. has TRICARE for Life

HIPAA: Health Insurance Portability and Accountability Act of 1996. Federal Regulation affecting portability of coverage; electronic transmission of claims and other health information; privacy and confidentiality protections of health information.

HRA Contribution: Also referred to as a "Benefit Credit" is the amount of money determined by your Years of Service that is deposited into your HRA account on a schedule determined by the Plan Administrator. Retired public employees enrolled in a medical plan through the contracted Third Party Administrator may qualify for an HRA Contribution based on the date of hire, date of retirement, and total Years of Service credit earned with each Nevada public employer.

- A. The following monthly amount will be credited on behalf of Eligible Retirees:
 - 1) For Eligible Retirees who retired prior to January 1, 1994, the dollar amount is equal to the base amount as determined by the Legislature during each Legislative Session. For detailed information regarding contribution amounts refer to PEBP's Master Plan Document located on the PEBP website at www.pebp.state.nv.us.
 - 2) For Eligible Retirees who retired on or after January 1, 1994, the dollar amount is equal to the base amount as determined by the Legislature during each Legislative Session multiplied by the Years of Service credit (calculated pursuant to NAC

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

287.485) up to a maximum of 20 Years of Service. For detailed information regarding contribution amounts refer to PEBP's Master Plan Document located on the PEBP website at www.pebp.state.nv.us.

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

HRA Contribution Eligibility: To receive the PEBP HRA Contribution, an Eligible Retiree must obtain and maintain an individual medical insurance policy through the PEBP sponsored Medicare Exchange. In other words, to receive the PEBP HRA Contribution amount, the Eligible Retiree must enroll in and maintain a medical insurance policy through the PEBP sponsored Medicare Exchange. If the Eligible Retiree does not enroll and maintain medical coverage as described above, the Eligible Retiree will NOT receive the PEBP HRA Contribution amount and will lose their PEBP sponsored benefits entirely including but not limited to life insurance and dental insurance. This policy also applies to Eligible Retirees who are covered under their Spouse's employer sponsored health plan.

NOTE: Effective July 1, 2015, the policy described under "HRA Contribution Eligibility" does not apply to Eligible Retirees or their Spouses who have health coverage under TRICARE for Life and Medicare Parts A and B. To receive the PEBP HRA Contribution, these individuals must submit a copy of their military ID card(s) to PEBP. PEBP will coordinate their enrollment with the Third Party Medicare HRA administrator.

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

Medicare Exchange Retiree-Only HRA Plan: The Medicare Exchange Health Reimbursement Arrangement (HRA) is a Medicare retiree-only arrangement that is provided to eligible PEBP retirees enrolled in a medical plan through Towers Watson's OneExchange and/or who have Medicare Parts A and B and Tricare for Life. The Medicare Exchange Retiree-Only Plan is an excepted benefit and not subject to the Patient Protection Affordable Care Act (PPACA) group market reforms.

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

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

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

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

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

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

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

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

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

Years of Service: Years of Service as calculated pursuant to NAC [287.485](#) and maintained in the eligibility records of PEBP. Retired public employees enrolled in a medical plan through Towers Watson's OneExchange may qualify for an HRA Contribution based on the date of hire, date of retirement, and total Years of Service credit earned with each Nevada public employer.

Participation

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

- A. becomes eligible for coverage under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code (Medicare Parts A and B), and;
- B. obtains an individual health insurance policy through the Plan Administrator's contracted Individual Market Medicare Exchange³ (Third Party Administrator); or is entitled to and enrolled in TRICARE for Life and Medicare Parts A and B; and
- C. completes any enrollment form (which may be electronic) or any enrollment procedures as specified by the Plan Administrator.

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

- A. on the date the Eligible Retiree ceases to be an Eligible Retiree for any reason, including but not limited to:
 - 1) enrollment in PEBP PPO or HMO coverage, if eligible;
 - 2) enrollment in other group coverage that may preclude enrollment in the individual Medicare plan, for example:
 - a. If a retiree is actively employed by an organization that does not participate in PEBP and the retiree enrolls in the active coverage of that organization. If the retiree declines their coverage, they can continue as a retiree in EH with an HRA.
 - b. If the retiree is the covered dependent of a Spouse who has employer group coverage because they are still actively employed, the retiree needs to obtain information from the current employer to determine if the termination of the PEBP group coverage is a qualifying event to change their other employer based coverage or if their other employer based coverage coordinates with Medicare and Medicare Supplement and/or Advantage plans.
 - 3) obtains employment as an active employee of the State of Nevada or a participating local government;
 - 4) ineligibility for coverage under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code (Medicare); or,
 - 5) Death of the Eligible Retiree;
- B. on the effective date of any Medicare Exchange HRA Plan amendment that renders the Eligible Retiree ineligible to participate;
- C. on the effective date of termination of the Medicare Exchange HRA Plan;
- D. with respect to a Dependent, the date he or she ceases to be a Dependent for any reason, including but not limited to:
 - 1) Death of the Dependent;
 - 2) divorce from the Eligible Retiree;
 - 3) if the dependent is otherwise no longer considered a dependent pursuant to IRS Code 152; or
 - 4) the cessation of participation of the Eligible Retiree.

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

Funding

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

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

Benefits

Provision of Benefits: The Medicare Exchange Retiree-Only HRA Plan will reimburse Eligible Retirees for Eligible Medical Expenses, up to the unused amount in the Eligible Retiree's Medicare Exchange Retiree-Only HRA Account. An Eligible Retiree shall be entitled to reimbursement under this Medicare Exchange Retiree-Only HRA Plan only for Eligible Expenses incurred after he or she becomes an Eligible Retiree in the Medicare Exchange Retiree-Only HRA Plan and before his or her participation has ceased. In no event shall any benefits under this Medicare Exchange Retiree-Only HRA Plan be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Eligible Medical Expenses. Medicare Exchange Retiree-Only HRA Account is considered a retiree only arrangement and is not subject to PPACA group market reforms.

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

Expense Reimbursement Procedure

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

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

- A. Each request for reimbursement shall include the following information:
 - 1) Requests for medical reimbursements must be attached to a claim form:
 - a. Obtain a claim form available on the PEBP website (www.pebp.state.nv.us).
 - b. Complete the Account Holder and Reimbursement Request Information sections of the claim form. Provide all requested information including your Social Security number.

- c. You must sign the claim form and by signing you acknowledge the Eligible Retiree has not been and will not be reimbursed for the Eligible Medical Expense by insurance or otherwise, and has not been allowed a deduction in a prior year (and will not claim a tax deduction) for such Eligible Medical Expense under IRS Code Section 213, and;
- d. Expenses eligible for coverage under any medical, HMO, dental, or vision care plans in which the Eligible Retiree or his or her Dependents are enrolled must be submitted first to all appropriate claims administrators for such plans before submitting the expenses to the Third Party Administrator for reimbursement under the Medicare Exchange Retiree-Only HRA Plan. An Eligible Retiree who is entitled to payment or reimbursement under a health care reimbursement account in a cafeteria plan under IRS Code Section 125 must receive his or her maximum annual reimbursement under the health care reimbursement account in the cafeteria plan before he or she is entitled to any reimbursement under this Medicare Exchange Retiree-Only HRA Plan.
- e. Refer to the back of the claim form for additional submission information (i.e. what documents or medical information is necessary to support the claim.)
- f. If you are submitting a reimbursement request for services provided by your physician, other health care practitioner, pharmacy or dentist, please attach the itemized bill of statement for professional services if it contains all of the following information:
 - the amount of the Eligible Medical Expense for which reimbursement is requested;
 - the date the Eligible Medical Expense was incurred;
 - a brief description and the purpose of the Eligible Medical Expense for example;
 - Provider's name, address, phone number, and professional degree or license;
 - Date(s) the services or supplies were provided;
 - A description of the services or supplies provided including appropriate procedure codes;
 - Details of the charges for those services or supplies;
 - Patient's name;
 - A copy of the Explanation of Benefits provided by your health plan (e.g. Medicare or Medicare supplemental plan) indicating your financial responsibility.
 - Reimbursement requests for prescription drugs must include an itemized receipt produced by the Pharmacy that provides the pharmacy name and address, patient's name, date the medication was dispensed, name of medication, and the amount that the patient paid.

- 2) Requests for premium reimbursements must be attached to a claim form:
 - a. Obtain a claim form available on the PEBP website (www.pebp.state.nv.us).
 - b. Complete the Account Holder and Reimbursement Request Information sections of the claim form. Provide all requested information including your Social Security number.
 - c. You must sign the claim form and by signing you acknowledge the Eligible Retiree has not been and will not be reimbursed for the Eligible Medical Expense by insurance or otherwise, and has not been allowed a deduction in a prior year (and will not claim a tax deduction) for such Eligible Medical Expense under IRS Code Section 213.
 - d. Refer to the back of the claim form for additional submission information (i.e. what documents or medical information is necessary to support the claim.)
 - e. You must provide a copy of the premium statement from your Insurance Carrier (e.g. Medicare or Medicare supplemental plan) unless automatic reimbursement arrangements have been made. The statement must include the name of the person for whom the premium statement was incurred. If the person is not the Eligible Retiree requesting reimbursement, please provide the relationship of the person to such Eligible Retiree.

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

Claim Review Timing: Claims will be paid in the order in which they are received by the Third Party Administrator and will be charged to the Medicare Exchange Retiree-Only HRA Account of the Eligible Retiree who submits the claim. PEBP may establish such other rules as it deems desirable regarding the frequency of reimbursement of expenses, the minimum dollar amount that may be requested for reimbursement and the maximum amount available for reimbursement during any single month.

The Third Party Administrator shall review received claims and respond within thirty (30) days of receipt. If the Third Party Administrator determines that an extension is necessary due to matters beyond the control of the Medicare Exchange Retiree-Only HRA Plan, the Third Party Administrator will notify the claimant within the initial thirty (30) day period that the Third Party Administrator needs up to an additional fifteen (15) days to review the claim. If such an extension is necessary because the claimant failed to provide the information necessary to evaluate the claim, the notice of extension will describe the information that the claimant will need to provide to the Third Party Administrator. The Third Party Administrator encourages you to submit the requested documentation as soon as possible. Please be reminded, in accordance

with [NAC 287.610](#), all claims must be submitted to the Third Party Administrator within one year (12 months) from the date the service(s) were incurred. No plan benefits will be paid for any claim submitted after this period.

Claims Denied

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

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

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

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

Loss of Coverage

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

- A. his or her Eligible Expenses incurred after such date will not be reimbursed even if Benefit Credits remain in the Eligible Retiree's Medicare Exchange Retiree-Only HRA Account; and
- B. the Eligible Retiree may submit claims for reimbursement for Eligible Expenses incurred prior to his or her loss of coverage (e.g. break in coverage, loss of eligibility, etc.), provided the Eligible Retiree files such claims within one hundred eighty (180) days of loss of coverage. In other words, when your coverage ends and you are an eligible Medicare HRA retiree you will have one hundred eighty days (6 months) from the date your coverage ends to file a claim for reimbursement from your HRA account for Eligible Expenses incurred during your coverage period.

Medicare Exchange Retiree-Only HRA Claim Appeal Process

Written Notice of Claim Denial

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

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- a description of our right to request all documentation relevant to your claim.

Your request for appeal must be made in writing to the office where the claim was originally submitted or online at <https://medicare.oneexchange.com/pebp> (the HRA Third Party Administrator) within 180 days after you receive a notice of denial. A Participant or their designee cannot circumvent the claims and appeals procedures by initiating a cause of action against the PEBP (or State of Nevada) in a court proceeding.

The appeal process works as follows:

Level 1 Appeal

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

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

You have the right to review documents applicable to the denial and to submit your own comments in writing. The HRA third party administrator will review your claim. If any additional information is needed to process your request for appeal, it will be requested promptly.

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

Level 2 Appeal

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

If, after a Level 1 appeal is completed, you are still dissatisfied with the denial of your HRA claim, rescission of coverage, or amount paid on your claim you may submit your written request to the Executive Officer of PEBP or his designee (see the Plan Administrator's section of the Participant Contact Guide in this document for the address) within 35 days after you receive the decision on the Level 1 appeal, together with any additional information you have in support of your request. Your Level 2 appeal must include a copy of:

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

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

General Provisions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Administration

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

Duties of the Plan Administrator

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

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

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

- A. To implement procedures to be followed by Eligible Retirees in making elections under the Medicare Exchange HRA Plan and in filing claims under the Medicare Exchange HRA Plan;
- B. To prepare and distribute information explaining the Medicare Exchange HRA Plan to Eligible Retirees;
- C. To receive from Eligible Retirees and Dependents such information as shall be necessary for the proper administration of the Medicare Exchange HRA Plan;
- D. To keep records of elections, claims, and disbursements for claims under the Medicare Exchange HRA Plan, and any other information required by the Public Health Services Act or the Code;
- E. To appoint individuals or committees to assist in the administration of the Medicare Exchange HRA Plan and to engage any other agents as it deems advisable;
- F. To make available election forms and claims forms to be used by Eligible Retirees, which may include electronic forms;
- G. To determine and enforce any limits on benefit elections described in this document; and

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

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

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

Continuation Coverage

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

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

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

Privacy Notice

Disclosure and Access to Medical Information

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

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

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

We are required by the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) to maintain the privacy of Protected Health Information and to provide individuals covered under our group health Plan with notice of our legal duties and privacy practices concerning Protected Health Information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all Protected Health Information maintained by us. If we make material changes to our privacy practices, copies of revised notices will be provided 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 use your PHI to communicate with you 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. Some examples of these products could include flexible spending accounts or health reimbursement arrangements.

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

- We may use or disclose your PHI for any purpose required by law. For example, we may be required by law to use or disclose your PHI to respond to a court order.
- We may disclose your PHI for public health activities, such as reporting of disease, Injury, birth and death, and for public health investigations.
- We may disclose your PHI to the proper authorities if we suspect Child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for cadaveric organ, eye or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to workers' compensation agencies for your workers' compensation benefit determination.
- We will, if required by law, release Your PHI to the Secretary of the Department of Health and Human Services for enforcement of HIPAA.
- We may disclose your PHI to report adverse reactions to medications.
- We may disclose your PHI to assist with certain product recalls.

Plan Sponsors - PEBP may use or disclose protected health 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, we or our business associates, have made 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 accounting requests must be in writing and signed by you or your representative. You are entitled to one free disclosure 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.

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)

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

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

Office of Civil Rights
Dept. of Health & Human Services
907 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/oct/privacy/hipaa/complaints/index.html>

By law, PEBP is required to follow the terms in this privacy notice. PEBP has the right to change the way your personal medical information is used and given out. If PEBP makes any changes to the way your personal medical information is used and given out, you will get a new notice within 60 days of the change. 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 work weeks 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 employers to provide certain retirement and welfare benefits for returning military personnel and their beneficiaries. For more information on the HEART Act (Heroes Earning Assistance and Relief Tax), PEBP directs you to the IRS website at: www.irs.gov.

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.

Wellstone & Domenici Mental Health Parity & Addiction Equity Act

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 is effective for PEBP on July 1, 2010. This legislation requires that full parity be established between mental health/ Substance Abuse benefits and other surgical and medical Benefits offered under the Plan. You can find more information at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html and searching for The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Genetic Information Non-discrimination Act of 2008

The Genetic Information Non-discrimination Act of 2008 (GINA) was enacted May 21, 2008. Title I (regarding genetic nondiscrimination in group health plans) is effective for Plan Years beginning after May 21, 2009. Title II (regarding genetic nondiscrimination in employment) becomes effective November 21, 2009. GINA amends ERISA, the Code and Public Health Service Act to prevent group health plans and health insurance companies from basing enrollment decisions, premium costs, or Participant contributions on genetic information. Group health plans and group insurers will be prohibited from requiring that individuals undergo Genetic Testing. Employers are preventing conditioning of hiring or firing decisions on the basis of genetic information. Lastly, GINA will extend medical privacy and confidentiality rules to the disclosure of genetic information. Currently, PEBP and the State of Nevada do not use genetic information in regards to either employment or the determination of Benefits. Genetic Testing is a Plan exclusion. You can read more about GINA at www.genome.gov/10002328.

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.