NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Access.
Quality.
Affordability.

MEDICARE EXCHANGE
HEALTH REIMBURSEMENT ARRANGEMENT
SUMMARY PLAN DESCRIPTION
Plan Year 2019

(Effective July 1, 2018 – June 30, 2019)

Public Employees' Benefits Program

Administered By:

VIA BENEFITS™

formerly OneExchange™ from Towers Watson

10975 S. Sterling View Dr. Suite 1A
South Jordan, UT 84095
1-888-598-7545

https://my.viabenefits.com/pebp
www.pebp.state.nv.us

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Carson City, Nevada 89701
(775) 684-7000 (800) 326-5496

Contents

Amendment Log

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.

Medicare Exchange 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)
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:

	VIA Benefits formerly Towers Watson's OneExchange
Address:	10975 Sterling View Drive, Suite A1 South Jordan, UT 84095
Telephone Number:	(888) 598-7545
Website Address:	https://my.viabenefits.com/PEBP

Third Party Administrator for the Medicare Exchange HRA:

Address:	PayFlex 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
Plan Origination:	July 1, 2011

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 (the Consumer Driven Health Plan, the Premier (Exclusive Provider Organization) Plan, or Health Maintenance Organization Plan) offered in your geographical area that best meets your needs, subject to specific eligibility and Plan requirements.

All PEBP participants enrolled in coverage through the Medicare Exchange should examine this document, the PEBP PPO Dental Plan Master Plan Document (MPD), Health and Welfare Wrap Plan Document, Section 125 Health and Welfare Benefits Plan Document, and the PEBP Enrollment and Eligibility Master Plan Document. These documents are available at www.pebp.state.nv.us.

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

The Basics of Health Reimbursement Arrangement (HRA)

Introduction

Eligible retirees enrolled in a medical plan through Via Benefits (formerly Towers Watson's OneExchange) and retirees enrolled in Tricare for Life and Medicare Parts A and B, receive a month years of service contribution to a Medicare Exchange Health Reimbursement Arrangement (Medicare-HRA). The monthly contributions are based on the retirees' years of service and date of retirement. Eligible retirees may use the HRA money for reimbursement of medical, dental and vision premiums, Medicare Part B premium, and IRS qualified out-of-pocket health care expenses.

PEBP intends the Medicare-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 Via Benefits or the Medicare Exchange HRA third party administrator. The *Plan information* section of this document provides contact information for the Plan Administrator and third party administrators.

This Summary Plan Description document describes the Medicare Exchange-HRA plan provided to Medicare retirees enrolled 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.

Participation

Agreement to Participate

Participation in the Medicare Exchange HRA plan shall begin on the date the eligible retiree fulfills the following requirements:

1) Becomes eligible for coverage under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code (Medicare Parts A and B), and;
2) obtains an individual health insurance policy through the Plan Administrator's contracted Individual Market Medicare Exchange[1] (third party administrator); or is entitled to and enrolled in TRICARE for Life and Medicare Parts A and B; and
3) completes any enrollment form (which may be electronic) or any enrollment procedures as specified by the Plan Administrator.

[1] 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.)

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 the CDHP, Premier Plan 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. However, if the retiree declines their coverage, they can continue as a retiree in the Medicare Exchange 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.

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 HRA established pursuant to the Medicare Exchange 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 HRA plan. In no event may any benefits under the Medicare Exchange HRA be funded with eligible retiree contributions.

Benefit Credits

The Plan Administrator will credit the Medicare Exchange HRA accounts of eligible retirees with the benefit credits as described under the definition of *HRA contribution*.

Benefits

Provision of Benefits

The Medicare Exchange HRA plan will reimburse eligible retirees for eligible medical expenses, up to the unused amount in the eligible retiree's Medicare Exchange HRA account. An eligible retiree shall be entitled to reimbursement under this Medicare Exchange HRA plan only for eligible expenses incurred after he or she becomes an eligible retiree in the Medicare Exchange HRA plan and before his or her participation has ceased. In no event shall any benefits under this Medicare Exchange 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 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 HRA plan for payment of eligible expenses in an amount that does not exceed the balance of his or her Medicare Exchange HRA account. Each reimbursement shall be deducted from the eligible retiree's Medicare Exchange HRA account for eligible expenses under the Medicare Exchange 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 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.

Each request for reimbursement must submitted on a Reimbursement Request Form. Forms are available on the Via Benefits website https://my.viabenefits.com/PEBP or by calling 1-888-598-7545. Questions regarding required supporting documents for your claim should be directed to Via Benefits at 1-888-598-7545.

You must sign the claim form and by signing you certify that the information provided on the form is correct and that the expenses for which you are requesting were incurred for expenses for the covered participant while eligible under the plan on or after its effective date, have not been reimbursed in any other way from any other source, and will not be submitted for future reimbursement. (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.)

If you are submitting a reimbursement request for services provided by your physician, other health care practitioner, pharmacy or dentist, you must attach one or more of the following with your reimbursement request.

- a copy of the explanation of benefits provided by your health plan (e.g. Medicare or Medicare supplemental plan) indicating your financial responsibility;
- 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;
- 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.

Requests for premium reimbursements must be attached to a claim form. Obtain a claim form available on the VIA Benefits website https://my.viabenefits.com/PEBP or by calling 1-888-598-7545.

You must sign the claim form and by signing you certify that the information provided on the form is correct and that the expenses for which you are requesting were incurred for expenses for the covered participant while eligible under the plan on or after its effective date, have not been reimbursed in any other way from any other source, and will not be submitted for future reimbursement. (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.)

- 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: 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 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 HRA plan.

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 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 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 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 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 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 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 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://my.viabenefits.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 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 Information* section 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.

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 month of the eligible retiree's death.

Eligible Dependent[2]: 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.
For a list of expenses eligible for reimbursement under the HRA refer to the Internal Revenue

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

Service (IRS) Publication 502, available by calling 1-800-tax-form (1-800-829-3676) 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. Below are examples of eligible expenses.

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

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

Eligible Retiree[2]: 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

[2] 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 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 HRA Plan: The Medicare Exchange HRA is provided to eligible PEBP retirees enrolled in a medical plan through VIA Benefits and or who have Medicare Parts A and B and Tricare for Life. The Medicare Exchange 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 Health Reimbursement Arrangement plan (Medicare Exchange 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 Consumer Driven Health Plan (CDHP) 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 HRA Funds: Credits remaining in a Medicare Exchange 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: VIA Benefits 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 VIA Benefits 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.