MEDICARE EXCHANGE
HEALTH REIMBURSEMENT ARRANGEMENT
SUMMARY PLAN DESCRIPTION
Plan Year 2020

(Effective July 1, 2019 – June 30, 2020)

Public Employees' Benefits Program

Administered By:

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South Jordan, UT 84095
1-888-598-7545

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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 (HRA)
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:	Contact member services by logging on to your E-PEBP member portal accessed by clicking on the orange log in icon at www.pebp.state.nv.us.
Telephone Number:	(775) 684-7000 or (800) 326-5496
Tax Identification Number:	88-0378065
Plan Information:	
Third-Party Administrator:	VIA Benefits formally 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 HRA:

Claims Address:	PayFlex Systems USA, Inc. Flex Dept. 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:	Medicare Exchange HRA
Plan Year:	Plan Year 2020; effective July 1, 2019 – June 30, 2020
Plan Origination:	July 1, 2011

Introduction

The Public Employees' Benefits Program provides a health reimbursement arrangement ("HRA") for the purpose of allowing Eligible Retirees to obtain reimbursement of Qualified Medical Expenses incurred by such retirees and their eligible dependents.

The HRA is intended to be a health reimbursement arrangement as defined under IRS Notice 2002-45 and a medical reimbursement plan under Code sections 105 and 106. The Qualifying Medical Expenses reimbursed under the HRA are intended to be eligible for exclusion from a retiree's gross income under Code section 105(b).

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

This Summary Plan Description will help you understand how the HRA works. It describes the benefits available, the advantages of a health reimbursement arrangement and the key features of the HRA. Please take the time to familiarize yourself with the contents of this document and keep it for your future reference.

All provisions of this document contain important information, if you have questions about the HRA or your obligations under the Plan, contact the Third-Party Administrators that is listed under "**Plan Information**".

The following list of documents provide additional related to dental insurance, life insurance, PEBP enrollment and eligibility provisions, HIPAA Privacy and Security, and Mandatory Notices. These documents are available at www.pebp.state.nv.us or by request by calling (775) 684-7000 or (800) 326-5496.

- PPO Dental Plan Master Plan Document (MPD)
- State of Nevada PEBP Health and Welfare Wrap Plan Document
- CDHP Summary of Benefits and Coverage for Individual and Family
- PEBP PPO Dental Plan and Summary of Benefits for Life and Long-Term Disability Insurance Master Plan Document
- Premier Plan Master Plan Document
- Premier Plan Summary of Benefits and Coverage for Individual and Family
- Section 125 Health and Welfare Benefits Plan Document
- Flexible Spending Accounts (FSA) Summary Plan Description
- Medicare Retiree Health Reimbursement Arrangement Summary Plan Description
- PEBP Enrollment and Eligibility Master Plan Document. These documents are available at www.pebp.state.nv.us.

It is important 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.

Exchange Health Reimbursement Arrangement Plan (HRA)

The Purpose of the HRA

The Plan offers each Eligible Retiree the opportunity to receive reimbursement through an HRA for Qualifying Medical Expenses incurred by the retiree, the retiree's spouse, and the retiree's IRS-qualified tax dependent(s). An HRA is established on behalf of an Eligible Retiree upon enrolling in an individual health insurance policy (Medicare Plan) through the Third-Party Administrator, VIA Benefits. The Plan Administrator intends to deposit a monthly reimbursement allowance to the HRA on behalf of each eligible retiree. A retiree is not required or allowed to contribute to his or her HRA. The reimbursement payments from a retiree's HRA are not includible in the retiree's gross income and consequently are not taxable to the retiree.

Participation

Agreement to Participate

Participation in the 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 (Medicare Plan) through VIA Benefits[1]; or is entitled to and enrolled in TRICARE for Life, Medicare Parts A and B, and has submitted copies of the Tricare for Life and Medicare Parts A and B cards to the Plan Administrator; and
3) completes any enrollment form (which may be electronic) or any enrollment procedures as specified by the Plan Administrator.

Cessation of Participation

Participation in the 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 Health Plan of Nevada (HMO) coverage, if eligible;
   2) enrollment in other employer group coverage that may preclude enrollment in an individual Medicare plan;
   3) upon obtaining 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

[1] Any eligible retiree who does not enroll in and maintain 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.)

States Code (Medicare); or,
5) death of the eligible retiree.

B. On the effective date of any HRA plan amendment that renders the eligible retiree ineligible to participate.
C. On the effective date of termination of the HRA.
D. With respect to an eligible dependent, the date he or she ceases to be an eligible dependent for any reason, including but not limited to:
   a) death of the eligible dependent;
   b) divorce from the Eligible Retiree;
   c) if the dependent is otherwise no longer considered a dependent pursuant to IRS Code 152; or
   d) the cessation of participation of the Eligible Retiree.

Funding

HRA Plan 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 HRA is established pursuant to the Medicare HRA plan as a hypothetical account which reflects a bookkeeping concept and does not represent assets that are set aside for the exclusive purpose of providing benefits to the eligible retiree under the terms of the Medicare HRA. In no event may any benefits under the HRA be funded with retiree contributions.

Benefit Credits

The Plan Administrator will credit each Eligible Retiree's HRA account with the benefit credits as described under the definition of *HRA Contribution*.

Benefits

Provision of Benefits

The HRA plan may be used to reimburse Qualifying Medical Expenses incurred by an Eligible retiree and/or for his or her spouse and eligible dependent(s). Qualifying Medical Expenses or "medical care" as defined in Code section 213(d) are not reimbursed through insurance or otherwise. The following is a partial list of Qualifying Medical Expenses:

- premiums for Medicare Parts A, B and D coverage,
- premiums for Medicare Plan coverage purchased through VIA Benefits,
- excess Medicare Part B charges,
- premiums for medical, dental and vision care plans, which are not paid on a pre-tax basis through a Code section 125 plan ("cafeteria" plan),

- premiums for coverage under a long-term care plan,
- deductibles for Medicare Parts A and B, medical, dental and vision care plans,
- co-payments under Medicare, Medicare Plans, medical, dental and vision care plans,
- out-of-pocket expenses for prescription drug copayments,
- charges in excess of reasonable and customary charges as determined under medical, dental and vision care plans,
- hearing exams and hearing aids,
- acupuncture fees, and, but not limited to
- eye exams, prescription eyeglasses and contact lenses.

Please refer to Internal Revenue Service Publications 969 and 502 for the definition of qualified medical expenses and a list of medical expenses.

In no event shall any benefits under this Medicare HRA plan be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for IRS-approved out-of-pocket health care expenses and qualifying health insurance premiums. The HRA is considered a retiree only arrangement and is not subject to PPACA group market reforms.

Amount of Reimbursement

Eligible retirees may request reimbursement of Qualifying Medical Expenses from the HRA at any time during the Plan Year. A retiree will only be reimbursed up to the amount in the HRA. If the amount of the Qualifying Medical Expense for which a retiree is requesting is more than the unused amount the his or her HRA, then the amount of the Qualifying Medical Expense will be carried forward until the unused amount in the HRA is sufficient to reimburse the Qualifying Medical Expense.

Automatic Reimbursement Requirement for Retirees Enrolled in PEBP's PPO Dental Plan

Automatic Premium Reimbursement is required for any retiree who enrolls in PEBP's PPO Dental Plan. Any retiree who enrolls in PEBP's PPO Dental Plan will automatically be reimbursed his or her PPO Dental Plan premium up to the amount in the HRA. If the amount of the PPO Dental Plan premium is more than the unused amount in the HRA, then the amount of the premium will be carried forward in his or her HRA until the unused amount in the HRA is sufficient to reimburse for the PPO Dental Plan premium.

Carryover (Rollover) of Account funds

For Plan Year 2020, effective July 1, 2019 – June 30, 2020), any unused amount credited to a retiree's HRA will carry over from month to month and to the next Plan Year.

Loss of Coverage

When coverage through VIA Benefits is terminated by the Eligible Retiree, PEBP, the insurance carrier (due to the Eligible Retiree's death, non-payment of premiums or the Medicare Exchange

[VIA Benefits] is no longer the "agent of record"), or by the Third-Party Administrator, the retiree shall receive no further benefit credits under the HRA and;

A. his or her eligible expenses incurred after such date will not be reimbursed even if benefit credits remain in the retiree's HRA account; and

B. the Eligible Retiree may submit claims for reimbursement for qualified medical 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. This means, when an Eligible Retiree's coverage is terminated, he or she will have one hundred eighty days (6 months) from the date coverage ends to file a claim for reimbursement from his or her HRA for qualified medical expenses incurred during the eligible coverage period.

Expense Reimbursement Procedure

Timely Filing of HRA reimbursement claims

In accordance with NAC 287.610, all claims must be submitted to the HRA's Third-Party Administrator within one year (12 months) from the date the service(s) were incurred. No HRA reimbursements will be paid for any claim submitted after this period.

Claims Substantiation – How to file a claim for HRA reimbursement

PEBP's HRA Third-Party Administrator may require the retiree to furnish a bill, receipt, cancelled check or other written evidence or certification of payment or of obligation to pay qualified medical expenses. The HRA Third-Party Administrator will reimburse the Eligible Retiree for expenses that it determines are eligible expenses up to the balance in the retiree's HRA at such intervals as PEBP may deem appropriate (but not less frequently than monthly). PEBP's HRA Third-Party Administrator reserves the right to verify that all claimed medical expenses satisfy the IRS 213D definition of Qualifying Medical Expenses prior to reimbursement.

Requests for reimbursements must be attached to a claim form. Claims may be submitted online at the VIA Benefits website https://my.viabenefits.com/PEBP. Claim forms may also be down loaded or mailed by calling (888) 598-7545.

By submitting the reimbursement request, you certify that the information provided on the Reimbursement Request Form is correct and complete. You also certify that the expenses for which you are requesting reimbursement were incurred for expenses for the covered participant while eligible under the plan on or after its effective date, the expenses have not been reimbursed in any other way from any other source, and the expenses will not be submitted for future reimbursement from any other source. (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 documents from a third party containing all the following information.

- provider name and professional information
- patient's name
- date eligible medical expense was incurred
- a brief description of the eligible medical expense
- amount that the patient paid or owed

Reimbursement requests for prescription drugs must include an itemized receipt produced by the pharmacy that provides the following:

- pharmacy name and address
- patient's name
- date the medication was dispensed
- name of medication
- amount that the patient paid

This information may be included in one or more documents. A copy of the explanation of benefit provided by your health plan (e.g. Medicare or Medicare supplemental plan) indicating your financial responsibility may be the simplest document to provide.

Requests for premium reimbursements must be attached to a claim form. Claims may be submitted online at the VIA Benefits website https://my.viabenefits.com/PEBP. Claim forms may also be down loaded or mailed by calling (888) 598-7545.

By submitting the reimbursement request, you certify that the information provided on the Reimbursement Request Form is correct and complete. You also certify that the expenses for which you are requesting reimbursement were incurred for expenses for the covered participant while eligible under the plan on or after its effective date, the expenses have not been reimbursed in any other way from any other source, and the expenses will not be submitted for future reimbursement from any other source. (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 request for premium for a health plan (e.g. Medicare or Medicare supplemental plan) you must attach one or more documents from a third party containing all of the following information.

- provider name
- covered participants name
- date of coverage
- type of coverage
- amount of the premium paid or incurred

This information may be included in one or more documents. A copy of the premium statement from your insurance carrier (e.g. Medicare or Medicare supplemental plan) indicating your payments or financial responsibility may be the simplest document to provide. If the person is not the eligible retiree requesting reimbursement, please provide the relationship of the person to such eligible retiree.

Claims for premium reimbursements may be scheduled for Automatic Premium Reimbursement where VIA Benefits submits your insurance company payment information from your insurance company in your behalf for reimbursement. Automatic Premium Reimbursement may be elected online at the VIA Benefits website https://my.viabenefits.com/PEBP or by calling (888) 598-7545.

Recurring Premium Reimbursement Requests are an option for those requesting reimbursement for Medicare Part B premiums or who do not have Automatic Premium Reimbursement available through their insurance company. Submit one Recurring Premium Reimbursement Request Form at the beginning of the year to set up recurring reimbursement for the following twelve months. Premiums must be a fixed monthly amount for a set period. Recurring premium requests must be resubmitted each calendar year.

For Medicare Part B premiums deducted from your Social Security check, use a copy of the Social Security Benefit Award/Proof of Income Letter issued by the Social Security Administration (SSA) each year, usually during the month of October or November, as your third-party documentation.

A Recurring Premium Reimbursement Request Form must be submitted mid-year if there is a change in your premium, you have a new policy, or if a policy ends for any reason during the calendar year.

Expenses eligible for coverage under any medical, HMO, dental, or vision care plans in which the Eligible Retiree or his or her eligible dependent(s) 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 HRA. 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 HRA.

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 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 HRA, 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. 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 HRA reimbursements/benefits will be paid for any claim submitted after this period.

Medicare Exchange HRA Claim Appeal Process

Notice of Claim Denial

The 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 specific reason or reasons for the denial;
- specific reference pertinent to 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;
- upon request, 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; and
- a description of the HRA's appeal procedures and the time limits applicable to such procedures.

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 twenty (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

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.

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. 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 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 HRA account.

Benefit Credit: The amount credited to an eligible retiree's Medicare HRA account for the provision of benefits under the Medicare HRA.

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. See also *Qualifying Medical Expenses*.

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;

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

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 the Plan Year 2020 Benefits Guide located on the PEBP website at www.pebp.state.nv.us or contact PEBP at 775-684-7000 or 800-326-5496 to request the Plan Year 2020 Benefits Guide.
   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 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 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 enroll in an individual medical insurance policy (Medicare Plan) and maintain an individual Medicare Plan through the PEBP sponsored Medicare Exchange, VIA Benefits. 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/domestic partner's employer sponsored health plan.

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.

Individual Market Medicare Exchange: The health care exchange for individuals who have Medicare Parts A and B and is operated by the Third-Party Administrator, whose name and address is provided in the *Plan information* section of this document, and its subcontractors.

Medicare: The coverage provided under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code (Medicare Parts A and B).

Medicare Exchange Health Reimbursement Arrangement (HRA) Account: is the bookkeeping account established by the Plan Administrator for an Eligible Retiree to hold his or her benefit credits.

Medicare Exchange HRA: The HRA is provided to Eligible Retirees enrolled in a Medicare Plan through VIA Benefits and Eligible Retirees who have Tricare for Life and Medicare Parts A and B. The HRA Plan is an excepted benefit and not subject to the Patient Protection Affordable Care Act (PPACA) group market reforms.

Medicare Plan: One of the following plans which supplements the benefits provided by Medicare purchased through the VIA Benefits:

- An individual Medicare Advantage Plan which excludes Medicare Part D prescription drug coverage (issued by an insurance carrier pursuant to a contract with the Centers for Medicare and Medicaid Services);
- An individual Medicare Advantage Plan which includes Medicare Part D prescription drug coverage (issued by an insurance carrier pursuant to a contract with the Centers for Medicare and Medicaid Services);
- A Medicare Supplement Plan (also called Medigap);
- A Special Needs Plan which is purchased through VIA Benefits.

Medicare Supplement Plan: An individual plan which supplements the benefits provided by Medicare, and which meets the requirements of a standard Medicare Supplemental Plan under applicable law.

Plan: Public Employees' Benefits Program Medicare Exchange Health Reimbursement Arrangement Plan (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 HRA Plan.

Qualifying Medical Expense: 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 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.

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 HRA at the end of a Plan Year shall be carried over to the following Plan Year to reimburse Eligible Retirees for Qualifying Medical Expenses incurred during subsequent Plan Years, up to a limit to be determined by PEBP at a later date.

Spouse: The Eligible 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.