NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Access.
Quality.
Affordability.

PEBP PPO DENTAL PLAN AND SUMMARY OF BENEFITS FOR LIFE AND LONG-TERM DISABILITY INSURANCE

MASTER PLAN DOCUMENT

PLAN YEAR 2021

(EFFECTIVE JULY 1, 2020 – June 30, 2021)

Public Employees' Benefits Program
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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.

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 enroll in whichever benefit plan offered in your geographical area that best meets your needs, subject to specific eligibility and Plan requirements. These plans include the Consumer Driven Health Plan (CDHP) with a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA), the Premier (EPO) Plan, and Health Plan of Nevada HMO Plan. (In general, Medicare retirees are required to enroll in a medical plan through PEBP's Medicare Exchange vendor). You are also encouraged to research plan provider access and quality of care in your service area.

This document describes PEBP's PPO Dental Plan, Life and Long-Term Disability Benefits. Active employees enrolled in a PEBP-sponsored medical plan (CDHP, Premier Plan or Health Plan of Nevada HMO Plan) receive dental, basic life and long-term disability benefits. Retirees enrolled in a PEBP-sponsored medical plan receive dental coverage and if eligible, basic life insurance coverage. Eligible retirees enrolled in a medical plan through PEBP's Medicare Exchange receive basic life insurance and the choice to enroll in PEBP's voluntary PPO Dental Plan option.

PEBP participants should examine this document to become familiar with the PPO Dental Plan, basic life insurance and life and long-term disability benefits. In addition to examining this document, participants are encouraged to read the Master Plan Documents or Evidence of Coverage Certificates (EOCs), Summary Plan Descriptions, and Summary of Benefits and Coverage applicable to their medical plan. Participants should also examine the PEBP Enrollment and Eligibility, PEBP Health and Welfare Wrap Plan, Section 125, Medicare Exchange HRA Summary Plan Description, and other plan materials relevant to their benefits. These documents and other materials are available at www.pebp.state.nv.us or to request a particular document by mail, contact PEBP at 775-684-7000 or 800-326-5496 or email member services by selecting the contact us feature in your E-PEBP portal member account.

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 plan provisions and other requirements described in PEBP's Master Plan Document and related materials.

Sincerely,

Public Employees' Benefits Program

Introduction

This Master Plan Document describes the PEBP self-funded PPO Dental Plan benefits offered to eligible employees, retirees, and their covered dependents. Additional benefits for life and long-term disability are summarized in this document.

This PEBP plan is governed by the State of Nevada.

This document is intended to comply with the Nevada Revised Statutes (NRS) Chapter 287, and the Nevada Administrative Code 287 as amended and certain provisions of NRS 695G and NRS 689B.

The Plan described in this document is effective July 1, 2020, and unless stated differently, replaces all other self-funded Dental Benefit Plan documents and summary plan descriptions previously provided to you.

This document will help you understand and use the benefits provided by the Public Employees' Benefits Program (PEBP). You should review it and show it to members of your family who are or will be covered by the Plan. It will give you an understanding of the coverage provided, the procedures to follow in submitting claims, and your responsibilities to provide necessary information to the Plan. Be sure to read the *Exclusions,* and *Key Terms and Definitions Sections.* Remember, not every expense you incur for health care is covered by the Plan.

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

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

The benefits offered with the Consumer Driven Health Plan, Premier Plan, and Health Plan of Nevada include prescription drug benefits, dental coverage, long-term disability, and basic life insurance as applicable. The medical and prescription drug benefits are described in separately in the applicable plan's Master Plan Document or Evidence of Coverage certificate. An independent third-party claims administrator pays the claims for the PPO Dental Plan.

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

Suggestions for Using this Document

This document provides important information about your benefits. We encourage you to pay attention to the following:

- The Table of Contents provides you with an outline of the sections.
- The *Participant Contact Guide* to become familiar with PEBP vendors and the services they provide.
- The *Participant Rights and Responsibilities* section located in the Introduction of this document.
- The *Key Terms and Definitions* section explains many technical, medical, and legal terms that appear in the text.
- The *Eligible Dental Expenses*, *Schedule of Dental Benefits* and *Exclusions* sections describe your benefits in more detail.
- How to *File a Dental Claim* section to find out what you must do to file a claim.
- The *Appeals Procedures* section to find out how to request a review (appeal) if you are dissatisfied with a claims decision.
- The section on *Coordination of Benefits* discusses situations where you have coverage under more than one health care plan including Medicare. This section also provides you with information regarding how the plan subrogates with a third party who wrongfully caused an injury or illness to you.

Accessing Other Benefit Information:

Refer to the following plan documents for information related to dental, life, flexible spending accounts, enrollment and eligibility, COBRA, third-party liability and subrogation, HIPAA Privacy and Security and mandatory notices. These documents are available at www.pebp.state.nv.us.

- State of Nevada PEBP Health and Welfare Wrap Plan
- Consumer Driven Health Plan (CDHP) Master 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
- Health Plan of Nevada Evidence of Coverage of Benefits and Coverage
- PEBP Enrollment and Eligibility Master Plan Document
- Flexible Spending Accounts (FSA) Summary Plan Description
- Section 125 Health and Welfare Benefits Plan Document
- Medicare Retiree Health Reimbursement Arrangement Summary Plan Description
- Summary Benefits and Coverage Document for Individual and Family

Participant Rights and Responsibilities

You have the right to:

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

You have the responsibility to:

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

- Provide PEBP with accurate and complete information needed to administer your health benefit plan, including if you or a covered dependent has other health benefit coverage.
- Retain copies of the documents provided to you from PEBP and PEBP's vendors. These documents include but are not limited to:
- Copies of the Explanation of Benefits (EOB) from PEBP's third party claims administrator. Duplicates of your EOB's may not be available to you. It is important that you store these documents with your other important paperwork.
- Copies of your enrollment forms submitted to PEBP.
- Copies of your medical, vision and dental bills.
- Copies of your HSA contributions, distributions, and tax forms.

The plan is committed to:

- Recognizing and respecting you as a participant.
- Encouraging open discussion between you and your health care professionals and providers.
- Providing information to help you become an informed health care consumer.
- Providing access to health benefits and the plan's network (participating) providers.
- Sharing the plan's expectations of you as a participant.

Self-Funded PPO Dental Benefits

Eligible Dental Expenses

You are covered for expenses you incur for most, but not all, dental services and supplies provided by a dental care provider as defined in the *Key Terms and Definitions* section of this document that are determined by PEBP or its designee to be "medically necessary," but only to the extent that:

- PEBP or its designee determines that the services are the most cost-effective ones that meet acceptable standards of dental practice and would produce a satisfactory result; and
- The charges for them are "usual and customary (U&C)" (see Usual and Customary in the *Key Terms and Definitions* section).

Non-Eligible Dental Expenses

The plan will not reimburse you for any expenses that are not eligible dental expenses. That means you must pay the full cost for all expenses that are not covered by the Plan, as well as any charges for eligible dental expenses that exceeds this Plan's Usual and Customary determination.

Out-of-Country Dental Purchases

The PPO Dental Plan provides you with coverage worldwide. Whether you reside in the United States and you travel to a foreign country, or you reside outside of the United States, permanently or on a part-time basis and require dental care services, you may be eligible for reimbursement of the cost.

Typically, foreign countries do not accept payment directly from PEBP. You may be required to pay for dental care services and submit your receipts to PEBP's third party administrator for reimbursement. Dental services received outside of the United States are subject to Plan provisions, limitations and exclusions, clinical review if necessary and determination of medical necessity. The review may include regulations determined by the FDA.

Prior to submitting receipts from a foreign country to PEBP's third party administrator, you must complete the following. (PEBP and this Plan's third-party administrator reserve the right to request additional information if needed):

- Proof of payment from you to the provider of service (typically your credit card invoice);
- Itemized bill to include complete description of the services rendered;
- Itemized bill must be translated to English;
- Any costs associated with the reimbursement request must be converted to United States dollars; and

Any foreign purchases of dental care and services will be subject to Plan limitations such as:

- Benefits and coverage under the Plan
- Deductibles
- Coinsurance

- Frequency maximums
- Annual benefit maximums
- Medical necessity
- FDA approval
- Usual and Customary (U & C)

Once payment is made to you or to the out of country provider, PEBP and its vendors are released from any further liability for the out of country claim. PEBP has the exclusive authority to determine the eligibility of all dental services rendered by an out of country provider. PEBP may or may not authorize payment to you or to the out of country provider if all requirements of this provision are not satisfied.

Note: Please contact this Plan's third-party administrator before traveling or moving to another country to discuss any criteria that may apply to a dental service reimbursement request.

Deductibles

Each Plan Year, you must satisfy the Plan Year Deductible before the Plan will pay benefits for Basic or Major dental services. Eligible dental expenses for preventive services are not subject to the Plan Year Deductible or the annual maximum benefit. Benefits for some services are available four times each Plan Year, for example preventive cleanings and periodontal maintenance cleanings. Oral examinations and bitewing x-rays are available twice per Plan Year. If a person covered under this Plan changes status from an employee or retiree to a dependent, or from a dependent to an employee and the person is continuously covered under this Plan before, during and after the change in status, credit will be given for portions of the Deductible already met, and accumulation of benefit maximums will continue without interruption.

There are two types of Deductibles: Individual and Family. The Individual Deductible is the maximum amount one covered person must pay each Plan Year before plan benefits are available for Basic or Major dental services. The Plan's Individual Deductible is $100. The Family Deductible is the maximum amount a family of three or more is required to pay in a Plan year. The plan's family Deductible is $300. The Family Deductible is accumulative meaning that one member of the family cannot satisfy the entire Family Deductible. Both in- and out-of-network services are combined to meet your Plan Year Deductible.

Coinsurance

There is no Coinsurance amount for preventive services, unless services are rendered by a non-PPO dental provider. For Basic or Major dental services, once you have met your Plan Year Deductible, the Plan pays its percentage of the eligible Usual and Customary dental expenses, and you are responsible for paying the rest (the applicable percentage paid by the Plan is shown in the Schedule of Dental Benefits). The part you pay is called the Coinsurance. Note: Your out-of-pocket expenses will be less if you use the services of a dental care provider who is part of the Preferred Provider Organization (PPO), also called in-network.

Plan Year Maximum Dental Benefits

The Plan Year maximum dental benefits payable for any individual covered under this Plan is $1,500. The Plan Year maximum dental benefit is combined to include both in-network and out-of-network services. Under no circumstances will the combination of in-network and out-of-network benefit payments exceed the $1,500 Plan Year maximum benefit. This maximum does not include your Deductible or any amounts over Usual and Customary. Benefits paid for eligible preventive dental services do not apply to the annual maximum dental benefit.

Payment of Dental Benefits

When charges for dental services and supplies are incurred, services and supplies are considered to have been incurred on the date the services are performed or on the date the supplies are furnished. However, this rule does not apply to the following services because they must be performed over a period of time.

- Fixed partial dentures, bridgework, crowns, inlays and onlays: All services related to installation of fixed partial dentures, bridgework, crowns, inlays and onlays are considered to have been incurred on the date the tooth (or teeth) is (or are) prepared for the installation.
- Removable partial or complete dentures: All services related to the preparation of removable partial or complete dentures are considered to have been incurred on the date the impression for the dentures is taken.
- Root canal treatment (endodontics): All services related to root canal treatment are considered incurred on the date the tooth is opened for the treatment.

Extension of Dental Coverage

If dental coverage ends for any reason, the Plan will pay benefits for you or your covered dependents through the last day of the month in which the coverage ends. The Plan will also pay benefits for a limited time beyond that date for the following:

- A prosthesis (such as a full or partial denture), if the dentist took the impressions and prepared the abutment teeth while you or your dependents were covered and installs the device within 31 days after coverage ends.
- A crown, if the dentist prepared the crown while you or your dependent(s) were covered and installs it within 31 days after coverage ends.
- Root canal treatment, if the dentist opened the tooth while you or your dependent(s) were covered and completes the treatment within 31 days after coverage ends.

Dental Pretreatment Estimates

Whenever you expect that your dental expenses for a course of treatment will be more than $300, you are encouraged to obtain a pretreatment estimate from the third-party claims administrator. This procedure lets you know how much you will have to pay before you begin treatment.

To obtain a pretreatment estimate, you and your dentist should complete the regular dental claim form (available from and to be sent to the third-party claims administrator, whose name and address are listed on the *Participant Contact Guide* in this document), indicating the type of work

to be performed also referred to as a treatment plan, along with supporting x-rays and the estimated cost (valid for a 60-day period following the submission of the pretreatment estimate request). Once it is received, the third-party claims administrator will review the treatment plan and then send your dentist a statement within the next 60 days showing what the Plan may pay. Your dentist may call the third-party claims administrator for a prompt determination of the benefits payable for a dental procedure.

Prescription Drugs Needed for Dental Purposes

Necessary prescription drugs needed for a dental purpose, such as antibiotics or pain medications, should be obtained using the prescription drug benefit provided under your medical plan.

NOTE: Some medications for a dental purpose are not payable, such as fluoride or periodontal mouthwash. See the *Medical Exclusions* section under Drugs for more information.

Voluntary PPO Dental Plan Option for Medicare Retirees Enrolled through VIA Benefits

Medicare retirees enrolled in a medical plan through VIA Benefits (Medicare Exchange) and those retirees with Tricare for Life and Medicare Parts A and B who are eligible for a Medicare Exchange Health Reimbursement Arrangement (HRA) have the option to enroll in PEBP's PPO Dental Plan. Enrollment in PEBP's PPO Dental Plan requires automatic dental premium reimbursement from the retiree's Health Reimbursement Arrangement (HRA). The dental premium will only be reimbursed up to the amount in retiree's HRA. When the amount of the dental premium is more than the unused amount in the retiree's HRA, the amount of the premium will be carried forward in the retiree's HRA until the unused amount in the HRA is sufficient to reimburse for the dental premium.

Schedule of Dental Benefits

Schedule of Dental Benefits (All benefits are subject to the Deductible except where noted) See also the *Exclusions*, and *Key Terms and Definitions* sections of this document for important information)		
Benefit Description	**In-Network**	**Out-of-Network**
Preventive Services • Oral examination • Prophylaxis (routine cleaning of the teeth without the presence of periodontal disease) • Bitewing X-Rays • Topical application of sodium or stannous fluoride • Space maintainers • Application of sealants	No Deductible 100% of the discounted allowed fee schedule	No Deductible 80% of the in-network provider fee schedule for the Las Vegas service area For services outside of Nevada, the Plan will reimburse at the U&C rates

Explanations and Limitations

- Preventive services are not subject to the individual Plan Year maximum dental benefit.
- Oral examinations are limited to four times per Plan Year.
- Prophylaxis, scaling, cleaning, and polishing limited to four times per Plan Year. Even if your dentist recommends more than four routine prophylaxes, the Plan will only consider four for benefit purposes. You will be responsible for charges in excess of four cleanings in a single Plan Year.
- Bitewing x-rays limited to twice per Plan Year.
- Fluoride treatment for individuals age 18 years and under is payable twice per Plan Year.
- Application of sealants for children under age 18 years.
- Initial installation of a space maintainer (to replace a primary tooth until a permanent tooth comes in) is payable for individuals under age 16 years. Plan allows fixed, unilateral (band or stainless-steel crown type), fixed cast type (distal shoe), or removable bilateral type.
- Benefits for preventive dental services do not apply to the annual maximum dental benefit.
- Out-of-Network: The Plan pays 80% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the Plan will reimburse at the U&C rates.

Schedule of Dental Benefits

(All benefits are subject to the Deductible except where noted)
See also the *Exclusions*, and *Key Terms and Definitions* Sections of this document for important information)

Benefit Description	In-Network	Out-of-Network
Basic Services	After the Deductible is met, the Plan pays 80% of the discounted allowed fee schedule	After the Deductible is met, Plan pays 50% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the Plan will reimburse at the U&C rates

Explanations and Limitations

- Plan Year Deductible applies
- Dental visit during regular office hours for treatment and observation of injuries to teeth and supporting structures (other than for routine operative procedures)
- After hours for emergency dental care
- Consultation by a specialist for case presentation when a general dentist has performed diagnostic procedures
- Emergency treatment
- Film fees, including examination and diagnosis, except for injuries
- Dental CT scans are allowed at varying frequencies depending on the type of service.
- Periapical, entire dental film series (14 films), including bitewings as necessary every 36 months **or** panoramic survey covered once every 36 months
- Basic services are subject to the individual Plan Year maximum dental benefit.
- Full-mouth periodontal maintenance cleanings, payable four times per Plan Year. Even if your dentist recommends more than four periodontal maintenance cleanings, the Plan will only consider four for benefit purposes. You will be responsible for charges in excess of four cleanings in a single Plan Year
- Laboratory services, including cultures necessary for diagnosis and/or treatment of a specific dental condition
- For multiple restorations, one tooth surface will be considered a single restoration
- Out-of-Network: After deductible, the Plan pays 80% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the Plan will reimburse at the U&C rates.

Schedule of Dental Benefits

(All benefits are subject to the Deductible except where noted)
See also the *Exclusions*, and *Key Terms and Definitions* Sections of this document for important information)

Benefit Description	In-Network	Out-of-Network
Basic Services (continued)	After the Deductible is met, the Plan pays 80% of the discounted allowed fee schedule	After the Deductible is met, Plan pays 50% of the in-network provider fee schedule for the Las Vegas service area For services outside of Nevada, the Plan will reimburse at the U&C rates

Explanations and Limitations (continued)

- Biopsy, examination of oral tissue, study models, microscopic exam
- Oral surgery, limited to alveoplasty or alveolectomy, removal of cysts or tumors, torus, and impacted wisdom teeth, including local anesthesia and postoperative care
- Amalgam restorations for primary and permanent teeth, synthetic, silicate, plastic and composite fillings, retention pin when used as part of restoration other than a gold restoration
- Appliance for thumb sucking (individuals under 16 years of age) or night guard for bruxism (grinding teeth)
- Dental CT scans, depending on the type and necessity are allowed by the Plan. Contact the claims administrator for more information. You must have the CDT code of your requested procedure before calling
- Initial installation of a removable, fixed or cemented inhibiting appliance to correct thumb sucking is payable for individuals under age 16 years
- No coverage for root canal therapy when the pulp chamber was opened before coverage under this dental plan began
- Out-of-Network: After deductible, the Plan pays 80% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the Plan will reimburse at the U&C rates.

Schedule of Dental Benefits

(All benefits are subject to the Deductible except where noted)
See also the *Exclusions*, and *Key Terms and Definitions* Sections of this document for important information)

Benefit Description	In-Network	Out-of-Network
Major Services	After the Deductible is met, Plan pays 50% of the discounted allowed fee schedule.	After the Deductible is met, Plan pays 50% of the in-network provider fee schedule for the Las Vegas service area For services outside of Nevada, the Plan will reimburse at the U&C rates

Explanations and Limitations

- Plan Year Deductible applies to Major services
- Major services are subject to the individual Plan Year maximum dental benefit
- No coverage for a crown, bridge, or gold restoration when the tooth was prepared before coverage under the dental Plan began
- Facings on crowns or pontics posterior to the second bicuspid are considered cosmetic and not covered. Gold restorations (inlays and onlays) covered only when teeth cannot be restored with a filling material
- Repair or re-cementing of inlays, crowns, bridges, and dentures
- Initial installation of fixed or removable bridges, dentures and full or partial dentures (except for special characterization of dentures) including abutment crowns
- Bridgework, dentures, and replacement of bridgework and dentures which are 5 years old or more and cannot be repaired. Covered expenses for temporary and permanent services cannot exceed the usual and customary fees for permanent services
- Dental implants (endosseous, ridge extension, and ridge augmentation only)
- Post and core on non-vital teeth only
- Denture relining and/or adjustment more than six months after installation
- Prosthodontics (artificial appliance of the mouth). No coverage of fees to install or modify an appliance for which an Impression was made before coverage under this dental plan began
- Crown (acrylic, porcelain, or gold with gold or non-precious metal), including crown build up only when teeth cannot be restored with a filling material
- Teeth added to a partial denture to replace extracted natural teeth, including clasps if needed
- If payment is requested for temporary appliances, the cost of the temporary appliance will be deducted from the benefits payable for the permanent appliance, meaning the Plan will not pay for both a temporary and a permanent appliance
- Under no circumstances will the benefit paid for a temporary appliance and permanent appliance exceed the PPO allowed amount or usual and customary allowance

Dental Network

In-Network Services

In-network dental care providers have agreements with the Plan under which they provide dental care services and supplies for a favorable negotiated discount fee for Plan participants. When a Plan participant uses the services of an in-network dental care provider, except with respect to any applicable deductible, the Plan participant is responsible for paying only the applicable Coinsurance for any medically necessary services or supplies. The in-network dental care provider generally deals with the Plan directly for any additional amount due.

The Plan's Preferred Provider Organization (PPO) is contracted with PEBP to provide a network of dental care providers located within a service area (defined below) and who have agreed to provide dental care services and supplies for favorable negotiated discount fees applicable only to Plan participants. Because providers are added and dropped from the PPO network periodically throughout the year, it is the participant's responsibility to verify provider participation each time before seeking services by contacting the PPO network. The PPO dental network's telephone number and website are listed on the *Participant Contact Guide* in this document.

If you receive medically necessary dental services or supplies from a PPO dental care provider, you will pay less money out of your own pocket than if you received those same services or supplies from a dental provider who is not a PPO provider because these providers discount their fees. Using PPO dental care providers means that you can obtain more dental services before reaching your Plan Year dental benefit maximum. In addition to receiving discounted fees for dental services, the PPO provider has agreed to accept the Plan's allowed payment, plus any applicable Coinsurance that you are responsible for paying, as payment in full.

The directory of dental care providers is available at www.pebp.state.nv.us. To request a hard copy of the directory, please call the PPO Dental Network shown in the *Participant Contact Guide* in this document.

Out-of-Network Services

Out-of-network (non-network) dental care providers have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. For participants receiving services outside of Nevada, the Plan will reimburse the Plan participant for the usual and customary charge for any medically necessary services or supplies, subject to the Plan's Deductibles, Coinsurance, copayments, limitations, and exclusions.

If a participant travels to an area serviced by the Plan's PPO network, the participant should use an in-network provider to receive benefits at the in-network benefit level. If a participant uses an out-of-network provider within this service area, benefits will be considered as out-of-network. In-network provider contracted rates for the Diversified Dental Las Vegas service area will apply to all out-of-network dental claims in Nevada. The participant may be responsible for any amount billed by the out-of-network provider that exceeds the in-network provider contracted rate. The annual benefit maximum for the dental benefit is $1,500 for each covered individual and includes both in-network and out-of-network dental services. Plan participants may be required to submit proof of claim before any such reimbursement will be made. Non-network dental care providers

may bill the Plan participant for any balance that may be due in addition to the amount payable by the Plan, also called balance billing. You can avoid balance billing by using in-network providers.

When Out-of-Network Providers May be Paid as In-Network Providers?

If a participant lives more than 50 miles from an in-network PPO provider, resides, or travels outside of Nevada, benefits for an out-of-network provider will be considered at the in-network benefit level. Usual and customary allowance will apply. The participant may be responsible for any amount billed by the provider that exceeds the usual and customary allowance.

A "service area" is a geographic area serviced by the in-network dental care providers who have agreements with the Plan's PPO dental network. If you and/or your covered dependent(s) live more than 50 miles from the nearest in-network dental care provider, the Plan will consider that you live outside the service area. In that case, your claim for services by an out-of-network dental care provider will be treated as if the services were provided in-network.

Exclusions: PPO Dental Plan

The following is a list of dental services and supplies or expenses not covered by the PPO Dental Plan. The Plan Administrator and its designees will have discretionary authority to determine the applicability of these exclusions and the other terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan.

Analgesia, Sedation, Hypnosis, etc.: Expenses for analgesia, sedation, hypnosis, and/or related services provided for apprehension or anxiety.

Any treatment or service for which you have no financial liability or that would be provided at no cost in the absence of dental coverage.

Concierge membership fees: Expenses for fees described or defined as membership, retainer or premiums that are paid to a concierge dental practice to have access to the dental services provided by the concierge dental practice.

Cosmetic Services: Expenses for dental surgery or dental treatment for cosmetic purposes, as determined by the Plan Administrator or its designee, including but not limited to all veneers regardless of medical necessity, and facings. However, the following will be covered if they otherwise qualify as covered dental expenses and are not covered under your medical expense coverage:

- Reconstructive dental surgery when that service is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part;
- Surgery or treatment to correct deformities caused by sickness;
- Surgery or treatment to correct birth defects outside the normal range of human variation;
- Reconstructive dental surgery because of congenital disease or anomaly of a covered dependent child resulting in a functional disorder.

Costs of Reports, Bills, etc.: Expenses for preparing dental reports, bills or claim forms; mailing, shipping, or handling expenses; and charges for broken appointments, telephone calls and/or photocopying fees.

Expenses Exceeding Maximum Plan Benefits: Expenses that exceed any Plan benefit limitation or Plan Year maximum benefits (as described in the *Dental Expense Coverage* section).

Drugs and Medicines: Expenses for prescription drugs and medications that are covered under your medical expense coverage, and for any other dental services or supplies if benefits as otherwise provided under the Plan's medical expense coverage; or under any other plan or program that the PEBP contributes to or otherwise sponsors (such as HMOs); or through a medical or dental department, clinic or similar facility provided or maintained by the PEBP.

Duplication of Dental Services: If a person covered by this Plan transfers from the care of one dentist to the care of another dentist during the course of any treatment, or if more than one dentist renders services for the same dental procedure, the Plan will not be liable for more than the amount that it would have been liable had but one dentist rendered all the services during each course of treatment, nor will the Plan be liable for duplication of services.

Duplicate or Replacement Bridges, Dentures or Appliances: Expenses for any duplicate or replacement of any lost, missing, or stolen bridge, denture, or orthodontic appliance, other than replacements described in the *Major Services* section of the *Schedule of Dental Benefits*.

Education Services and Home Use: Supplies and/or expenses for dental education such as for plaque control, oral hygiene or diet or home use supplies, including, but not limited to, toothpaste, toothbrush, water-pick type device, fluoride, mouthwash, dental floss, etc.

Expenses Exceeding Usual and Customary or the PPO Allowable Fee Schedule: Any portion of the expenses for covered dental services or supplies that are determined by the Plan Administrator or its designee to exceed the usual and customary charge or PPO fee schedule (as defined in the Definitions section of this document).

Expenses for Which a Third Party Is Responsible: Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortuous or wrongful act of that third party (see the provisions relating to Third Party Liability in the section on *Coordination of Benefits*).

Expenses Incurred Before or After Coverage: Expenses for services rendered or supplies provided before the patient became covered under the dental program, or after the date the patient's coverage ends (except under those conditions described in the Extension of Dental Benefits in the *Dental Expense Coverage* section or under the COBRA provisions of the Plan).

Experimental and/or Investigational Services: Expenses for any dental services, supplies, drugs or medicines that are determined by the claims administrator or its designee to be experimental and/or investigational (as defined in the *Definitions* section of this document).

Frequent Intervals Services: Services provided at more frequent intervals than covered by the PPO Dental Plan as described in the *Schedule of Dental Benefits*.

Gnathologic Recordings for Jaw Movement and Position: Expenses for gnathologic recordings (measurement of force exerted in the closing of the jaws) as performed for jaw movement and position.

Government-Provided Services (Tricare/CHAMPUS, VA, etc.): Expenses for services when benefits are provided to the covered individual under any plan or program in which any government participates (other than as an employer), unless the governmental program provides otherwise.

Hospital Expenses Related to Dental Care Expenses: Expenses for hospitalization related to dental surgery or care, except as otherwise explained in this document. Contact the claims administrator for more information if you require this service.

Illegal Act: Expenses incurred by any covered individual for injuries resulting from commission, or attempted commission by the covered individual, of an illegal act that PEBP determines involves violence or the threat of violence to another person or in which a firearm is used by the covered individual. PEBP's discretionary determination that this exclusion applies shall not be affected by any subsequent official action or determination with respect to prosecution of the covered individual (including, without limitation, acquittal, or failure to prosecute) in connection with the acts involved.

Installation or Replacement of Appliances: Restorations or procedures for altering vertical dimension.

Medically Unnecessary Services or Supplies: As determined by PEBP or its designee not to be medically necessary (as defined in the *Definitions* section of this document.)

Mouth Guards: Expenses for athletic mouth guards and associated devices.

Myofunctional*:* Therapy expenses for myofunctional therapy.

Non-Dental Expenses: Services rendered or supplies provided that are not recommended or prescribed by a dentist.

Occupational Illness, Injury or Conditions Subject to Workers' Compensation: All expenses incurred by you or any of your covered dependents arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law.

This applies even if you or your covered dependent were not covered by workers' compensation insurance, or if the covered individual's rights under workers' compensation or occupational disease or similar law have been waived or qualified.

Orthodontia: Expenses for any dental services relating to orthodontia evaluation and treatment.

Periodontal Splinting: Expenses for periodontal splinting (tying two or more teeth together when there is bone loss to gain additional stability).

Personalized Bridges, Dentures, Retainers or Appliances: Expenses for personalization or characterization of any dental prosthesis, including but not limited to any bridge, denture, retainer, or appliance.

Reconstructive Dental Surgery: When that service is:

- Incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part;
- Surgery or treatment to correct deformities caused by sickness;
- Surgery or treatment to correct birth defects outside the normal range of human variation;
- Reconstructive dental surgery because of congenital disease or anomaly of a covered dependent child resulting in a functional disorder.

Services Not Performed by a Dentist or Dental Hygienist: Expenses for dental services not performed by a dentist (except for services of a dental hygienist that are supervised and billed by a dentist and are for cleaning or scaling of teeth or for fluoride treatments).

Treatment of Jaw or Temporomandibular Joints (TMJ): Expenses for treatment, by any means, of jaw joint problems including temporomandibular joint (TMJ) dysfunction disorder and appliances.

War or Similar Event: Expenses incurred as a result of an injury or illness due to you or your covered dependents participation in any act of war, either declared or undeclared, war-like act, riot, insurrection, rebellion, or invasion, except as required by law.

Self-Funded PPO Dental Claims Administration

How Dental Benefits are Paid

Plan benefits are considered for payment on the receipt of written proof of claim, commonly called a bill. Generally, health care providers send their bill to PEBP's third-party administrator directly. Plan benefits for eligible services performed by health care providers will then be paid directly to the provider delivering the services. When Deductibles, Coinsurance or copayments apply, you are responsible for paying your share of these charges.

If services are provided through the PPO dental network, the PPO dental provider may submit the proof of claim directly to PEBP's third-party administrator; however, you will be responsible for the payment to the PPO dental care provider for any applicable Deductible, Coinsurance, or copayments.

If a dental care provider does not submit a claim directly to PEBP's third-party administrator and instead sends the bill to you, you should follow the steps outlined in this section regarding *How to File a Claim*. If, at the time you submit your claim, you furnish evidence acceptable to the Plan Administrator or its designee (PEBP's third-party administrator) that you or your covered dependent paid some or all of those charges, Plan benefits may be paid to you, but only up to the amount allowed by the Plan for those services after Plan Year Deductible, Coinsurance and copayment amounts are met.

How to File a Dental Claim

All claims must be submitted to the Plan within 12 months from the date of service. No Plan benefits will be paid for any claim submitted after this period. Benefits are based on the Plan's provisions in place on the date of service.

Most providers send their bills directly to the PEBP's third-party administrator; however, for providers who do not bill the Plan directly, you may be sent a bill. In that case, follow these steps:

- Obtain a claim form from PEBP's third-party administrator or in your E-PEBP portal member account (see the *Participant Contact Guide* in this document for details on address, phone and website).
- Complete the participant part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
- The instructions on the claim form will tell you what documents or medical information is necessary to support the claim. your physician, health care practitioner or dentist can complete the health care provider part of the claim form, or you can attach the itemized bill for professional services if it contains all the following information:
- A description of the services or supplies provided including appropriate procedure codes;
- Details of the charges for those services or supplies;
- Appropriate diagnosis code;
- Date(s) the services or supplies were provided;
- Patient's name;
- Provider's name, address, phone number, and professional degree or license;
- Provider's federal tax identification number (TIN);
- Provider's signature.

Please review your bills to be sure they are appropriate and correct. Report any discrepancies in billing to the third-party administrator. This can reduce costs to you and the Plan. Complete a separate claim form for each person for whom Plan benefits are being requested. If another plan is the primary payer, send a copy of the other plan's explanation of benefits (EOB) along with the claim you submit to this Plan.

To assure that medical, pharmacy or dental expenses you incur are eligible under this Plan, the Plan has the right to request additional information from any hospital, facility, physician, laboratory, radiologist, dentist, pharmacy or any other eligible medical or dental provider. For example, the Plan has the right to deny deductible credit or payment to a provider if the provider's

bill does not include or is missing one or more of the following components. This is not an all-inclusive list.

- Itemized bill to include but not be limited to: Proper billing codes such as CPT, HCPCS, Revenue Codes, CDT, ICD 9, and ICD 10.
- Date(s) of service.
- Place of service.
- Provider's Tax Identification Number.
- Provider's signature.
- Operative report.
- Patient ledger.
- Emergency room notes.
- For providers such as hospitals and facilities that bill for items such as orthopedic devices/implants or other types of biomaterial, the Plan has the right to request a copy of the invoice from the organization that supplied the device/implant/biomaterial to the hospital or facility. The Plan has the right to deny payment for such medical devices until a copy of the invoice is provided to the Plan's claims administrator.

NOTE: Claims are processed by PEBP's third-party administrator in the order they are received. If a claim is held or "soft denied" that means that PEBP's third-party administrator is holding the claim to receive additional information, either from the participant, the provider or to get clarification on benefits to be paid. A claim that is held or soft denied will be paid or processed when the requested additional information is received. Claims filed while another is held or soft denied may be paid or processed even though they were received at a later date.

NOTE: It is your responsibility to maintain copies of the explanation of benefits provided to you by PEBP's third party administrator or prescription drug administrator. Explanation of benefits documents are available on the third-party administrator's website application but cannot be reproduced.

Where to Send the Claim Form

Send the completed claim form, the bill you received (you keep a copy, too) and any other required information to the third-party administrator at the address listed in the *Participant Contact Guide* in this document.

Dental Appeal Process

Written Notice of Denial of Claim

The Plan's third-party administrator will notify you in writing on an Explanation of Benefits (EOB) of an Adverse Claim Determination (see *Adverse Determination* in the *Key Terms and Definitions* section) resulting in a denial, reduction, termination, or failure to provide or make payments (in whole or in part) of a benefit. The notice will explain the reasons why, with reference to the Plan provisions as to the basis for the adverse determination and it will explain what steps to take to submit a Level 1 Claim Appeal. When applicable, the notice will explain what additional information is required from you and why it is needed. A participant or their designee cannot

circumvent the claims and appeals procedures by initiating a cause of action against the PEBP (or the State of Nevada) in a court proceeding.

The appeal process works as follows:

Level 1 Appeal NAC 287.670

If your claim is denied, or if you disagree with the amount paid on a claim, you may request a Level 1 Claim Appeal from the third-party administrator within 180 days of the date you received the Explanation of Benefits (EOB) which provides the claim determination. Failure to request a Level 1 Claim Appeal in a timely manner will be deemed to be a waiver of any further right of review of appeal under the Plan, unless good cause can be demonstrated. The written request for appeal must include:

- The name and Social Security Number, or identification number of the participant;
- A copy of the EOB related to the claim being appealed; 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 third-party administrator will review your claim (by a person at a higher level of management than the one who originally denied the claim). If any additional information is needed to process your request for appeal, it will be requested promptly.

The third-party administrator will issue a decision of your Level 1 Claim Appeal in writing within 20 days after receipt of your request for appeal. If the decision upholds the denial of benefits in whole or in part, the notification to you will explain the reasons for the decision, with reference to the applicable provisions of the Plan upon which the denial is based. The notification will 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 NAC 287.680

If you are unsatisfied with the Level 1 Claim Appeal decision made by the third-party administrator, you may file a Level 2 Claim Appeal to the PEBP Executive Officer or designee by completing a Claim Appeal Request form. *Claim Appeal Request form*s are available at www.pebp.state.nv.us or by request by contacting PEBP Customer Service at 775-684-7000 or 800-326-5496. A Level 2 Appeal must be submitted to PEBP within 35 days after you receive the Level 1 Appeal determination. Your Level 2 Appeal must include a copy of:

- Any document submitted with your Level 1 Appeal request;
- A copy of the Level 1 Appeal decision; and
- Any documentation to support your request.

The Executive Officer or designee will use all resources available to assure a thorough review is completed in accordance with provisions of the Plan.

A Level 2 Appeal decision will be given to you in writing by certified mail within 30 days after the Level 2 Appeal request is received by the Executive Officer or designee. A Level 2 Appeal determination will explain and reference the reasons for the decision, including the applicable provisions of the Plan upon which the determination is based.

Standard Request for External Claim Review NAC 287.690
An External Claim Review may be requested by a participant and/or the participant's treating physician after exhausting the Level 1 and Level 2 Claim Appeals process. This means that you may have a right to have the Plan's or its designee's decision reviewed by independent health care professionals if the adverse benefit determination involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.

An External Claim Review request must be submitted in writing to the Office for Consumer Health Assistance (OCHA) within four (4) months after the date of receipt of a notice of the Level 2 Claim Appeal decision. An *External Review Request Form* is available on the PEBP website at www.pebp.state.nv.us. The OCHA will assign an independent external review organization within five (5) days after receiving the request. The external review organization will issue a determination within 15 days after it receives the complete information. For standard Request for External Claim Review, a decision will be made within 45 days of receiving the request.

A Request for External Claim Review must include:

- completed and signed External Review Request Form;
- a copy of the EOB(s) related to the claim(s) being reviewed;
- a detailed written explanation why the external review is being requested; and
- any additional supporting documentation.

The Request for External Claim Review must be submitted to:

Office for Consumer Health Assistance
555 East Washington #4800
Las Vegas, NV 89101
Phone: (702) 486-3587,
(888) 333-1597
Fax 702-486-3586
Web: www.govcha.nv.gov

Coordination of Benefits (COB)

When you or your covered dependents also have medical, dental or vision coverage from some other source it is called Coordination of Benefits (COB). In many of those cases, one plan serves as the primary plan or program and pays benefits or provides services first. In these cases, the other plan serves as the secondary plan or program and pays some or all the difference between the total cost of those services and payment by the primary plan or program. Benefits paid from two

different plans can occur if you or a covered dependent is covered by PEBP and is also covered by:

- Another group health care plan;
- Medicare;
- Other government program, such as Medicaid, Tricare/CHAMPUS, or a program of the U.S. Department of Veterans Affairs, motor vehicle including (but not limited to) no-fault, uninsured motorist or underinsured motorist coverage for medical expenses or loss of earnings that is required by law, or any coverage provided by a federal, State or local government or agency; or
- Workers' Compensation.

NOTE: This Plan's Prescription Drug Benefit does not coordinate benefits for prescription medications, or any covered Over the Counter (OTC) medications, obtained through retail or mail order pharmacy programs. Meaning, there will be no coverage for prescription drugs if you have additional prescription drug coverage that is primary.

This Plan operates under rules that prevent it from paying benefits which, together with the benefits from another source (as described above), would allow you to recover more than 100% of allowable expenses you incur. In some instances, you may recover less than 100% of those allowable expenses from the duplicate sources of coverage. It is possible that you will incur Out-of-Pocket expenses, even with two payment sources.

When and How Coordination of Benefits (COB) Applies

Many families that have more than one family member working outside the home are covered by more than one medical or dental plan. If this is the case with your family, you must let the Plan Administrator, or its designee, know about all your coverages when you submit a claim.

COB operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan, (called the secondary plan) may then pay additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental allowable expenses incurred. Sometimes the combined benefits that are paid will be less than the total expenses.

If the PEBP Plan is secondary coverage, the participant will be required to meet their PEBP Plan Year medical and dental Deductibles.

For the purposes of this *Coordination of Benefits* section, the word "plan" refers to any group medical or dental policy, contract or plan, whether insured or self-insured, that provides benefits payable for medical or dental services incurred by the covered individual, or that provides medical or dental services to the covered individual. A "group plan" provides its benefits or services to employees, retirees or members of a group who are eligible for and have elected coverage.

"Allowable expense" means a health care service or expense, including Deductibles, Coinsurance, or copayments, that is covered in full or in part by any of the plans covering the person, except as described below, or where a statute requires a different definition. This means that an expense or

service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense. Examples of what is not an allowable expense:

- the difference between the cost of a semi-private room in the hospital and a private room;
- when both plans use usual and customary (U&C) fees, any amount in excess of the highest of the U&C fee for a specific benefit;
- when both plans use negotiated fees, any amount in excess of the highest negotiated fee is not an allowable expense (except for Medicare negotiated fees, which will always take precedence); and
- when one plan uses U&C fees and another plan uses negotiated fees, the secondary plan's payment arrangement is not the allowable expense.

NOTE: If the spouse or domestic partner of a primary PEBP participant is eligible for health insurance coverage from their employer, that spouse or domestic partner is not eligible for PEBP coverage whether they have enrolled in their employer sponsored health insurance or not. This includes spouses or domestic partners who are eligible for PEBP coverage.

Which plan Pays First: Order of Benefit Determination Rules

The Overriding Rules

Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform order of benefit determination rules in a specific sequence. PEBP uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC), and which are commonly used by insured and self-insured plans. Any group plan that does not use these same rules always pays its benefits first.

When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan (pays first) and which is the secondary plan (pays second). If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

Rule 1: Non-Dependent/Dependent

The plan that covers a person other than as a dependent, for example as an employee, retiree, member, or subscriber, is primary and the plan that covers the person as a dependent is secondary. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:

- secondary to the plan covering the person as a dependent;
- primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee);
- then the order of benefits is reversed, so that the plan covering the person as a dependent will pay first; and the plan covering the person other than as a dependent (that is, as a retired employee) pays second.

This rule applies when both spouses are employed and cover each other as dependents under their respective plans. The plan covering the person as an employee pays first, and the plan covering the same person as a dependent, pays benefits second.

Rule 2: Dependent Child Covered under More Than One plan

The plan that covers the parent whose birthday falls earlier in the calendar year pays first; the plan that covers the parent whose birthday falls later in the calendar year pays second, if:

- the parents are married;
- the parents are not separated (whether or not they ever have been married); or
- a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.
- if both parents have the same birthday, the plan that has covered one of the parents for a longer period pays first, and the plan that has covered the other parent for the shorter period pays second.
- the word "birthday" refers only to the month and day in a calendar year; not the year in which the person was born.

If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.
If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

- The plan of the custodial parent pays first; and
- The plan of the spouse of the custodial parent pays second; and
- The plan of the non-custodial parent pays third; and
- The plan of the spouse of the non-custodial parent pays last.

Rule 3: Active/Laid-Off or Retired Employee

The plan that covers a person, as an active employee (that is, an employee who is neither laid-off nor retired) or as an active employee's dependent pays first; the plan that covers the same person as a laid-off/retired employee or as a laid-off/retired employee's dependent pays second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period-of-time pays first; and the plan that covered the person for the shorter period-of-time pays second. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

Administration of COB

To administer COB, the Plan reserves the right to:

- exchange information with other plans involved in paying claims;
- require that you or your health care provider furnish any necessary information;
- reimburse any plan that made payments this plan should have made; or
- recover any overpayment from your hospital, physician, dentist, other health care provider, other insurance company, you or your dependent.

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount the Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.

This Plan follows the customary Coordination of Benefits rule that the medical program coordinates with only other medical plans or programs (and not with any dental plan or program), and the dental program coordinates only with other dental plans or programs (and not with any other medical plan or program). Therefore, when this Plan is secondary, it will pay secondary medical benefits only when the coordinating primary plan provides medical benefits, and it will pay secondary dental benefits only when the primary plan provides dental benefits.

If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO or other plan that provides benefits in the form of services, this plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary Plan. The reasonable cash value of such a service may be determined based on the prevailing rates for such services in the community in which the services were provided.

If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained out-of-network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary plan.

If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the plan participant may have against the other plan, and the plan participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

This Plan does not coordinate pharmacy benefits when PEBP is the secondary or tertiary payor.

Coordination with Medicare

Coordination with Medicare is not applicable for participants and their dependents who are eligible for Medicare Parts A and B; and who are required to transition to the Medicare Exchange. Refer to the Enrollment and Eligibility Master Plan Document available at www.pebp.state.nv.us for more information regarding enrollment in the Medicare Exchange.

Coverage under Medicare and This Plan When you have End-Stage Renal Disease

If, while you are actively employed, you or any of your covered dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pay will be the primary payer (will pay first) and Medicare will be the secondary payer (pays second) for 30 months starting the earlier of the month in which Medicare ESRD coverage begins, or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage or the first month after the individual receives a kidney transplant, Medicare will be the primary payer (pays first) and this Plan will be the secondary payer (pays second). If you are under age 65 years and are receiving Medicare ESRD benefits you will not be required to transition to PEBP's Medicare Exchange program. When you reach age 65 years you will be transitioned to the Medicare Exchange in accordance with PEBP's eligibility requirements as stated in the Enrollment and Eligibility Master Plan Document.

How Much This Plan Pays When It Is Secondary to Medicare

When the plan participant is covered by Medicare Parts A and B and this Plan is secondary to Medicare, this Plan pays as secondary to Medicare, with the Medicare negotiated allowable fee taking precedence. If a service is not covered under Medicare but is covered under this Plan, this Plan will pay as primary with the Plan's allowable fee for the service taking precedence.

When the retiree or their retired spouse is eligible for Medicare Part B: This Plan will always be secondary to Medicare Part B, whether or not you have enrolled. This Plan will estimate Medicare's benefit. This Plan will always be secondary to Medicare Part B, whether or not you have enrolled. This Plan will assume that Medicare has paid 80% of Medicare Part B eligible expenses. This Plan will only consider the remaining 20% of Medicare Part B expenses.

When the plan participant enters into a Medicare private contract: a Medicare participant is entitled to enter into a Medicare private contract with certain health care practitioners under which he or she agrees that NO claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that health care practitioner. If a Medicare participant enters into such a contract this Plan will NOT pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to it.

Coordination with Other Government Programs

Medicaid

If a covered individual is covered by both this Plan and Medicaid, this Plan pays first, and Medicaid pays second.

Tricare

If a participant or their covered dependent is covered by both this Plan and Tricare (the program that provides health care services to active or retired armed services personnel and their eligible dependents), this Plan pays first, and Tricare pays second. For an employee called to active duty for more than 30 days, Tricare is primary, and this Plan is secondary.

Veterans Affairs facility Services

If a participant receives services in a U.S. Department of Veterans Affairs hospital or facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If a covered individual receives services in a U.S. Department of Veterans Affairs hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan at the in-network benefit level at the usual and customary charge, only to the extent those services are medically necessary and are not excluded by the Plan.

Worker's Compensation

This Plan does not provide benefits if the expenses are covered by workers' compensation or occupational disease law. If a participant contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. However, before such payment will be made, you and/or your covered dependent must execute a subrogation and reimbursement agreement (described in the separate Health and Welfare Benefits Wrap Plan) that is acceptable to the Plan Administrator or its designee.

Third Party Liability

Subrogation and Rights of Recovery

Subrogation applies to situations where the Participant is injured, and another person or entity is or may be responsible, liable, or contractually obligated, for whatever reason, for the payment of certain damages or claims arising from or related in any way to the Participant's injury (the "Injury"). These damages or claims arising from the Injury, irrespective of the way they are categorized, may include, without limitation, medical expenses, pain and suffering, loss of consortium, and/or wrongful death. The Plan has a right of subrogation irrespective of whether the damages or claims are paid or payable to the Participant, the Participant's estate, the Participant's survivors, or the Participant's attorney(s). Any and all payments made by the Plan for which it claims a right of subrogation are referred to as Subrogated Payments.

The subrogation provision provides the Plan with a right of recovery for certain payments made by the Plan, irrespective of fault, or, negligence wrongdoing. Any and all payments made by the Plan relating in any way to the injury may be recovered directly from the other person or from any judgment, verdict or settlement obtained by the participant in relation to the injury.

The Participant must cooperate fully, at all times, and provide all information needed or requested by the Plan to recover payments, execute any papers necessary for such recovery, and do whatever is necessary or requested in order to secure and protect the Subrogation rights of the Plan. The Participant's required cooperation includes, but is not limited to, the following actions, which must be performed immediately, upon request by the Plan:

(1) Executing an acknowledgment form or other document acknowledging and agreeing to protect the Plan's right of Subrogation;
(2) Cooperating and participating in the Plan's recovery efforts, including but not limited to participating in litigation commenced or pursued by the Plan or its Board; and
(3) Filing a claim or demand with another insurance company, including but not limited to the Participant's own first party insurance policy or another person's or entity's insurance policy.

Refer to the separate Health and Welfare Benefits Wrap Plan document available at www.pebp.state.nv.us for more information regarding third party liability and subrogation.

The Participant must cooperate fully, at all times, and provide all information needed or requested by the Plan to recover payments, execute any papers necessary for such recovery, and do whatever is necessary or requested in order to secure and protect the Subrogation rights of the Plan. The Participant's required cooperation includes, but is not limited to, the following actions, which must be performed immediately, upon request by the Plan:

(1) Executing an acknowledgment form or other document acknowledging and agreeing to protect the Plan's right of Subrogation;
(2) Cooperating and participating in the Plan's recovery efforts, including but not limited to participating in litigation commenced or pursued by the Plan or its Board; and

(3) Filing a claim or demand with another insurance company, including but not limited to the Participant's own first party insurance policy or another person's or entity's insurance policy.

Refer to the separate Health and Welfare Benefits Wrap Plan document available at www.pebp.state.nv.us for more information regarding third party liability and subrogation.

Basic Life Insurance

This section provides a summary of the fully insured group basic life insurance available from PEBP. Since this is only a summary, for complete information you must refer to the Certificate of Coverage Booklet available from the insurance company who insures this benefit. Their name and contact information are listed in the *Participant Contact Guide* section of this document.

Eligibility for Life Insurance

To be eligible for the basic life insurance, you must be covered under the PEBP sponsored medical Plan, and be in one of the following classes:

- Class 1: Full-time employees of the State of Nevada (or any non-State agency approved by the PEBP board), professional full-time employees of the Nevada System of Higher Education (under annual contract), and members of the Nevada Senate or Assembly are all eligible for this benefit. A full-time employee is one who works at least 80 hours per month. Your employer pays the full cost of Basic Life Insurance.
- Class 2: retirees of the State of Nevada receiving PERS, or judge retirement benefits and legislators qualifying under Chapter 242 of the Sessions Law of the sixty-third Session of the Nevada State Legislature (or NRS 287.045), professional employees qualifying per NAC 287.135, and retirees eligible to join PEBP upon retirement pursuant to NRS 287.023 are eligible for this benefit. Reinstated retirees are not eligible for basic life insurance benefits or voluntary life Insurance coverage. Certain retirees pay a contribution toward the cost of basic life insurance.

Coverage

Basic Life Insurance Benefits are as follows:

Basic Life Insurance	Class 1 (employee) Benefit Amount	Class 2 (retiree) Benefit Amount
Life insurance amount	$25,000	$12,500

Long-Term Disability (LTD) Insurance

Long-Term Disability (LTD) Insurance is provided to active employees who are enrolled in a PEBP-sponsored medical Plan, a professional full-time employee of the Nevada System of Higher Education (under annual contract), and members of the Nevada Senate or Assembly are eligible for this benefit. A full-time employee is one who works at least 80 hours per month. If you are a person with a disability for an extended period due to an illness or injury and are under the regular care of a physician, long-term disability (LTD) benefits help you financially while your ability to work is limited. The LTD benefits are insured through an insurance company whose name and address are listed on the Participant Contact Guide. Questions about your LTD benefits should be directed to the insurance company whose name and contact information is located in the *Participant Contact Guide* section of this document.

Premium Payment

Your employer pays the full cost of your LTD insurance.

How the LTD Benefit Works

LTD benefits are designed to be a source of income if your ability to work is limited due to a disability. You should notify the LTD insurance company as soon as possible so that a claim decision can be made in a timely manner. You must send the LTD insurance company proof of your claim no later than 90 days after the benefit waiting period ends. If it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is required.

Since the information provided in this document is only a summary of benefits, for complete information you must refer to the Certificate of Coverage Booklet available from the insurance company who insures this benefit. Their name and contact information are listed in the *Participant Contact Guide* section of this document.

NOTE: This insurance does not replace or affect the requirements for coverage by any workers' compensation insurance.

Participant Contact Guide

Participant Contact Guide	
Public Employees' Benefits Program (PEBP) 901 S. Stewart Street, Suite 1001 Carson City, NV 89701 Customer Service: (775) 684-7000 or (800) 326-5496 Fax: (775) 684-7028 www.pebp.state.nv.us	**Plan Administrator** • Enrollment and eligibility • COBRA information and premium payments • Level 2 claim appeals • External review coordination
HealthSCOPE Benefits Claims Submission P O Box 91603 Lubbock, TX 79490-1603 Appeal of Claims P O Box 2860 Little Rock, AR 72203 Group Number: NVPEB Customer Service: (888) 763-8232 www.healthscopebenefits.com Diabetes Care Management form submission HealthSCOPE Benefits 27 Corporate Hill Drive Little Rock, AR 77205 Fax: 800-458-0701 Email: diabetes@healthscopebenefits.com FSA Claims Submission P.O. Box 3627 Little Rock, AR 72203 Fax: (877) 240-0135 pebphsahra@healthscopebenefits.com	**PPO Dental Plan Claims Administrator/Third Party Administrator** • Claim submission • Claim status inquiries • Level 1 claim appeals • Verification of eligibility • Plan Benefit Information • CDHP & Dental only ID Cards • HSA and HRA Claims Administrator • Healthcare Bluebook • Obesity Care Management Program • Disease Care Management Program • Flexible Spending Account (FSA) Administrator

Participant Contact Guide

American Health Holdings, Inc. **Utilization Management Company - CDHP and Premier Plan** 7400 West Campus Road, F-510 New Albany, OH 43054 Customer Service: (888) 323-1461 Fax: (833)336-3986	• Precertification/Prior authorization • Utilization management Case management
CDHP Statewide PPO Network Customer Service: (800) 336-0123 Contact HealthSCOPE Benefits: (888) 763-8232 www.pebp.state.nv.us	**Statewide (Nevada) PPO Medical Network** • Network Providers • Provider directory • Additions/deletions of Providers
Premier Plan Northern Customer Service: (800) 336-0123 Contact HealthSCOPE Benefits: (888) 763-8232 www.pebp.state.nv.us	**Northern Nevada Medical Network** • Network Providers • Provider directory • Additions/deletions of Providers
CDHP and Premier Plan National PPO Network (Outside Nevada) **Aetna Signature Network** Contact HealthSCOPE Benefits: (888) 763-8232	**National PPO Network (outside of Nevada)** • Network Providers • Provider directory • Additions/deletions of Providers
CDHP and Premier **Express Scripts Pharmacy Benefit Administrator for the CDHP** Customer Service and Prior Authorization (855) 889-7708 Formulary, forms, online ordering: www.Express-Scripts.com **Express Scripts Home Delivery** PO Box 66566 St. Louis, MO 63166-6566 Customer Service: (855) 889-7708	Pharmacy Benefit Manager for the CDHP and Premier Plan Prescription drug information • Retail network pharmacies • Prior authorization • Price a Medication tool • Home Delivery service and Mail Order forms • Preferred Mail Order for diabetic supplies

Participant Contact Guide

Accredo Specialty Pharmacy Customer Service: (855) 889-7708	Accredo Specialty Drug Services Provider Refills and order status
Express Scripts Benefit Coverage Review Department PO Box 66587, St. Louis, MO 63166-6587 Phone: 800-946-3979	Administrative Coverage Review and Administrative Reviews and Appeals
Express Scripts Clinical Appeals Department PO Box 66588 St. Louis, MO 63166-6588 Phone: 800-753-2851 Fax: 877-852-4070	Clinical Reviews
MCMC LLC **Attn: Express Scripts Appeal Program** 300 Crown Colony Dr. Suite 203 Quincy, MA 02169-0929 Phone: 617-375-7700 ext. 28253 Fax: 617-375-7683	External Review Requests for Adverse Benefit Determinations
Diversified Dental Services PO Box 36100 Las Vegas, NV 89133-6100 Customer Service: Northern Nevada: (866) 270-8326 Southern Nevada: (800) 249-3538 www.ddsppo.com	PPO Dental Network • Statewide PPO Dental Providers • National PPO Dental Providers Dental Provider directory
Health Plan of Nevada (702) 242-7300 or (877) 545-7378 www.stateofnv.healthplanofnevada.com	Southern Nevada Health Maintenance Organization (HMO) • Medical claims • Pre-authorizations • Provider Network
VIA Benefits 10975 Sterling View Drive, Suite A1 South Jordan, UT 84095 (888)598-7545 https://my.viabenefits.com/pebp Customer Service: (888) 598-7545 Claims Fax: (402) 231-4310	Medicare Exchange offering Medicare Supplemental or replacement medical coverage for Medicare retirees HRA claims administrator

Participant Contact Guide	
The Standard Insurance Company 900 SW Fifth Avenue Portland, OR 97204 (888) 288-1270 www.standard.com/mybenefits	• Basic Life Insurance • Voluntary (Supplemental) Life Insurance • Long-Term Disability • Voluntary Short-Term Disability • Generali Travel Assistance • Beneficiary designations
Core Stream - Voluntary Products/Services Customer Care Center: (855) 901-1100	Various Voluntary Products and Services
Office for Consumer Health Assistance 555 E. Washington Avenue, Suite 4800 Las Vegas, NV 89101 Customer Service: (702) 486-3587 or (888) 333-1597 http://dhhs.nv.gov	**Consumer Health Assistance** • Concerns and problems related to coverage • Provider billing issues External review information
Nevada Secretary of State Office The Living Will Lockbox c/o Nevada Secretary of State 101 North Carson St., Ste. 3 Carson City, NV 89701 Phone: (775) 684-5708 Fax: (775) 684-7177 www.livingwilllockbox.com	**Living Will Information** • Declaration governing the withholding or withdrawal of life-sustaining treatment • Durable power of attorney for health care decisions • Do not resuscitate order

Key Terms and Definitions

The following terms or phrases are used throughout the MPD. These terms or phrases have the following meanings. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Accident: A sudden and unforeseen event that is not work-related, resulting from an external or extrinsic source.

Adverse Benefit Determination: A determination that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed, and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

Allowable Expense: A health care service or expense, including Deductibles or Coinsurance, that is covered in full or in part by any of the plans covering a plan participant (see also the *COB section* of this document), except as otherwise provided by the terms of this Plan or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an allowable expense.

Ancillary Services: Services provided by a hospital or other health care facility other than room and board, including (but not limited to) use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g., general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g., regional or local anesthesia). Anesthetics are commonly administered by injection or inhalation.

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

Appliance (dental): A device to provide or restore function or provide a therapeutic (healing) effect.

Appropriate: See the definition of medically necessary for the definition of appropriate as it applies to medical services that are medically necessary.

Average Wholesale Price (AWP): the average price at which drugs are purchased at the wholesale level.

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

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the usual and customary charge, after calculation of all Deductibles, Coinsurance, and copayments, and after determination of the Plan's exclusions, limitations, and maximums.

Bitewing X-Rays (dental): Dental x-rays showing the coronal (crown) halves of the upper and lower teeth when the mouth is closed.

Bridge, Bridgework (dental) Fixed: A prosthesis that replaces one or more teeth and is cemented in place to existing abutment teeth. It consists of one or more pontics and one or more retainers (crowns or inlays). The patient cannot remove the prosthesis.

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

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

Coinsurance: That portion of eligible medical expenses for which the covered person has financial responsibility. In most instances, the covered individual is responsible for paying a percentage of covered medical expenses in excess of the Plan's Deductible. The Coinsurance varies depending on whether in-network or out-of-network providers are used.

Coordination of Benefits (COB): The rules and procedures applicable to the determination of how plan benefits are payable when a person is covered by two or more health care plans. (See also the *Coordination of Benefits* section).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes (but is not limited to) removal of tattoos, breast augmentation, or other medical, dental, or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Cost-Efficient: See the definition of medically necessary for the definition of cost-efficient as it applies to dental services that are medically necessary.

Course of Treatment (Dental): The planned program of one or more services or supplies, provided by one or more dentists, to treat a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment begins when a dentist first renders a service to correct or treat the diagnosed dental condition.

Covered Dental Expenses: See the definition of Eligible Dental Expenses.

Crown (Dental): The portion of a tooth covered by enamel. An artificial crown is a dental prosthesis used to return a tooth to proper occlusion, contact and contour, as used as a restoration or an abutment for a fixed prosthesis.

Customary Charge: See the definition of Usual and Customary Charge.

Deductible: The amount of eligible dental expenses you are responsible for paying before the Plan begins to pay benefits. The amount of deductibles is discussed in the *Dental Expense Coverage* section of this document.

Dental: As used in this document, dental refers to any services performed by (or under the supervision of) a dentist, or supplies (including dental prosthetics). Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat: teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection. Dental services and supplies are covered under the dental expense coverage

plan and are not covered under the medical expense coverage of the Plan unless the medical plan specifically indicates otherwise in the Schedule of Medical Benefits.

Dental Care Provider: A dentist, dental hygienist nurse, or other health care practitioner (as those terms are specifically defined in this section of the document) who is legally licensed and who is a dentist or performs services under the direction of a licensed dentist; and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dental Subspecialty Areas:

Subspecialty Area	Services related to the diagnosis, treatment, or prevention of diseases
Endodontics	The dental pulp and its surrounding tissues.
Implantology	Attachment of permanent artificial replacement of teeth directly to the jaw using artificial root structures.
Oral Surgery	Extractions and surgical procedures of the mouth.
Orthodontics	Abnormally positioned or aligned teeth.
Pedodontics	Treatment of dental problems of children.
Periodontics	Structures that support the teeth (gingivae, alveolar bone, periodontal membrane or ligament, cementum).
Prosthodontics	Construction of artificial appliances for the mouth (bridges, dentures, crowns, implants).

Dental Hygienist: A person who is trained, legally licensed and authorized to perform dental hygiene services (such as prophylaxis, or cleaning of teeth), under the direction of a licensed dentist; and who acts within the scope of his or her license; and is neither the patient, the parent, spouse, sibling (by birth or marriage) nor child of the patient.

Dental Implant: A dental implant is an artificial tooth root that is placed into your jaw to hold a replacement tooth or bridge.

Dentist: A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice all branches of dentistry under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

Denture: A device replacing missing teeth.

Domestic Partner: As defined by NRS 122A.030.

Eligible Dental Expenses: Expenses for dental services or supplies, but only to the extent that they are medically necessary, as defined in this *Definitions* section; and the charges for them are usual and customary, as defined in this *Definitions* section; and coverage for the services or

supplies is not excluded, as provided in the *Dental Exclusions* section of this document and the Plan Year maximum dental benefits for those services or supplies has not been reached.

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

Exclusions: Specific conditions, circumstances, and limitations, as set forth in the *Exclusions* section for which the Plan does not provide Plan benefits.

Explanation of Benefits (EOB): When a claim is processed by the claims administrator you will be sent a form called an explanation of benefits, or EOB. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to your deductible, if your Out-of-Pocket Maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, etc.

Fixed Appliance: A device that is cemented to the teeth or attached by adhesive materials.

Fluoride: A solution applied to the surface of teeth, or a prescription drug (usually in pill form) to prevent dental decay.

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain prescription drugs and other medical services and supplies to be lawfully marketed.

Health Care Practitioner: A physician, behavioral health practitioner, chiropractor, dentist, nurse, nurse practitioner, physician assistant, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist, master's prepared audiologist, optometrist, optician for vision plan benefits, oriental medicine doctor for acupuncture or Christian Science Practitioner, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice.

Health Care Provider: A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this *Definitions* section).

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.

HIPAA Special Enrollment: Enrollment rights under HIPAA for certain employees and dependents who experience a loss of other coverage and when there is an adoption, placement for adoption, birth, or marriage.

Impression: A negative reproduction of the teeth and gums from which models of the jaws are made. These models are used to study certain conditions and to make dental appliances and prostheses.

Injury to Sound and Natural Teeth (ISNT): An injury to the teeth caused by trauma from an external source. This does not include an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for injury to sound and natural teeth are payable under the medical plan (see also the definition of Sound and Natural Teeth).

Inlay: A restoration made to fit a prepared tooth cavity and then cemented into place (see the definition of restoration).

In-Network Services: Services provided by a health care provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from out-of-network services that are provided by a health care provider that is not a member of the PPO network.

In-Network Contracted Rate: The negotiated amount determined by the PPO network to be the maximum amount charged by the PPO provider for a covered service. In some cases, the in-network contracted amount may be applied to out-of-network provider charges.

Medically Necessary: A medical or dental service or supply will be determined to be "medically necessary" by the Plan Administrator or its designee if it:

- is provided by or under the direction of a physician or other duly licensed health care practitioner who is authorized to provide or prescribe it (or dentist if a dental service or supply is involved); and
- is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; and
- is determined by the Plan Administrator or its designee to meet all the following requirements:

    - It is consistent with the symptoms or diagnosis and treatment of the illness or injury; and
    - It is not provided solely for the convenience of the patient, physician, dentist, hospital, health care provider, or health care facility; and
    - It is an "appropriate" service or supply given the patient's circumstances and condition; and
    - It is a "cost-efficient" supply or level of service that can be safely provided to the patient; and
    - It is safe and effective for the illness or injury for which it is used.

- A medical or dental service or supply will be considered to be "appropriate" if:

    - It is a diagnostic procedure that is called for by the health status of the patient and is: as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

- It is care or treatment that is: as likely to produce a significant positive outcome as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

A medical or dental service or supply will be considered to be "cost-efficient" if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply. The fact that your physician or dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be medically necessary for the medical or dental coverage provided by the Plan.

A hospitalization or confinement to a health care facility will not be considered to be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

A medical or dental service or supply that can safely and appropriately be furnished in a physician's or dentist's office or other less costly facility will not be considered to be medically necessary if it is furnished in a hospital or health care facility or other more costly facility.

- The non-availability of a bed in another health care facility, or the non-availability of a health care practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is medically necessary.
- A medical or dental service or supply will not be considered to be medically necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any dental or health care practitioner, hospital or health care facility.

Non-Network: See Out-of-Network Services.

Non-Participating Provider: A health care provider who does not participate in the Plan's Preferred Provider Organization (PPO).

Office Visit: A direct personal contact between a dentist or other dental care practitioner and a patient in the dental care practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirement of such CDT coding.

Onlay: An inlay restoration that is extended to cover the biting surface of the tooth, but not the entire tooth. It is often used to restore lost and weakened tooth structure.

Oral Surgery: The specialty of dentistry concerned with surgical procedures in and about the mouth and jaw.

Orthodontics, Orthodontia: The science of the movement of teeth to correct a malocclusion or "crooked teeth."

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as prognathism, retrognathism or TMJ syndrome. See the definitions of Prognathism, Retrognathism and TMJ.

Out-of-Network, Out-of-Network Services (Non-Network): Services provided by a health care provider that is not a member of the Plan's Preferred Provider Organization (PPO), as distinguished from in-network services that are provided by a health care provider that is a member of the PPO. Greater expense could be incurred by the participant when using out-of-network providers.

Outpatient Services: Services provided either outside of a hospital or health care facility setting or at a hospital or health care facility when room and board charges are not incurred.

Partial Denture: A Prosthesis that replaces one or more, but less than all, of the natural teeth and associated structures. The denture may be removable or fixed.

Participating Provider: A health care provider who participates in the Plan's Preferred Provider Organization (PPO).

Periodontal Disease: Bacterial gum infections that destroy gum tissue and supporting bone that hold teeth in place.

Pharmacy: A licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

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

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

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

Plan Year Deductible: The amount you must pay each Plan Year before the Plan pays benefits.

Plan Year Maximum Benefits: The maximum amount of benefits payable each Plan Year for certain dental expenses incurred by any covered plan participant (or any covered family member of the plan participant) under this Plan.

Plan Participant; Participant: The employee or retiree or their enrolled spouse or domestic partner or dependent child(ren) or a surviving spouse of a retiree.

Pontic: The part of a fixed bridge that is suspended between two abutments and replaces a missing tooth.

Post-Service Claim: Means any claim for benefits under a health benefit plan regarding payment of benefits that is not considered a pre-service claim or an urgent care claim.

Preferred Provider Organization (PPO): A group or network of health care providers (*e.g.*, hospitals, physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted/reduced rates.

Pre-Service/Dental Pre-Estimate: Means any estimate for benefits under a health benefit plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining dental care.

Prescribed for a Medically Necessary Indication: The term medically accepted indication means any use of a covered outpatient drug which is approved under the Federal Food, Drug and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the following compendia: American Hospital Formulary Service Drug Information, United States Pharmacopeia-Drug Information, the DRUGDEX Information System or American Medical Association Drug Evaluations.

Prescription Drugs: For the purposes of this Plan, prescription drugs include:

1. **Federal Legend Drugs:** Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
2. **Other Prescription Drugs:** Drugs that require a prescription under state law but not under federal law.
3. **Compound Drugs:** Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face.

Program: The Public Employees' Benefits Program established in accordance with NRS 287.0402 to 287.049, inclusive.

Prophylaxis: The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth are performed by a dentist or dental hygienist.

Prosthesis (dental): An artificial replacement of one or more natural teeth and/or associated structures.

Prosthetic Appliance (dental): A removable device that replaces a missing tooth or teeth.

Provider: See the definition of health care provider.

Removable: A prosthesis that replaces one or more teeth and which are held in place by clasps. The patient can remove the prosthesis.

Restoration: A broad term applied to any filling, crown, bridge, partial denture, or complete denture that restores or replaces loss of tooth structure, teeth, or oral tissue. The term applies to the result of repairing and restoring or reforming the shape and function of part or all the tooth or teeth.

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

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face.

Root Canal (Endodontic) Therapy: Treatment of a tooth having damaged pulp. The treatment is usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with a sealing material.

Root Planning and Scaling: Also known as conventional periodontal therapy, non-surgical periodontal therapy, or deep cleaning, is the process of removing or eliminating dental plaque and calculus, which cause inflammation.

Service Area: The geographic area serviced by the in-network health care or dental providers who have agreements with the Plan's PPO networks. Refer to the *Participant Contact Guide* for additional information regarding the PPO networks.

Sound and Natural Teeth: Natural teeth (not dentures, bridges, pontics or artificial teeth) that are free of active or chronic clinical decay; and have at least 50% bone support; and are functional in the arch; and have not been excessively weakened by previous dental procedures.

Spouse: The employee's lawful spouse (opposite sex or same sex) as determined by the laws of the State of Nevada**.** The Plan will require proof of the legal marital relationship. A former spouse or domestic partner of an employee or retiree is not an eligible spouse under this Plan.

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

Subrogation: This is a technical legal term for the right of one party to be substituted in place of another party in a lawsuit. See the *Third Party Liability* section of this document for an explanation of how the Plan may use the right of subrogation to be substituted in place of a covered individual in that person's claim against a third party who wrongfully caused that person's injury or illness, so that the Plan may recover medical benefits paid if the covered individual recovers any amount from the third party either by way of a settlement or judgment in a lawsuit.

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

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome: The temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including (but not limited to) masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking); myofacial pain, headaches, earaches, limitation of the joint, clicking sounds during chewing; tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

Topical: Painting the surface of teeth, as in a fluoride treatment or application of a cream-like anesthetic formula to the surface of the gum.

Tortfeasor: Means an individual or entity who commits a wrongful act, either intentionally or through negligence, that injures another or for which the law provides a legal right through a civil case for the injured person to seek relief.

Usual and Customary Charge (U&C): While your medical or dental care provider may charge whatever he feels his services are worth, the Plan has the right to determine what it will allow as the usual and customary charge, sometimes referred to as usual and customary fee or allowable fee or prevailing fee. The usual and customary charge for medically necessary services or supplies will be determined by the claims administrator or Plan Administrator and will be the lowest of:

- With respect to a PPO (in-network) participating medical health care or dental care provider, the fee set forth in the agreement between the PPO network or the claims administrator or the Plan Administrator and the participating medical health care or dental care provider. or
- The medical health care or dental care provider's actual charge; or
- The usual charge by the medical health care or dental care provider for the same or similar service or supply.
- For out-of-network medical or dental services, no more than the 70th percentile of fair health. Fair health is a national schedule of prevailing health care charges that is updated twice per year. Information regarding fair health is located on the PEBP website.

- For services provided by an out-of-network medical or dental care provider that are not addressed by fair health, the claims administrator or the Plan Administrator may refer to the PPO (in-network) fee schedule of the nearest (geographically) or the most prevalently used PPO provider of the nearest (geographically) for the same or similar service when determining the usual and customary charge by the out-of-network provider.

The "prevailing charge" of most other health care or dental care providers in the same or similar geographic area for the same or similar health care service or supply will be determined by the claims administrator using proprietary data that is provided by a reputable company or entity and is updated no less frequently than annually. The Plan will not always pay benefits equal to or based on the health care or dental care provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible and Coinsurance. This is because the Plan covers only the usual and customary charge for health care services or supplies. Any amount in excess of the usual and customary charge does not count toward the Plan Year's Out-of-Pocket Maximum. The usual and customary charge is sometimes referred to as the U & C charge, the reasonable and customary charge, the R & C charge, the usual, customary, and reasonable charge, or the UCR charge. Note: to obtain the most current usual and customary amount, please contact PEBP's claims administrator, listed in the *Participant Contact Guide* in this document. You must provide the claims administrator with the specific procedure code, provider name and the zip code for the location where the procedure will take place. This service is only available to PEBP plan participants.

NOTE: The Claims Administrator has the discretionary authority to determine the usual and customary charge based upon standards set forth by the Plan Administrator.

Visit: See the definition of Office Visit.

You, your: When used in this document, these words refer to the employee or retiree who is covered by the Plan. They do not refer to any dependent of the employee or retiree.