NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Access.
Quality.
Affordability.

PEBP ENROLLMENT AND ELIGIBILITY

MASTER PLAN DOCUMENT

Plan Year 2022

(Effective July 1, 2021 – June 30, 2022)

Public Employees' Benefits Program
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Amendment Log

Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.

Welcome PEBP Participant

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). PEBP offers medical, dental, life insurance, long-term disability, flexible spending accounts, and other voluntary insurance benefits to eligible State and local government employees, retirees, and their eligible dependents.

As a PEBP participant, you may select whichever benefit plan offered in your geographical area that best meets your needs, subject to specific eligibility and Plan enrollment requirements. These plans include the Consumer Driven Health Plan, Premier Plan, Low Deductible PPO Plan, Health Plan of Nevada HMO, and individual Medicare Advantage or Supplement plans through Via Benefits. You are also encouraged to research Plan provider access and quality of care in your service area.

PEBP participants should examine this document, the Consumer Driven Health Plan, PEBP PPO Dental Plan, Premier Plan, and the Low Deductible PPO Plan MPD. Important information is also available in the Active Employee Health and Welfare Wrap Plan Document, Retiree Health and Welfare Wrap Plan Document, Section 125 Document, Health Reimbursement Summary Plan Description for Medicare retirees, and the Summary of Benefits and Coverage (SBC) for applicable plans. These documents are available at www.pebp.state.nv.us.

The Master Plan Documents, Summary Plan Descriptions, Summary of Benefits and Coverage and provide a comprehensive description of the benefits, eligibility, and plan provisions. Relevant statutes and regulations are detailed in the Active Employee and Retiree Health and Welfare Wrap Plan Document. The *Participant Contact Guide* section contains telephone numbers, website addresses and other important vendor information associated with each plan.

As a PEBP participant, it is important that you stay informed and keep abreast of your plan benefits, rights, and responsibilities. You are encouraged to read the various publications such as benefit guides, newsletters, plan documents, summary plan descriptions, and other materials. You are also encouraged to contact the PEBP office and any of the vendors listed in the *Participant Contact Guide* when you have questions about your benefits.

Sincerely,

Public Employees' Benefits Program

Introduction

This Master Plan Document describes the enrollment and eligibility provisions for state and non-state employees and retirees. It also includes information regarding initial enrollment requirements, qualifying life status events and applicable notification timeframes, COBRA, military, FMLA and other types of leave.

PEBP plans are 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 provisions and information described in this document are effective July 1, 2021.

This document will help you understand eligibility and enrollment requirements. You should review it and show it to members of your family who are or will be covered by the Plan.

It describes the process and timeframes for submitting new hire or retiree enrollment elections, qualifying life status changes, and supporting document requirements. Be sure to read the *Key Terms and Definitions* sections.

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 program of benefits indefinitely, but reserves the right to terminate, suspend, discontinue, or amend its Plan offerings and benefits at any time and for any reason. As PEBP amends its Plan(s), 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.

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* helps you become familiar with PEBP vendors and services they provide.
- The *Participant Rights and Responsibilities* section describes your rights and responsibilities as a participant of the Premier Plan.
- The *Key Terms and Definitions* explains many technical, medical, and legal terms that appear in the text.
- The *Summary of Benefit Options* provides a summary of the benefit options depending on the eligibility and status of the participant.
- *Enrollment Processes* provides information for enrollment in benefit options.
- *Eligibility for Coverage* provides information regarding program eligibility depending on status of the participant.
- The *Summary of Supporting Eligibility Documents* provides information regarding what documents are required for enrollment purposes.
- *Qualifying Events* for enrollment and disenrollment information depending on the event type of the participant and their family.
- *COBRA Continuation of Medical Coverage* provides information on continuing health insurance coverage if PEBP coverage is terminated.

Accessing Other Benefit Information:

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

- *State of Nevada PEBP Active Employee Health and Welfare Wrap Plan Document*
- *State of Nevada PEBP Retiree Health and Welfare Wrap Plan Document*
- *Consumer Driven Health Plan (CDHP) Master Plan Document*
- *CDHP Summary of Benefits and Coverage for Individual and Family*
- *PEBP Low Deductible PPO (LD-PPO) Master Plan Document*
- *PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document*
- *Premier Plan Master Plan Document (EPO)*
- *Premier Plan Summary of Benefits and Coverage for Individual and Family*
- *Health Plan of Nevada Evidence of Coverage (EOC) and Summary of Benefits and Coverage*
- *Flexible Spending Accounts (FSA) Summary Plan Description*
- *Section 125 Health and Welfare Benefits Plan Document*
- *Medicare Retiree Health Reimbursement Arrangement Summary Plan Description*

Participant Rights and Responsibilities

You have the right to:

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

You have the responsibility to:

- Establish a patient relationship with a participating primary care physician and a participating dental care provider.
- Take personal responsibility for your overall health by adhering to healthy lifestyle choices. Understand that you are solely responsible for the consequences of unhealthy lifestyle choices.
- If you use tobacco products, seek advice regarding how to quit.
- Maintain a healthy weight through diet and exercise.
- Take medications as prescribed by your health care provider.
- Talk to your health care provider about preventive medical 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. Copies of these documents include but are not limited to:
    - 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.
    - Enrollment forms submitted to PEBP.
    - Your medical, vision and dental bills.
    - 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.

Rescission of Coverage

The Plan Administrator is prohibited from rescinding or retroactively terminating the coverage of a covered person under a benefit option that is a group health plan that is not excepted or exempt under Section 2712 of the PHSA, unless such covered person commits an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; provided however, that the foregoing prohibition shall not prohibit retroactive termination in the event: (i) a Participant fails to timely pay premiums towards the cost of coverage; (ii) the Plan erroneously covers an ex-spouse of a Participant because the Participant failed to timely report a divorce to the Plan Administrator; (iii) the Plan erroneously covers a Participant due to a reasonable administrative delay in terminating coverage; or (iv) any other circumstance under which retroactive termination would not violate the PPACA. The covered person. The covered person may appeal the rescission of coverage as a denial of a post-service claim under Article 7 in the Health and Welfare Wrap Document available at www.pebp.state.nv.us. In the event the Plan Administrator rescinds a Covered Person's coverage on account of an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent, such rescission shall not cause the individual to incur a "qualifying event" as provided under COBRA.

Summary of Benefit Options

	Full-Time Employees			Active Legislator	Retirees (non-Medicare)			Survivors of Retirees (non-Medicare)	
	State	Non-State	NSHE		State	Non-State	Reinstated (State or Non-State)	Spouse	Dependent Child
Medical Options									
Consumer Driven Health Plan (CDHP)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Exclusive Provider Organization Plan (EPO)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Low Deductible PPO Plan (LD PPO)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health Plan of Nevada (HPN) HMO	✓	✓	✓	✓	✓	✓	✓	✓	✓
Other Options									
Self-funded PPO Dental	✓	✓	✓	✓	✓	✓	✓	✓	✓
Basic Life	✓	✓	✓	✓	✓	✓			
					Retirees eligible for Medicare Parts A and B			**Survivors of Retirees**	
Medicare Exchange for Medicare eligible retirees and their covered Medicare eligible dependents					✓	✓	✓	✓	

Summary of Voluntary Product Options

	Full-Time Employees			Active Legislator	Retirees			Survivors of Retirees	
	State	Non-State	NSHE		State	Non-State	Reinstated (State or Non-State)	Spouse	Dependent Child
Summary of Voluntary Product Options									
VSP Vision	✓	✓	✓	✓	✓	✓	✓		
AFLAC Employee Critical Illness	✓	✓	✓	✓					
AFLAC Spouse Critical Illness	✓	✓	✓	✓					
AFLAC Hospital Indemnity	✓	✓	✓	✓					
AFLAC Accident Insurance	✓	✓	✓	✓					
The Standard Employee Voluntary Life and AD&D	✓	✓	✓	✓					
The Standard Spouse Voluntary Life	✓	✓	✓	✓					
The Standard Child Voluntary Life	✓	✓	✓	✓					
Legal Ease – Legal Plan	✓	✓	✓	✓	✓	✓	✓		
ID Theft Protection	✓	✓	✓	✓	✓	✓	✓		
The Standard Retiree Voluntary Life	✓	✓	✓	✓	✓	✓	✓		
AFLAC Retiree Critical Illness	✓	✓	✓	✓	✓	✓	✓		
AFLAC Retiree Accident Insurance	✓	✓	✓	✓	✓	✓	✓		
Auto, Home, Renters' Insurance (Met Life, Liberty Mutual, and Travelers' Insurance)	✓	✓	✓	✓	✓	✓	✓		
Pet Insurance (Nationwide and ASPCA)	✓	✓	✓	✓	✓	✓	✓		
Standard Short-Term Disability Insurance	✓	✓	✓	✓					

Enrollment Processes

Enrollment Options

Enrollment Online

Log on to your E-PEBP portal account at www.pebp.state.nv.us and click on the orange "Login" button, then follow the instructions to access your account.

Most enrollment events may be completed online and will eliminate having to complete a paper enrollment form. If you are enrolling in the Consumer Driven Health Plan (CDHP) you may also establish your Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) online.

Enrollment must include without limitation:

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

A participant who desires to enroll or add a dependent to the Plan must agree to the authorization section of the enrollment form by signing (submittal of the online enrollment is considered a digital signature) and dating the enrollment.

Paper Form Enrollment

If an event cannot be completed online or if an employee or retiree does not have internet access, enrollment forms may be obtained from PEBP.

Initial Enrollment

Initial Enrollment for Active Employees

As a new benefits-eligible employee you must enroll or decline coverage online at www.pebp.state.nv.us and upload any required supporting documents (if adding dependents) to your E-PEBP portal no later than the last day of the month your coverage is scheduled to become effective.

Enrollment Requirement Example:

Date of Hire/Contract Date	Coverage Effective Date	Date Enrollment Must Be Completed	Date Supporting Documents Must be Submitted (if any)	Default Coverage Date
June 1st	June 1st	June 30th	June 30th	June 30th Coverage Effective June 1st
June 2nd	July 1st	July 31st	July 31st	July 31st Coverage Effective July 1st

Default Coverage – Failure to Enroll When Eligible

PEBP requires eligible employees to enroll in a medical Plan or decline benefits no later than the last day of the month coverage is scheduled to become effective. If an employee fails to enroll or decline coverage as specified above, the employee will be automatically enrolled in the Consumer Driven Health Plan (CDHP) with a Health Reimbursement Arrangement (HRA), in the "employee-only" tier without coverage for dependents.

Initial Enrollment for Retirees

Retirees who wish to enrollment in retiree coverage must complete the required enrollment documents and submit to the PEBP office within 60 days of the date of retirement. Required forms include the Retiree Benefit Enrollment and Change Form (RBECF) and the Years of Service Certification Form (YOSCF) and are available by requesting by contacting the PEBP office. Eligible dependents must be enrolled at the same time as the retiree.

Initial Enrollment for Survivors

Eligible surviving dependent(s) who wish to be covered under PEBP must complete an enrollment election within 60 days of the date of death of the employee or retiree.

Initial Enrollment for COBRA

Qualified beneficiaries who wish to elect COBRA continuation coverage must submit their COBRA enrollment election within 60 days of the qualifying event date. Coverage will not be processed until payment is received.

Open Enrollment

Open enrollment is typically held May 1 - May 31 and any changes made during open enrollment become effective on July 1st, immediately following the open enrollment period.

During this time active employees and retirees may:

- Enroll in a medical Plan or change Plan options; or
- Add or delete eligible dependents to/from medical coverage; or
- Decline coverage.
- Retirees covered under the Medicare Exchange may:
  - Opt-in/out of PEBP dental coverage (must be covered under a PEBP sponsored medical Plan)
  - Add or delete eligible dependents

During a positive enrollment period or if a medical Plan option is discontinued, the covered participant must submit a new plan election within the required timeframe as determined by PEBP. Failure to make a new enrollment election will cause the Participant and any covered dependents to be defaulted to the CDHP Plan (default Plan).

Retiree Late Enrollment

A retired public officer or employee of the State, NSHE, a participating local government, or the surviving spouse thereof, may reinstate insurance during the open enrollment period if the retired public officer or employee did not have more than one period during which he or she was not

covered under the PEBP Plan on or after October 1, 2011, or on or after the date of his or her retirement, whichever is later. Meaning, the above individuals will only have one opportunity to rejoin the PEBP Plan following retirement. To enroll as a late enrollee, contact PEBP between April 15th and May 15th to request the retiree late enrollment form. Retiree late enrollment forms must be completed and submitted to the PEBP office by May 31st. Approved enrollment for reinstated retires will become effective July 1st. Reinstated retirees are not eligible for basic life insurance coverage through the PEBP.

In accordance with AB 48 [2021 Legislative Session], a retired public officer or employee or the surviving spouse thereof, may reinstate insurance, except life insurance, under the Public Employees' Benefits Program, if the retired public officer or employee (1) did not have more than one period during which he or she was not covered by insurance under the Program on or after October 1, 2011; (2) retired from a nonparticipating local governmental agency; (3) was enrolled in the Program as a retiree on November 30, 2008; and (4) is enrolled in Medicare Parts A and B at the time of the request for reinstatement. For Plan Year 2022 and this section only, retirees or the surviving spouse thereof, may apply for reinstatement by submitting the required reinstatement enrollment form(s) between July 1, 2021 – May 31, 2022.

For Plan Years 2023 and beyond, requests for reinstatement must be completed through the submission of the required forms to the PEBP office between May 1st and May 31st.

HIPAA Special Enrollment Notice

If you are declining medical benefits for yourself or your eligible dependents (including your eligible spouse or domestic partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in medical benefits provided under a PEBP-sponsored plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

If you request a change due to a special enrollment event within the 60-day timeframe, coverage will be effective the date of birth, adoption, or placement for adoption. For all other events, coverage will be effective the first day of the month following qualifying event date.

HIPAA Special Enrollment Rights [26 CFR §1.125-4(b)] allow a "special enrollee" to change his or her existing enrollment after:

- A loss of eligibility for group health coverage, health insurance coverage, Medicare Part A, CHIP, or Medicaid.
- Becoming eligible for state premium assistance, Medicaid, or CHIP subsidies; and
- Attaining a new spouse or dependent by marriage, birth, adoption, or placement for adoption.

Change in Status applies to marital status (marriage, divorce), number of dependents (includes birth, adoption, placement for adoption and death), employment status, dependent satisfies or ceases to satisfy eligibility requirements, change in residence [26 CFR §1.125-4(c)(1)(i)].

Special enrollment rights are subject to certain circumstances. If you are a State or non-State retiree, special enrollment does not apply to you, but it does apply to your dependents if you are covered under the Plan. If you are a surviving spouse or surviving domestic partner, special enrollment does not apply to you or your dependents.

To request special enrollment or to obtain more information, contact PEBP at 775-684-7000 or 800-326-5496 or email member services by selecting the contact us feature in your E-PEBP portal member account.

Eligibility for Coverage

Summary of PEBP Eligibility and Enrollment Requirements

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

- Any spouse or domestic partner that is eligible for coverage as both a primary participant and a dependent shall be enrolled as a primary participant.
- A child that is eligible as both a primary participant and a dependent may enroll as a primary participant or continue coverage as a dependent of a PEBP participant until age 26 years.

Eligibility Determinations

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

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

Eligibility for Active Employees

The following full-time employees are eligible to participate in PEBP after satisfying their respective waiting period:

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

Eligibility for Retirees

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

- Public Employees' Retirement System (PERS)
- Legislators' Retirement System (LRS)
- Judges' Retirement System (JRS)
- Retirement Plan Alternative (RPA) for professional employees of the Nevada System of Higher Education
- A long-term disability plan of the public employer

Eligibility for Dependents

Your Spouse

For the purposes of this Plan, the participant's spouse is defined as opposite sex or same sex, as determined by the laws of the State of Nevada, is eligible for coverage under the PEBP Plan. Spouses that are eligible for health coverage through their current employer group health plan are typically not eligible for coverage under the PEBP Plan. If your spouse's employer group health plan satisfies PEBP's definition of "Significantly Inferior Coverage" and you comply with the items listed in the Exception paragraph below, you may be able to enroll or continue your spouse's coverage under PEBP. The definition of "Significantly Inferior Coverage" is provided in the *definition section* of this document.

The Plan requires proof of the legal marital relationship and completion of the enrollment (paper or online) declaring that the spouse is not eligible for an employer group health plan. A spouse is not an eligible dependent after divorce.

Your Domestic Partner

The participant's domestic partner, as recognized by the laws of the State of Nevada, is eligible for coverage under the PEBP Plan. Domestic partners that are eligible for group health insurance through their current employer are typically not eligible for coverage under the PEBP Plan. If your domestic partner's employer sponsored health coverage satisfies PEBP's definition of "Significantly Inferior Coverage" and you comply with the items listed in the Exception paragraph listed below, you may be able to enroll or continue your domestic partners coverage under PEBP. The definition of "Significantly Inferior Coverage" is provided in the *definition section* of this document.

The Plan requires a copy of the domestic partnership certification, and completion of the online enrollment or through the submission of a paper enrollment form declaring that the domestic partner is not eligible for an employer group health plan. By completing an enrollment election, the participant acknowledges their responsibility for any federal income tax consequences resulting from the enrollment of the domestic partner in the Plan. A domestic partner is not an eligible dependent after dissolution of the domestic partnership. Participants who have a legal union or domestic partnership validly formed in another jurisdiction which is substantially equivalent to a domestic partnership in Nevada, are not required to file with, or provide a certification from the Nevada Secretary of State.

PEBP requires the participant to provide an official summary of the coverage details from the employer of their spouse/domestic partner outlining all health insurance coverage plans available to their employees. PEBP has the authority to determine if the spouse's/domestic partner's employer sponsored health plan meets the definition of "Significantly Inferior Coverage."

Your Children/Stepchildren

A participant's children, stepchildren, or children of their domestic partner, under age 26 years, are eligible for coverage on:

- The day the participant becomes eligible for coverage, or
- The day the participant acquires the eligible dependent by birth, adoption, or placement for adoption, or
- The first day of the month concurrent with or following the date of the participant's marriage or certification of domestic partnership, or
- The first day of the month concurrent with or following the loss of coverage through an employer group health plan.

A dependent of two PEBP participants cannot be covered under more than one PEBP medical Plan at the same time.

To enroll a dependent child(ren), the participant must submit an enrollment election online or paper form.

In the case of a stepchild or domestic partner's child, a certified marriage certificate or certification of domestic partnership will also be required. Participants who have a legal union or domestic partnership validly formed in another jurisdiction which is substantially equivalent to a domestic partnership in Nevada, are not required to file with, or provide a certification from the Nevada Secretary of State.

Dependent children are automatically terminated from coverage on:

- The date of termination of the participant's coverage.
- The end of the month in which a dependent child under permanent legal guardianship turns age 19 years.
- The end of the month in which the dependent child reaches age 26 unless proof of disabled dependent child status has been provided to and approved by PEBP.

A dependent child under the age of 26 years who is covered as a dependent on his or her parent's PEBP Plan, and who later becomes eligible for their own PEBP coverage as a primary PEBP participant, may decline primary coverage as an active employee and retain coverage as a dependent on his or her parent's plan; or the newly eligible employee (dependent) may enroll in their own coverage as a primary PEBP participant.

A child who enrolls as a primary participant or who is defaulted as a primary participant will be removed as a dependent from their parent's PEBP coverage.

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

Your Newborn Child(ren)

The newborn dependent child(ren) of a PEBP participant will automatically be covered under a PEBP medical Plan option from the date of birth to 31 days following the date of birth (referred to as the initial coverage period) NRS 689B.033. If the newborn is covered under more than one health insurance plan, the PEBP Plan reserves the right to coordinate benefits as stated in the Coordination of Benefits section of the PEBP Consumer Driven Health Plan, Low Deductible PPO Plan, and Premier Plan Master Plan Documents or HMO Evidence of Coverage Certificate (as applicable).

To continue coverage beyond the initial coverage period, enrollment must be completed within 60 days of the newborn's date of birth. A copy of the child's hospital birth confirmation will be required within the first 60 days to add the child, followed by a copy of the child's certified birth certificate and social security number within 120 days following the date of birth. A newborn dependent child may not be enrolled for coverage unless the participant is also enrolled for coverage. If newborn enrollment is not completed within 60 days of the date of birth, coverage of the newborn will end 31 days after the child's date of birth. If all supporting documentation for the newborn is not received within the required timeframe(s) the dependent newborn coverage will terminate at the end of the month the documents were due. Under no circumstances shall a newborn child have dual coverage under two PEBP plans. If the mother and father of the newborn are both primary participants under PEBP, the participant who elects to continue coverage for the newborn after the initial 31-day period shall be deemed to have covered the newborn since the date of birth.

Your Adopted Dependent Children

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

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

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

Legal Guardianship

Unmarried children under age 19 who are under a legal permanent guardianship may be enrolled as a dependent. To continue coverage after age 19 (to age 26), the child must be unmarried and

either reside with the participant or be enrolled as a full-time student at an accredited institution and satisfy the following conditions:

1. Is eligible to be claimed as a dependent on the federal income tax return of the participant or his spouse/domestic partner for the preceding calendar year; and
2. Dependent is a grandchild, brother, sister, stepbrother, step-sister, or descendent of such relative.
3. Children covered under legal guardianship are not eligible to continue benefits under the provision of a disabled dependent.

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

Children under a temporary guardianship are **not** eligible for coverage as a dependent under the PEBP Plan.

Disabled Dependent Child

To cover a dependent child with a disability and who is 26 years old or older requires that the dependent has maintained continuous medical coverage with no break in service and the completion of the *Certification of Disabled Dependent Child Form* by the participant and the child's physician. To be eligible for coverage, the physician must diagnose the child as having a mental or physical impairment causing incapability of self-sustaining employment and depending chiefly on the participant and/or participant's spouse for support and maintenance. Evidence of disability must be provided within 30 days after the child reaches age 26 years (NAC 287.312(1)(d)). The Plan will require proof of support and maintenance through the submission of a copy of the preceding year's income tax return showing the child was or could have been claimed as a tax dependent in compliance with the IRS Code 152 (a) without regard to the gross income test.

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

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

Grandchildren

Grandchildren are not eligible for coverage unless they are adopted or qualify under permanent legal guardianship. Please refer to the *Guardianship* section of this document for more information.

Foster children

Foster children are not eligible for dependent coverage.

Survivors

Surviving dependents include a participant's spouse or domestic partner and dependent children to age 26 years (or to age 19 years for child(ren) under permanent legal guardianship) who are covered under the participant's medical Plan on the date of the participant's death.

Coverage for a surviving dependent(s) will end on the last day of the month of the participant's death. Surviving dependent(s) who meet the eligibility provisions to re-enroll as a surviving dependent(s) have the option to continue coverage as a surviving dependent(s). To re-enroll as an eligible surviving dependent(s), the surviving dependent(s) must re-enroll by submitting an enrollment election within 60 days of the date of death of the employee or retiree.

Surviving dependents are not eligible for a years of service premium subsidy or years of service Medicare Exchange HRA contribution or basic life insurance coverage.

Survivors of Active Employees

If an active employee dies with 10 or more years of service credit, the employee's covered dependent(s) are eligible to continue current PEBP Plan coverage as surviving dependent(s). Any dependent not enrolled for coverage on the date of the participant's death, is not eligible to enroll for coverage as a survivor. A surviving spouse may not enroll dependent children who were not covered on the date of the participant's death. Surviving dependents include an employee's covered spouse or domestic partner and child(ren) to age 26 years (or to age 19 years for a child under permanent legal guardianship) on the date of the employee's death. If an active employee dies with less than 10 years of service credit, any covered dependents will be offered 36 months of COBRA coverage.

A surviving dependent child shall pay the surviving/unsubsidized spouse rate if there is no surviving spouse or the surviving spouse declines coverage.

Survivors of Retirees

Survivor dependent(s) of retirees who were covered on the date of the retiree's death have the option either to continue or cancel PEBP coverage. Any dependent that is not enrolled at the time of the retiree's death will not be eligible to enroll as a survivor. A surviving spouse may not enroll dependent children who were not covered on the date of the retiree's death.

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

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

The participating public agency that employed the police officer or firefighter shall pay the entire cost of the premiums or contributions to the Public Employees' Benefits Program for the surviving dependent who meets the requirements. The State will pay the entire cost of the premiums or contributions to the PEBP for the surviving dependent(s) of a police officer or firefighter.

A surviving spouse is eligible to receive coverage pursuant to this section for the duration of the life of the surviving spouse. A surviving child is eligible to receive coverage pursuant to this section until the child reaches age 26 years. (A surviving child under permanent guardianship of deceased police officer or firefighter killed in the line of duty is eligible for coverage to age 19 years.)

Unsubsidized Dependents Covered under a PEBP Plan

An unsubsidized dependent is an otherwise eligible spouse/domestic partner or dependent child who remains covered under PEBP while the primary Plan participant transitions medical coverage to the Medicare Exchange.

Termination of a retiree's coverage through the Medicare Exchange will result in the termination of any unsubsidized dependents. See *Survivors of Retirees* for exceptions to this provision.

Unsubsidized dependents enrolled in the CDHP, Premier Plan, LD PPO or HMO Plan can decline their coverage at any time (coverage ends the last day of the month of notification).

Unsubsidized Dependents Covered under the Medicare Exchange

An unsubsidized dependent is an otherwise eligible spouse/domestic partner who transitions to the Medicare Exchange and elects PEBP dental coverage, while the primary Plan participant remains covered under a PEBP Plan. See *Survivors of Retirees* for exceptions to this provision.

Termination of a primary participant's coverage will result in termination of the unsubsidized dependent.

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

Retirees with Tricare for Life and Medicare Parts A and B

Retirees who are otherwise eligible for the Health Reimbursement Arrangement (HRA) and who have Tricare for Life and Medicare Parts A and B are not required to enroll in a medical plan through the Medicare Exchange. To receive the monthly HRA contribution, PEBP will require a copy of the Tricare for Life military ID card (front and back) and a copy of the retiree's Medicare Parts A and B card. The required documents must be submitted to PEBP within 60 days of the Medicare Parts A and B effective date, or within 60 days of the retirement date of the employee, whichever date is later. Retirees enrolled in Tricare for Life and Medicare Parts A and B and a medical plan through the Medicare Exchange may disenroll from the Medicare Exchange without experiencing a qualifying life status change or waiting for the Open Enrollment period.

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

When Coverage Begins

Active Employees

New Hire

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

Reinstated Employee

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

Rehired Employee

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

Retirees

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

Retiree Premium Subsidy or Exchange HRA Contribution for certain employees initially hired on or after January 1, 2010

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

Except for persons to whom subsection 8 of NRS 287.043 applies, the initial date of hire is defined by NAC 287.059 as the first date on which service credit is earned by a participant during the participant's last period of continuous employment with a public employer, as determined by PERS or NSHE.

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

Retiree Years of Service Premium Subsidy or Exchange HRA Contribution for Employees Initially Hired with a PEBP Participating Agency on or after January 1, 2012

- Employees of a State agency, judges, professional (contracted) employees of the Nevada System for Higher Education, legislators and employees of participating local government entities with an initial date of hire on or after January 1, 2012, may participate in the program,

but will not be eligible for a years of service premium subsidy or Medicare Exchange HRA contribution upon retirement.

- Eligibility for a subsidy at retirement is based on the initial date of hire as defined by NAC 287.059 as the first date on which service credit is earned by a participant during the participant's last period of continuous employment with a public employer (as determined by PERS or NSHE). Continuous employment (defined by NAC 287.021) includes a break in employment of less than 1 year; and does not include a break in employment of 1 year or more.
- Pursuant to NRS 287.046 (8), this section does not apply to a person who was employed by the State on or before January 1, 2012, who has a break in service and returns to work for the State at the same or another participating State agency after that date, regardless of the length of the break in service, so long as the person did not withdraw their retirement from PERS and was eligible to participate in the Public Employees' Retirement System (PERS) or the retirement plan alternative for the Nevada System of Higher Education (NSHE) before or during the break in service.

State Retirees

Retirees whose last employer is a State agency, NSHE, PERS, the Legislature, Legislative Counsel Bureau or a State Board or Commission are considered State retirees.

Non-State Retirees

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

Dependents

Benefit Coverage for any Eligible Dependent is effective on:

- The day an employee or retiree becomes eligible for medical coverage,
- The day an employee or retiree acquires an eligible dependent by birth, adoption, placement for adoption, or
- The first day of the month concurrent with or following a qualifying event.

Eligible Dependents may be Enrolled if:

- Benefit coverage is in effect for the active employee or retiree on that day;
- Any required supporting documents are received in the PEBP office within 60 days of the qualifying event (for example: certified birth certificate, certified marriage certificate, etc.); or
- Within 30 days following the last day of open enrollment; or
- No later than the last day of the month coverage becomes effective; and
- Any required contribution for coverage of the dependent(s) is paid.

Covered dependents must be enrolled in the same medical plan option as the employee or retiree except as described in the *Coverage Options for Individuals with Medicare* section. Eligible dependents include a spouse, domestic partner, and/or dependent child(ren) (as defined in the *Definitions* section of this document). Anyone who does not qualify as a spouse, domestic partner, or dependent child has no right to any benefits or services under this Plan. Any retiree covered through the Medicare Exchange will have the option to enroll in the CDHP or Premier Plan, or HMO Plan when a non-Medicare eligible dependent is enrolled, subject to the rules described in the *Coverage Options for Individuals with Medicare* section and the rules of the Plan chosen through the Medicare Exchange.

When Coverage Ends

In Case of Death

In all cases of death, coverage ends on the date of death of the employee, retiree, or dependent. Dependent coverage ends on the last day of the month of the primary insured date of death.

Active Employees

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

- Employment ends.
- Employment contract ends.
- Employee is no longer eligible to participate in the Plan.
- The last day of the month that precedes the effective date of the other employer's coverage if gaining coverage during an open enrollment offered through the employer of a spouse or domestic partner.
- The last day of the Plan Year if the employee declines coverage during open enrollment.
- Premium payment was last received (see *Termination for Non-Payment*); or
- The Plan is discontinued.

Retirees

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

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

Dependents

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

- The active employee or retiree coverage ends.
- The covered spouse, domestic partner, or dependent child(ren) no longer meet the definition of spouse, domestic partner, or dependent child(ren) as provided in the *Definitions section* of this document.
- Premium payment was last received (see *Termination for Non-Payment*);
- Dependent was covered under a medical plan through the Medicare Exchange; or
- The Plan is discontinued.

Surviving Spouse/Domestic Partner of a Retiree

Coverage for a surviving spouse/domestic partner of a retiree ends on the last day of the month in which:

- PEBP is notified of voluntary declination of coverage;
- Premium payment was last received (see *Termination for Non-Payment*);
- Surviving spouse/domestic partner was covered under a medical plan through the Medicare Exchange; or
- The Plan is discontinued.

Unsubsidized Dependent

Coverage for an unsubsidized dependent will end on the last day of the month in which:

- The covered dependent no longer meets the definition of dependent as provided in the *Definitions section* of this document.
- Premium payment for the primary plan participant or the covered dependent was last received; PEBP is notified of declination of coverage; or
- The Plan is discontinued.

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

Coverage for dependent children of a surviving spouse or domestic partner of a retiree ends on the last day of the month in which:

- The covered dependent child(ren) no longer meets the definition of dependent child(ren) as provided in the *Definitions section* of this document.
- Premium payment was last received (see *Termination for Non-Payment*); or
- The Plan is discontinued.

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

An employee, spouse/domestic partner, or any dependent child(ren) must notify the Plan no later than 60 days after the date:

- Of a divorce or dissolution of a domestic partnership.
- On which a dependent child ceases to meet the definition of dependent as defined in the *Definitions section* of this document; or
- On which a dependent child over age 26 years ceases to have a physical or mental impairment where the child no longer has a disability.

Failure to give such a notice within 60 days will cause the spouse/domestic partner, and/or dependent child(ren) to lose their right to obtain COBRA Continuation Coverage or will cause the coverage of a dependent child with a disability to end when it otherwise might continue. For information regarding other notices that must be furnished to the Plan, see *Qualifying Events*.

Qualified Medical Child Support Orders (QMCSO) or National Medical Support Notice (NMSN)

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

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

- Name of the issuing authority.
- Name and mailing address (if any) of an individual who is eligible for coverage as a primary participant under the Plan, whether they are enrolled or in declined coverage status.
- Name and mailing address of one or more alternate recipients (i.e., the child or children of the participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the alternate recipient(s)); and
- Identity of an underlying child support order.

According to federal law, a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) is a child support order of a court or state administrative agency that:

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

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

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

1. Notify the issuing authority with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
   a. Whether the child is covered under the Plan; and
   b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and

2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

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

If the employee is a Plan participant, the QMCSO/NMSN may require the Plan to provide coverage for the employee's dependent child(ren). If the employee is covered by a medical plan option that will not cover the dependent child(ren) specified in the QMCSO/NMSN (for example, the child lives outside a Premier Plan or HMO coverage area), the participant will be enrolled in the base plan option that allows compliance with the QMCSO/NMSN. Coverage under the new medical plan option begins on the first day of the month following receipt of the QMCSO/NMSN in the PEBP office and may not be reverted until the next open enrollment period.

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

Coverage of the dependent child(ren) named in the QMCSO/NMSN will be subject to all terms and provisions of the Plan, including limits on selection of provider and requirements for authorization of services, as permitted by applicable law. No coverage will be provided for any dependent child under a QMCSO/NMSN unless the employee (as applicable) and dependent contributions are paid, and all the Plan's requirements for coverage of that dependent child have been satisfied. Coverage of a dependent child under a QMCSO/NMSN will terminate when coverage of the employee-parent terminates for any reason, including failure to pay any required contributions, subject to the dependent child's right to elect COBRA continuation coverage if that right applies. Refer to the *COBRA section* for information on the dependent's right to elect COBRA, if applicable.

If the dependent listed on the QMCSO/NMSN is covered under another PEBP Plan participant, the dependent will be dropped from the non-QMCSO/NMSN participant's Plan and added to the QMCSO/NMSN participant's Plan.

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

Any dispute over terms of a QMCSO/NMSN must be appealed directly to the issuing child support enforcement agency.

Restoration of Benefits by a Hearing Officer

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

1. If health care coverage was provided to the employee and their eligible dependents under the CDHP, LD PPO Plan or Premier Plan coverage will be restored retroactively to the date specified by the hearing officer. Any retroactive health insurance subsidy due from the agency will be paid to PEBP. Any retroactive health insurance premiums due from the employee will be paid by the employee to PEBP within 60 days of the hearing officer's decision. The amount due to PEBP will be determined by PEBP.
   a. Restoration of coverage will comply with NRS 287, NAC 287 and this Master Plan Document.
   b. Upon restoration of coverage, PEBP will notify its third-party administrator, pharmacy benefits manager, life insurance vendor and any other applicable vendors of the restoration of coverage.
   c. If the employee and/or their eligible covered dependents incurred medical, dental, vision or prescription drug expenses, PEBP will assist the employee with obtaining reimbursement for the eligible health care expenses.

2. If health care coverage was provided to the employee and their eligible dependents under the PEBP-sponsored Health Maintenance Organization (HMO), coverage will be restored retroactive to a date not to exceed six (6) months prior to PEBP's receipt of the notice from the hearing officer. Any retroactive health insurance subsidy amounts due to PEBP by the employee's agency will be paid to PEBP by the agency. Any retroactive health insurance premiums due to PEBP by the employee will be paid by the employee to PEBP within 60 days of the hearing officer's decision. The amount due to PEBP will be determined by PEBP.
3. If an employee chooses not to proceed with a retroactive effective date for health insurance coverage, coverage shall be reinstated on the first day of the month following the hearing officer's decision.
4. Coverage will be restored to the same coverage that was in place before the suspension of benefits. If a new Plan Year intervenes, the employee will be allowed to indicate the desired coverage retroactive to the beginning of the new Plan Year.
5. Any premiums associated with voluntary insurance products are the employee's responsibility.

PEBP and Medicare

Premium Free Medicare Part A

Retirees and their covered dependents who are eligible for premium free Medicare Part A are required to enroll in premium free Medicare Part A coverage.

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

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

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

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

Premium Free Medicare Part A Enrollment Timeframe

Retirees and/or their covered dependents who are eligible for premium free Medicare Part A are required to enroll in Part A coverage three months prior to their 65th birthday.

Disabled retirees and/or their covered dependents who are eligible for Social Security disability insurance must enroll in premium free Medicare Part A and purchase Medicare Part B coverage.

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

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

If you are not eligible for Premium Free Medicare Part A

If you are not eligible for premium free Medicare Part A, PEBP will require a copy of the Medicare benefit verification letter, sometimes referred to as a Medicare Award letter from Social Security. The letter will indicate that you are not eligible for premium free Medicare Part A. Retirees who are not eligible for premium free Medicare Part A may remain on the PEBP CDHP, LD PPO, Premier Plan or HMO Plan.

You must submit a copy of the Medicare benefit verification letter/Medicare Award letter to the PEBP office as follows:

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

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

Medicare Part B

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

If you are a retiring active employee (or a dependent of a retiring active employee) eligible for Medicare, you will be required to purchase Medicare Part B.

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

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

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

- For birthdays occurring on the first day of the month, the Part B card must be received no later than the last day of the month the individual turns 65 years of age.
- For birthdays NOT occurring on the first day of the month, the Part B card must be received no later than the last day of the month, following the 65th birthday month.
- For retirees and covered dependents under age 65 who become eligible for Medicare due to a disability, proof of Medicare Part B enrollment must be received within 60 days of the Medicare Part A effective date.
- For newly retiring employees, the Part B card must be received within 60 days of the retirement coverage effective date.

- Disabled retirees and/or their covered dependents who are entitled to Social Security disability benefits must enroll in premium-free Medicare Part A and purchase Medicare Part B coverage and submit a copy within 60 days of Medicare effective date.

NOTE: Failure to provide proof of Medicare Part B coverage (through submission of a copy of the Medicare Part B card) will result in termination of coverage.

Retirees eligible for premium free Medicare Part A are required to purchase Medicare Part B and enroll in a medical plan and maintain medical coverage through the Medicare Exchange to receive a years of service Health Reimbursement Arrangement (HRA) contribution (if applicable).
Exceptions:

- Retirees who are eligible for premium-free Medicare Part A and who have purchased Medicare Part B coverage and who cover a non-Medicare dependent(s) may enroll in the:
  - PEBP CDHP, LD PPO, Premier Plan or HMO Plan with the non-Medicare dependent(s) until all covered dependents become Medicare eligible.

- Retirees who permanently reside outside the United States may remain on the PEBP CDHP or LD PPO Plan.

Medicare Retirees Covered through the Medicare Exchange

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

Contributions to a retiree's Health Reimbursement Arrangement through the Medicare Exchange will become effective concurrent with the retiree's medical plan effective date through the Medicare Exchange.

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

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

Retirees who experience a break in medical coverage or who terminate medical coverage through the PEBP-sponsored Medicare Exchange will also terminate the years of service HRA contribution, PEBP dental coverage, basic life insurance, and voluntary life insurance (if applicable). See the *Retiree Late Enrollment* section for re-enrollment rights.

Retirees that fail to pay dental premiums will not be subject to forfeiture of PEBP benefits.

Medicare Retirees Not Eligible for Premium Free Medicare Part A

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

A retiree/survivor covered under the PEBP CDHP, LD PPO, Premier Plan, or HMO that experiences a qualifying event that changes their eligibility status to participant only, must enroll in a medical plan through the Medicare Exchange.

Medicare Part B Premium Credit

Retirees who are covered under the PEBP CDHP, LD PPO, Premier Plan, or HMO Plan and who have Medicare Part B will receive a premium credit in an amount determined by PEBP. Dependents are not eligible for the Part B premium credit.

The premium credit will apply concurrent with the Medicare Part B effective date or the first of the month concurrent with or following PEBP's receipt of the retiree's Medicare Part B card, whichever is later.

Retiree Years of Service Benefit

Years of Service Eligibility

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

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

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

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

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

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

Years of Service Premium Subsidy

Retired public employees enrolled in the CDHP, LD PPO, Premier Plan, or HMO Plan may qualify for a premium subsidy based on the date of hire, date of retirement, and total years of service credit earned with each Nevada public employee. For more information on retiree years of service premium subsidy, refer to the Retiree Enrollment Guide available at www.pebp.state.nv.us.

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

Retired public employees enrolled in a medical plan through Medicare Exchange may qualify for an HRA contribution based on the date of hire, date of retirement, and total years of service credit earned with each Nevada public employer. For more information on retiree years of service HRA contribution, please refer to the years of service contribution table located on the PEBP website at www.pebp.state.nv.us.

Health Reimbursement Arrangement for Retirees Covered Through the Medicare Exchange

The Medicare Exchange HRA accounts are employee-owned accounts established on behalf of eligible retirees covered in a medical plan through the Medicare Exchange.

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

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

Medicare Exchange HRA Contribution Eligibility

To receive the PEBP HRA contribution, an eligible retiree must enroll in and maintain coverage in an individual medical insurance policy through the PEBP sponsored individual market Medicare exchange. If the eligible retiree does not enroll and maintain medical coverage as described above, the eligible retiree will NOT receive the PEBP HRA contribution amount and will lose their PEBP sponsored benefits entirely. For re-enrollment eligibility and information, please see the *Retiree Late Enrollment* section for re-enrollment rights.

NOTE: This policy does not apply to eligible retirees or their (PEBP retired) spouses/domestic partners who have health coverage under TRICARE for Life and Medicare. These individuals must submit a copy of their military ID card(s) to PEBP. PEBP will coordinate their enrollment with the HRA administrator.

Summary of Supporting Eligibility Documents

Dependent Type	Social Security Number	Marriage Certificate	Birth Certificate	Hospital Birth Confirmation	Adoption Decree Signed by a Judge	Certificate of Registered Domestic Partner	Legal Permanent Guardianship signed by a judge	Disabled Dependent Child age 26 Years or Older
Newborn Child	✓		✓	✓				
Child Under Age 26	✓		✓					
Adoption	✓		✓		✓			
Permanent Legal Guardianship (child)	✓		✓				✓	
Stepchild	✓	✓	✓					
Domestic Partner's Child	✓		✓			✓		
Domestic Partner's Adopted Child	✓		✓		✓	✓		
Disabled Child	✓		✓					✓
Disabled Stepchild	✓	✓	✓					✓
Domestic Partner's Disabled Child	✓		✓			✓		✓
Spouse	✓	✓						
Domestic Partner	✓					✓		

- Required supporting documentation must be uploaded into your E-PEBP Portal account within the specified timeframe.
- When adding a dependent, other dependents cannot be dropped for the same qualifying event.
- Enrollment of a newly acquired spouse, domestic partner, and/or dependent child(ren) must occur no later than 60 days after the date of the qualifying event.
- Employees in declined coverage status and who experience a change in number of dependents may opt to enroll in coverage mid-year if adding a newly acquired dependent.
- All foreign documents must be translated to English.

Enrollment and Eligibility Events Quick Reference Table

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
New Hire	Within 15 days after the first day of employment, or no later than the last day of the month in which coverage is scheduled to become effective	Full-time employees are eligible for coverage on the first day of the month concurrent with or following the date of hire	May add eligible dependent(s) in the family unit

Required Supporting Documents

Spouse/domestic partner

- ❑ Social Security number of spouse or domestic partner
- ❑ Copy of the certified marriage certificate or domestic partnership certificate

Dependent child(ren):

- ❑ Social Security number of child(ren)
- ❑ Copy of child(ren)'s certified birth certificate(s)

Child(ren) under legal guardianship to age 19 years:

- ❑ Copy of legal guardianship papers (signed by a judge)
- ❑ Copy of certified birth certificate(s)
- ❑ Social Security number of child(ren)
- ❑ If not the primary insured's child, a copy of the certified marriage certificate or domestic partnership certificate recognized under Nevada law

Stepchild(ren):

- ❑ Copy of certified birth certificate(s)
- ❑ Social Security number of child(ren)
- ❑ A copy of the certified marriage certificate

Enrollment and Eligibility Events Quick Reference Table

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
Newborn Child	Within 60 days of the event date	• Newborn coverage is effective on the date of birth • Coverage for other dependent(s) is effective on the first day of the month concurrent with or following the newborn's date of birth	May add the newborn child and other eligible dependent(s) in the family unit
Required Supporting Documents ❑ Copy of the hospital's birth confirmation for the child (within 60 days of the date of birth) ❑ If not the primary insured's child, a copy of the certified marriage certificate or domestic partnership certificate (within 60 days of the date of birth) ❑ Child's Social Security number (within 120 days of the date of birth) ❑ Copy of child's certified birth certificate (within 120 days of date the date of birth)			
Adoption of a Child or Placement for Adoption of a Child	Within 60 days of the event date	• Coverage effective on the first day of the month in which child is adopted or placed for adoption, whichever date is earlier • Coverage for a child adopted within 60 days of the child's date of birth becomes effective on the date of birth	May add the designated adopted child(ren) and other eligible dependent(s) in the family unit
Required Supporting Documents ❑ Copy of legal adoption papers or placement for adoption (signed by a judge) ❑ Adoption papers (signed by a judge) within 60 days of issuance ❑ Child's Social Security number (within 120 days of the adoption) ❑ A copy of the child's certified birth certificate (within 120 days of the adoption) ❑ If not the primary insured's child, a copy of the certified marriage certificate or domestic partnership certificate recognized under Nevada law			

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
Permanent Guardianship of a Child to Age 19	Within 60 days of the event date	• Coverage effective on the first day of the month concurrent with or following the legal guardianship papers signed by a judge • Coverage is provided only up to age 19 years	May add the child(ren) to age 19 years and other eligible dependent(s) in the family unit
Required Supporting Documents ❑ Copy of legal guardianship papers (signed by a judge) ❑ Child's Social Security number ❑ Copy of certified birth certificate ❑ If not the primary insured's child, a copy of the certified marriage certificate or domestic partnership certificate			
Permanent Guardianship of Unmarried Child Aged 19 to Age 26 Currently Enrolled in a PEBP Plan	Within 60 days of the event date	• Coverage continues to age 26 assuming child continues to meet eligibility requirements as set forth in Legal Guardianship Form • Coverage ends the last day of the month child turns age 19 or last day of the month PEBP determines the child is no longer eligible	Not applicable
Required Supporting Documents ❑ Completion of the Legal Guardianship Certification Form; and ❑ Any required supporting documents listed in the certification			

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
Disabled Child (Age 26 or Older)	Within 31 days of dependent child turning age 26 years	• If already covered under PEBP, coverage will continue • If new to PEBP Plan, coverage becomes effective on the first day of the month concurrent with or following the qualifying event	Not applicable
Required Supporting Documents ❑ Certification of Disabled Dependent Child Form (completed by primary participant and child's physician) ❑ Child's Social Security number ❑ If not the participant's child, copy of the certified marriage certificate or domestic partnership certificate ❑ Verification that the child has had continuous health insurance since the age of 26 years; and proof of support and maintenance through the submission of a copy of the participant's preceding year's income tax returns showing the child is a tax dependent. The Plan will thereafter require proof of the child's continuing incapacity and dependency not more than once a year beginning 2 years after the child attains age 26 per NRS 689B.035.			
Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)	Within 60 days of issuance of QMCSO or Release of QMCSO	• QMCSO: First of the month concurrent with or following the date PEBP receives the QMCSO • Release of QMCSO: Coverage terminates on the last day of the month concurrent with or following the date PEBP receives the Release of QMCSO	• Must add dependent(s) as stated in the QMCSO • May add other eligible dependent(s) in the family unit
Required Supporting Documents ❑ Copy of QMCSO appropriately signed by issuing agency/county			

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
Declination of coverage for an employee, retiree, spouse, or dependent who becomes eligible for and enrolls in Medicare Part A or B	Within 60 days of Medicare effective date	Coverage terminates on the last day of the month preceding the Medicare coverage effective date	Employee/Retiree may decline coverage May delete spouse/domestic partner or dependent who enrolls in Medicare Part A or B.
Required Supporting Documents ❑ Copy of the Medicare card			
Declination of Coverage for employee, retiree spouse, or dependent who becomes eligible for and enrolled in CHIP Medicaid or Nevada Check Up	Within 60 days of Medicaid effective date	PEBP coverage terminates the last day of the month preceding coverage effective under CHIP/Medicaid or Nevada Check Up coverage effective date	Employee, retiree, spouse/domestic partner or dependent may decline coverage due to enrollment in CHIP/Medicaid
Required Supporting Documents ❑ Documentation from Medicaid, CHIP or Nevada Check Up showing that the dependent's eligibility for Medicaid or CHIP was approved and the coverage effective date			
Special enrollment opportunity due to the loss of Medicare Part A, CHIP, Medicaid, or Nevada Check UP (applies to employees and their eligible dependents), does not apply to retirees)	Within 60 days of Medicare Part A, Medicaid, CHIP, or Nevada Check Up termination date	Coverage of employee and/or applicable dependents will become effective on the first day of the month following PEBP's receipt of loss of coverage from Medicaid and/or Nevada Check Up	Eligible employee and/or applicable dependents may enroll for coverage.
Required Supporting Documents ❑ Documentation from Medicaid, CHIP or Nevada Check Up showing that eligibility for Medicaid or CHIP was denied, the date it was denied or that Medicaid, CHIP or Nevada Check Up coverage ended or will end, and a copy of a marriage certificate, domestic partnership certification, or certified birth certificate(s) for each dependent child(ren) being added to the Plan.			

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
Dependent Gains Coverage Spouse/domestic partner or eligible dependent experiences a change of status resulting *in a gain of eligibility and enrolls in* another employer group health plan	Within 60 days of the event date	Coverage terminates on the last day of the month the event occurs	Must delete spouse or domestic partner if coverage is employer based; and may delete any dependent(s) that are being added to the employer group health plan
Required Supporting Documents ❑ Documentation from the spouse's/domestic partner's or dependent's employer or from the other health plan listing the first and last name(s) of the individuals to be deleted from PEBP coverage, including their new plan's coverage effective date.			
Dependent Loses Coverage Spouse/domestic partner or eligible dependents experience a change of status *resulting in a loss* of eligibility from another employer group health plan	Within 60 days of the event date	Coverage effective on the first day of the month concurrent with or following the date of the loss of coverage	May add the spouse or domestic partner and all other eligible dependent(s) in the family unit who experienced a loss of coverage
Required Supporting Documents ❑ Documentation from the spouse/domestic partner or dependent's employer or from the other health plan listing the first and last name(s) of the individuals being added to your plan and the coverage termination date of that other plan. ❑ Social Security number for all dependent(s) being added. ❑ Copy of a certified marriage certificate or domestic partnership certificate recognized under Nevada law. ❑ If adding dependent child(ren), a copy of the child(ren)'s certified birth certificates.			

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
Marriage or the establishment of Domestic Partnership	Enrollment election must be submitted within 60 days of the event date	Coverage effective on the first day of the month following the date of marriage or domestic partnership registration, or the first day of the month following the date the employee notifies the Plan and requests enrollment, whichever is later.	May add spouse or domestic partner and other eligible dependent(s) in the family unit
Required Supporting Documents ❑ Copy of marriage certificate or registered domestic partnership certificate ❑ Social Security Number for spouse or domestic partner and/or covered child(ren) ❑ If adding dependent child(ren), copy of the child(ren)'s certified birth certificates; and a copy of the marriage or domestic partnership registration if not adding the spouse or domestic partner			
Declination of Coverage due to Marriage or Establishment of Domestic Partnership (DP) and enrollment in spouse's/DP's Employer Group Health Plan	Within 60 days of the date of marriage or establishment of domestic partnership	Coverage for the primary participant and any covered dependents will terminate on the last day of the month of marriage or establishment of domestic partnership	Primary participant may decline coverage
Required Supporting Documents ❑ Copy of certified marriage certificate or copy of domestic partnership certificate recognized under Nevada law; and ❑ Documentation from the other employer or group health plan stating the effective date of the new coverage and the first and last name(s) of the newly covered individual(s).			

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
Employer of Spouse/ Domestic Partner Offers an Open Enrollment Period	Within 60 days of the event date	• If deleting dependent child(ren) from the other employer's group health plan and enrolling them in PEBP coverage, the effective date is the first day of the month concurrent with or following the coverage end date • If declining PEBP coverage, the coverage terminates on the last day of the month prior to the month the other coverage becomes effective	• Participant and any covered dependents may decline PEBP coverage to newly enroll in the other employer's coverage; or • Participant and eligible dependent in declined status with PEBP may re-enroll in PEBP coverage if the other employer coverage is terminated
Required Supporting Documents ❑ Proof of open enrollment from the employer ❑ Documentation from the other employer or group health plan stating the effective date of the new coverage and the first and last name(s) of the newly covered individual(s)			
Medicare Part B Premium Credit (Retirees covered under the CDHP, LD PPO, Premier plan, or HMO plan only.)	No later than the end of the month in which your Medicare Part B is effective	The Part B premium credit will apply concurrent with the Medicare Part B effective date or the first day of the month concurrent with or following PEBP's receipt of the retiree's Medicare Part B card, whichever is later.	Premium credit will only apply to primary retirees covered under the CDHP, LD PPO, Premier plan, or HMO plan
Required Supporting Documents ❑ Copy of Medicare Part B card; or ❑ Copy of the Medicare Part B award letter			

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
Initial Retirement Coverage for Eligible Retiring Employees	Within 60 days of the employee's date of retirement	Retiree coverage is effective on the first day of the month concurrent with or following the date of retirement	• May add dependent(s) • May select a new health plan option If retiree is eligible for free Medicare Part A, must purchase Part B, and may be required to enroll for coverage through the Medicare Exchange as shown in the *Initial Enrollment Section*
Required Supporting Documents ❑ Enrollment election completed via paper form. ❑ Years of Service Certificate Form ❑ If age 65 or older, copy of Medicare Parts A and/or B card ❑ If age 65 or older and ineligible for premium-free Medicare Part A, a copy of the Medicare Benefits Verification Letter and a copy of the Medicare B card.			
Retiree/ Dependent or Survivor's entitlement to Medicare Parts A and/or B	End of the month following the date the individual becomes eligible for Medicare	Coverage under Medicare Exchange becomes effective within 60 days of Medicare effective date or retirement date, whichever is later	• Must enroll in a Medicare Exchange plan if retiree and all covered dependents (if any) are eligible for free Part A; otherwise, coverage is terminated • If one family member is not eligible for free Part A, the family may remain on the CDHP, LD PPO, Premier Plan, or HMO, or the individual with Part A may choose coverage through the Medicare Exchange

Required Supporting Documents

- ❑ Copy of Medicare Parts A and B card, if eligible for free Part A, or
- ❑ Copay of Part B card (if ineligible for free Medicare Part A); and a copy of the Medicare Benefit Verification Letter from the Social Security Administration (SSA); or
- ❑ If covered under Tricare for Life, a copy of the military ID card and a copy of the Medicare A and B card
- ❑ Enrollment election completed via online/paper form (only if Medicare entitlement includes Parts A and B and participant is changing health plans to the Medicare Exchange).

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
Divorce, Annulment or Termination of Domestic Partnership*	Within 60 days of the event date	• Coverage terminates on the last day of the month in which divorce decree is signed by the judge or termination of domestic partnership is received • If the divorce decree/ termination of domestic partnership is received more than 60 days after the divorce, coverage ends at the end of the month of receipt of the divorce decree/termination of domestic partnership	Must delete ex-spouse or ex-domestic partner and all other ineligible dependent(s)

Required Supporting Documents

- ❑ Copy of the divorce/annulment decree signed by the judge (all pages)
- ❑ Copy of the termination of domestic partnership filed with appropriate issuing agency

***Late Notification of Divorce, Annulment or Termination of Domestic Partnership**
Adjustments in premium resulting from a divorce, annulment or termination of domestic partnership will be refunded if notification of event is received within 60 days of the date of event. Notification of event beyond the 60-day period will not be refunded.

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
PEBP's Open Enrollment Period	Typically, May 1- May 31 of each year	Coverage effective date is July 1 immediately following open enrollment period	May add or delete dependents, change plan options, or decline coverage
Required Supporting Documents ❑ If adding a dependent, refer to the Summary of Supporting Eligibility Documents provided in this document ❑ Required supporting documents are due by June 15			
Primary Participant Moves Outside the Premier Plan or HMO Plan Coverage Area	Within 30 days after moving outside Premier Plan or HMO coverage area	Coverage under the CDHP, LD PPO, Premier Plan, or HMO plan will begin on the first day of the month concurrent with or following the date PEBP is notified of the address change	Participants who move outside a Premier Plan or HMO coverage area must select another coverage option. Note: Moving outside the Premier Plan or HMO coverage area is not a qualifying event to add or delete dependents
❑ Call PEBP to update address; or ❑ Send a secure message through your E-PEBP portal			
Termination of Retiree Benefits	Upon request from participant	Written request by the retiree to decline all PEBP benefits	Coverage terminates for retiree and any covered dependents on the last day of the month request is received
Required Supporting Documents ❑ Must provide a written request to decline PEBP benefits.			

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
Survivor's Coverage Surviving dependent must covered on as dependent on the primary participant's plan on the date of death	Within 60 days of the primary participant's date of death	Coverage for eligible survivor(s) is effective on the first day of the month following the primary participant's date of death	May qualify for survivor's coverage if the dependent meets the survivor's eligibility requirements as shown in the *Initial Enrollment Section*
Required Supporting Documents ❑ Copy of certified death certificate ❑ Submission of a completed Retiree Benefit Enrollment and Change Form.			
Participant Death*	Within 60 days of the event date	• Participant coverage terminates on the date of death; and • Coverage for any covered dependent terminates on the last day of the month concurrent with the participant's date of death	Covered dependents may qualify for re-enrollment in survivor's coverage if he/she meets the eligibility requirements as stated in this document
Dependent Death*	Within 60 days of the event date	Coverage for the deceased dependent terminates on the date of death	Must delete the deceased dependent from coverage and any ineligible dependent(s) (e.g. children of domestic partner or stepchildren)
Required Supporting Documents ❑ Copy of certified death certificate ***Late Notification of Death** Adjustments in premiums resulting from the death of a covered participant or dependent will be refunded if notification of death is received within 60 days of the participant's or dependent's date of death. Notification of death beyond the 60-day period will not be refunded.			

Enrollment and Eligibility Events Quick Reference Tables

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
Survivor of Police/ Firefighter killed in the line of Duty	Within 60 days of the police officer's or firefighter's date of death	Coverage for eligible survivor(s) is effective on the first of the month following the police officer's or firefighter's date of death	May qualify for survivor's coverage if the dependent meets the survivor's eligibility requirements as stated in this document
Required Supporting Documents ❑ Submission of a completed Retiree Benefit Enrollment and Change Form (RBECF). ❑ Copy of death certificate. ❑ SSN and copy of the certified marriage certificate			
Settlement Agreement	Within 60 days of Settlement Agreement	• Retroactive to date established by the hearing officer decision, but not more than 12 months under the CDHP, LD PPO, or Premier Plan; or not more than 6 months prior to PEBP's receipt of the hearing officer's decision for the HMO; or • The first month after the decision is received by PEBP if the employee chooses not to pay back premiums	• Employee may re-enroll in coverage; or • Decline coverage
Required Supporting Documents ❑ Copy of hearing officer's decision.			

Qualifying Events

Dependent Loses Other Employer Group Health Care Coverage

An eligible spouse, domestic partner or dependent that ceases to be covered by another employer group health plan may be added to the participant's coverage if enrollment and proof of loss of coverage is provided within 60 days after the termination of coverage under that other employer group health insurance policy or plan if that other coverage terminated because:

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

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

Gain of Other Employer Group Health Care Coverage

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

PEBP must be notified within 60 days of the effective date of the spouse's or domestic partner's coverage under the spouse's or domestic partner's employer group health plan. Notification after 60 days will result in coverage terminating at the end of the month PEBP receives proof of the other employer's coverage. Premium refunds will not be given for late notification.

If a dependent child gains coverage through their employer, the dependent child can be removed from coverage by the participant or the child can remain on the PEBP Plan. The order of benefit determination rules is described in the Coordination of Benefits section in the PEBP Premier Plan,

Low Deductible PPO or Consumer Driven Health Plan for Medical, Vision and Prescription Drug Benefits Master Plan Document or the HMO Evidence of Coverage Certificate to establish which plan is the primary plan (pays first) and which is secondary (pays second).

Open Enrollment for Employer of Spouse or Domestic Partner

If the employer of an eligible spouse or domestic partner offers an open enrollment period for their employees, the primary participant and any covered dependents may opt to accept the other employer's coverage and decline PEBP coverage during the spouse's/domestic partner's open enrollment period. This option only applies when the participant's coverage is new under the spouse's/domestic partner's plan.

The participant will be required to submit an enrollment election along with proof of the open enrollment period, effective date of coverage, including the names of covered dependents within 60 days of the new coverage effective date.

Change of Residence

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

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

Declining Active Employee Coverage

An employee may decline coverage at initial enrollment, during PEBP's open enrollment, during the spouse's/domestic partner's open enrollment period or marriage (see *open enrollment for employer of spouse or domestic partner* section). An employee will not receive a financial incentive or compensation when in declined coverage status and will not be eligible for basic life and long-term disability insurance or any voluntary products.

Declining Retiree or Survivor's Coverage

Retirees and survivors may decline coverage at any time during the year. Coverage will terminate on the last day of the month PEBP receives the written request to decline coverage. Declining

coverage will terminate medical, dental, vision, prescription drug coverage, basic life insurance, voluntary life insurance, years of service premium subsidy and HRA contribution (if applicable). See the *Retiree Late Enrollment* section for re-enrollment rights.

Declining Unsubsidized Dependent Coverage

Unsubsidized dependents enrolled in a PEBP-sponsored medical plan may decline coverage at any time during the year. Coverage will terminate on the last day of the month PEBP receives the written request to decline coverage.

Significantly Inferior Coverage

If PEBP determines the coverage available to the spouse/domestic partner by their employer meets the definition of "Significantly Inferior Coverage", the spouse/domestic partner is required to decline such coverage from their employer prior to being enrolled as a dependent on the participant's PEBP plan.

The PEBP Board has defined significantly inferior coverage as either:

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

In order for PEBP to make the determination to allow a spouse/domestic partner with "Significantly Inferior Coverage" to enroll as a dependent in the PEBP Plan, an official summary of the coverage details from spouse/domestic partner's employer outlining the health insurance coverage plans available to their employees must be provided to PEBP.

If your spouse/domestic partner cannot decline coverage from their employer until the open enrollment period, the decline of coverage at that time will be considered a qualifying event to add the spouse/domestic partner to the participant's PEBP Plan.

Leaves of Absence

Family and Medical Leave Act (FMLA)

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

During FMLA leave, the employer must maintain the employee's health coverage under any employer group health plan on the same terms as if the employee had continued to work, regardless of whether the employee is on paid or unpaid leave. Upon return from FMLA leave, most

employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

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

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

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

Any changes in the Plan's terms, rules or practices that went into effect while an employee is away on leave will apply to the employee and any dependents in the same way they apply to all other employees and their dependents. Employees should contact their agency representative to find out more about their entitlement to family or medical leave as required by federal and/or state law, and the terms on which it may be entitled.

Leave Without Pay (LWOP)

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

An employee who is on approved LWOP may pay the full cost of premiums for their coverage and insurance to PEBP. An employee on LWOP is not eligible for coverage as a dependent of another PEBP covered participant (spouse/domestic partner, child, etc.).

At the initial start of leave, it is the employee's responsibility to inform PEBP of their coverage preference while on leave. If the employee fails to inform PEBP of his or her coverage preference while on leave, PEBP will continue the same medical plan and coverage tier that the employee had

in effect prior to taking that leave. When the employee returns from leave, their coverage will revert to their original plan selection prior to going on leave.

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

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

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

Worker's Compensation Leave

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

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

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**COLORADO** **Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 1-800-359-1991 State Relay 711
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.myflfamilies.com/service-programs/access/medicaid.shtml Phone: 1-850-300-4323
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext. 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**

Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com/ Phone 1-800-403-0864
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Website: http://dhs.iowa.gov/Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB

under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.
OMB Control Number 1210-0137 (expires 1/31/2023)

Payment for Coverage

Most eligible State employees are provided a subsidy toward the cost of plan coverage. To obtain information about subsidy amounts, service calculations, and premium information, please visit the PEBP website (www.pebp.state.nv.us) or call Member Services (775-684-7000 or 1-800-326-5496). Employees on leave without pay, dependents, legislators and survivors are not eligible for a subsidy. The option of electing additional voluntary products at cost may be available to an employee or retiree.

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

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

Premiums for CDHP, LD PPO Plan, HMO or Premier Plan coverage are automatically deducted from the participant's paycheck or pension. Each monthly premium applies to coverage for that same month. In the following circumstances, premiums shall be paid directly to PEBP monthly:

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

If COBRA coverage is terminated due to non-payment, that individual will not be able to re-enroll in the Plan under COBRA. If employee coverage is terminated due to non-payment, that employee will not be able to re-enroll in the Plan until the next open enrollment or until the employee returns from leave and the account has been paid in full. If coverage of a retiree, survivor or unsubsidized dependent is terminated for non-payment that individual will not be able to re-enroll in the Plan until the next open enrollment period (if eligible) and until the account is paid in full.

Participants will be billed via premium invoice and will be required to pay the following directly to PEBP:

- Contributions resulting from retroactive coverage changes; or
- Claims incurred by the participant or their dependents who access the Plan during a period when they are ineligible for coverage.

Premium overpayments due to lack of proper notification by the participant will not be refunded. Participants who fail to pay their premiums or ineligible claims may be reported to the State Controller's office or to a private collection agency for collection of past due amounts. Collection costs may also be assessed to the participant.

PERS Deduction for the Medicare Exchange Plan

Federal rules for the Medicare Exchange require the individual to pay medical insurance premiums directly to the carrier. PEBP will not take automatic deductions from retirement distributions to pay for coverage provided through the Medicare Exchange except dental coverage provided by PEBP if the retiree elects to enroll in the PEBP Self-funded PPO dental plan.

Late Notification of Death

Adjustments in premiums resulting from the death of a covered participant or dependent will be refunded if notification of death is received within 60 days of the participant's or dependent's date of death. Notification of death beyond the 60-day period will not be refunded.

Billing Errors

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

Termination for Non-Payment

Payment for the current month's coverage is due on the 20th of each month. Acceptance and deposit of a payment does not in itself guarantee coverage. If the participant fails to meet eligibility and enrollment requirements, coverage may be terminated, and the payment refunded to the participant.

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

Non-payment of dental premiums will not require a retiree to forfeit their PEBP benefits.

Change to Years of Service Re-Audit Results for Retirees

Years of service premium subsidy and years of service Exchange HRA contribution are effective upon the date of retirement, based on the audit from either the Public Employees' Retirement System (PERS) or the Nevada System of Higher Education (NSHE). Changes to the years of service premium subsidy and years of service Exchange HRA contribution resulting from a future audit will occur on the first (1st) day of the month concurrent with or following the date PEBP receives the audit results from the PERS or NSHE. (NAC 287.485)

COBRA Continuation of Medical Coverage Notice

You are getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* aren't required to pay] for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies.
- Your spouse's hours of employment are reduced.
- Your spouse's employment ends for any reason other than his or her gross misconduct.
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies.
- The parent-employee's hours of employment are reduced.
- The parent-employee's employment ends for any reason other than his or her gross misconduct.
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both).
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the Plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment.
- Death of the employee.
- Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Public Employees' Benefits Program,
901 South Stewart Street, Suite 1001
Carson City, NV 89701

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

Maximum Period of COBRA Continuation Coverage

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

Who is entitled to COBRA continuation coverage (the qualified beneficiary), when (the qualifying event), and for how long is shown in the following chart:

Qualifying Event Causing Health Care Coverage to End	**Duration of COBRA for Qualified Beneficiaries**		
	Employee	**Spouse or Domestic Partner**	**Dependent Child(ren)**
Employee terminated (for other than gross misconduct).	18 months	18 months	18 months

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Employee reduction in hours worked (making Employee ineligible for the same coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee or retiree becomes divorced.	N/A	36 months	36 months
Employee becomes entitled to Medicare.	N/A	36 months	36 months
Dependent child ceases to have dependent status.	N/A	N/A	36 months
Retiree coverage is terminated or substantially eliminated within one year before or after PEBP files for bankruptcy reorganization under Chapter 11 of the federal Bankruptcy Act.	Life	Life plus 36 months after death of retiree	Life plus 36 months after death of retiree

When Cobra Continuation Coverage May be Cut Short

The Plan may terminate continuation coverage earlier than the end of the maximum period for any of the following reasons:

- Premiums are not paid in full on a timely basis.
- The employer ceases to maintain any group health plan.
- A qualified beneficiary begins coverage under another group health plan after electing continuation coverage.
- A qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage; or
- A qualified beneficiary engages in fraud or other conduct that would justify terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage.

If continuation coverage is terminated early, the plan must provide the qualified beneficiary with an early termination notice. If you decide to terminate your COBRA coverage early, you generally will not be able to enroll in a Marketplace plan outside of the open enrollment period.

If you have questions

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Subrogation and Third-Party 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). 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.

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: 1-800-458-0701 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 • 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** 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
Aetna Signature Network Customer Service: (800) 336-0123 Contact HealthSCOPE Benefits: (888) 763-8232 www.pebp.state.nv.us	• Network Providers • Provider directory • Additions/deletions of Providers
Diversified Dental Services PO Box 36100 Las Vegas, NV 89133-6100 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
Express Scripts Pharmacy Benefit Administrator Customer Service and Prior Authorization (855) 889-7708 www.Express-Scripts.com **Express Scripts Home Delivery/Accredo Specialty Drug Services** PO Box 66566 St. Louis, MO 63166-6566 Customer Service: (855) 889-7708 **Express-Scripts Benefit Coverage Review Department** PO Box 66587, St. Louis, MO 63166-6587 Phone: 800-946-3979 Administrative Coverage Review and Appeals **SavonSP** 1-800-683-1074	Pharmacy Benefit Manager • Prior authorization, Formulary, forms, online ordering, Customer service, Price a Medication tool • Home delivery, Mail Order forms • Preferred Mail Order for diabetic supplies **Express-Scripts Clinical Appeals Department** PO Box 66588 St. Louis, MO 63166-6588 Phone: 800-753-2851 Fax: 877-852-4070 **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

Participant Contact Guide	
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	Medicare Exchange offering Medicare Supplemental or replacement medical coverage for retirees and covered dependents with Medicare Parts A and B
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 • 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/Programs/CHA/Contact_GovCHA/*	• Concerns and problems related to coverage • Provider billing issues • External review requests
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 *https://www.nvsos.gov/sos/online-services/nevada-lockbox*	**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.

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

Business Day: Refers to all weekdays, except Saturday or Sunday, or a State or Federal holiday.

Child(ren): See the definition of dependent child(ren).

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

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

Coordination of Benefits (COB): The rules and procedures applicable to the determination of how plan benefits are payable when a person is covered by two or more health care plans. (See also the Coordination of Benefits section of the Consumer Driven Health Plan, Low Deductible PPO Plan, Premier Plan (EPO) Master Plan Documents, or the HMO or Premier Plan Evidence of Coverage Certificate).

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

- An eligible participant only.
- An eligible participant and eligible spouse.
- An eligible participant and eligible dependent child(ren).
- An eligible participant, their eligible spouse, and their eligible child(ren).
- An eligible participant and eligible domestic partner.
- An eligible participant and eligible domestic partner's child(ren); or
- An eligible participant, their eligible domestic partner, and their eligible child(ren).

Covered Individual: Any employee or retiree (as those terms are defined in this Plan), and that person's eligible spouse/domestic partner or dependent child who has completed all required formalities for enrollment for coverage under the Plan and is covered by the Plan.

Dependent: Any of the following individuals: dependent child(ren), spouse or domestic partner as those terms are defined in this document.

Dependent Child(ren): For the purposes of this Plan, a dependent child is any of your children under the age of 26 years, including:

- natural child,
- child(ren) of a domestic partner,
- stepchild,
- legally adopted child or child placed in anticipation for adoption (the term placed for adoption means the assumption and retention by the employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child and the child must be available for adoption and the legal adoption process must have commenced),
- child who qualifies for benefits under a QMCSO/NMSN (see the *Eligibility* section for details on QMCSO/NMSN),
- any other person who:
  (1) Bears a relationship described in 26 U.S.C. § 152(c)(2) to the participant or his or her spouse or domestic partner.
  (2) Is unmarried.
  (3) Has not attained the age set forth in 45 C.F.R. § 147.120(a).
  (4) Either resides with the participant or is enrolled in a program of secondary education or an independently accredited program of postsecondary education, including, without limitation, a college, university, community or junior college, graduate school or accredited trade or business school, on a full-time basis
  (5) Satisfies one of the following conditions:
  (I) Is currently under a permanent legal guardianship of the participant or his or her spouse or domestic partner pursuant to chapter 159 of NRS; or
  (II) Was eligible to be claimed as a dependent on the federal income tax return of the participant or his or her spouse or domestic partner for the immediately preceding calendar year; and
  (6) Is in a relationship with the participant or his or her spouse or domestic partner that is like a child-parent relationship. The participant or his or her spouse or domestic partner must complete and submit to the Program an affidavit attesting to the fact of the relationship.

Dependent Coverage Ends: Coverage of a dependent child ends at the end of the month:

- The child reaches his or her 26th birthday.
- The active employee or retiree coverage ends.
- The spouse, domestic partner, or dependent child(ren) no longer meet the definition of spouse, domestic partner, or dependent child(ren) as provided in the Definitions section of this document.
- Premium payment was last received (see Termination for Non-Payment);
- The plan is discontinued

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

Domestic Partner/Domestic Partnership: As defined by NRS 122A.030. The Plan will require the participant to provide a copy of the domestic partner certification from the Nevada Secretary

of State. Participants who have a legal union or domestic partnership validly formed in another jurisdiction which is substantially equivalent to a domestic partnership in Nevada, are not required to file with, or provide a certification from the Nevada Secretary of State. The participant must also provide a statement acknowledging the participant's responsibility for any federal income tax consequences resulting from the enrollment of the domestic partner in the Plan. A domestic partner is not eligible for coverage as a dependent after termination of the domestic partnership.

Eligible Dependent: Your spouse/domestic partner and your dependent child(ren). An eligible dependent may be enrolled for coverage under the Plan by following the procedures required by the Plan.

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

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

Employer Group Health Plan: Any employer who sponsors a health plan for their active employees.

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

Family Unit: The covered employee or retiree and the family members who are covered as dependents under the covered employee's or retiree's plan.

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

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

Health Reimbursement Arrangement: A Health Reimbursement Arrangement (HRA) is an employee-funded spending account that can be used to pay qualified medical expenses. The HRA is 100% funded by the employer. The terms of these arrangements can provide first dollar medical coverage until the funds are exhausted or insurance coverage kicks in. The contribution amount per employee is set by the employer, and the employer determines what the funds can be used to

cover and if the dollars can be rolled over to the next year. In most cases, if the employee leaves the employer, they can't take remaining HRA funds with them.

Health Care Provider: A health care practitioner, hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility.

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

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 for certain employees and dependents who experience a loss of other employer group coverage and when there is an adoption, placement for adoption, birth, marriage or a domestic partnership certification from the office of the Nevada Secretary of State or a domestic partnership validly formed in another jurisdiction which is substantially equivalent in Nevada.

Ineligible Dependents: Individuals living in the covered employee or retiree's home but who are not eligible as defined above are not eligible dependents under this Plan.

Medicare: The health insurance for the aged and disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

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

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

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

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

Open Enrollment Period: The period during which participants in the Plan may select among the alternate health benefit programs that are offered by the Plan or eligible individuals not currently enrolled in the Plan may enroll for coverage. The Plan's open enrollment period is described in the *Eligibility* section of this document.

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

Placed for Adoption: For the definition of placed for adoption as it relates to coverage of adopted dependent children, see the definition in the section on adopted dependent children in the *Eligibility* section.

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

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

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

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

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

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

Provider: See the definition of Health Care Provider.

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

Rescission: A cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage has only a prospective effect, or the cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay premium or costs of coverage.

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

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

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

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

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

Unsubsidized Dependent of a Retiree: An unsubsidized dependent is defined as the eligible spouse/domestic partner and/or eligible dependent(s) of a retiree who remains covered under the Consumer Driven Health Plan (CDHP), Low Deductible PPO (LD PPO), HMO Plan or Premier Plan (EPO) while the primary participant transitions coverage to the Medicare Exchange.

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.