NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Access.
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MEDICARE EXCHANGE
HEALTH REIMBURSEMENT ARRANGEMENT
SUMMARY PLAN DESCRIPTION
Plan Year 2022
(Effective July 1, 2021 – June 30, 2022)

Public Employees' Benefits Program

Administered By:

VIA BENEFITS™
formerly OneExchange™
from Towers Watson

10975 S. Sterling View Dr. Suite 1A
South Jordan, UT 84095
1-888-598-7545
https://my.viabenefits.com/pebp

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Carson City, Nevada 89701
(775) 684-7000 (800) 326-5496
www.pebp.state.nv.us

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Amendment Log

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

Medicare Exchange Health Reimbursement Arrangement Plan

Plan Information

Name of Plan (The Plan):	Public Employees' Benefits Program Medicare Exchange Health Reimbursement Arrangement (HRA)
Plan Sponsor:	State of Nevada Public Employees' Benefits Program (PEBP)
Plan Administrator:	State of Nevada Public Employees' Benefits Program (PEBP)
Address:	901 South Stewart Street, Suite 1001 Carson City, NV 89701
E-mail Address:	Contact member services by logging on to your E-PEBP member portal accessed by clicking on the orange log in icon at www.pebp.state.nv.us.
Telephone Number:	(775) 684-7000 or (800) 326-5496
Tax Identification Number:	88-0378065

Plan Information

Third-Party Administrator:	Via Benefits formally Towers Watson's One Exchange
Address:	10975 Sterling View Drive, Suite A1 South Jordan, UT 84095
Telephone Number:	(888) 598-7545
Website Address:	https://my.viabenefits.com/PEBP

Third-Party Administrator for the HRA:

	Via Benefits Reimbursement Accounts Administered by Extend Health, LLC.
Claims Address:	P.O. Box 891155 El Paso, TX 79998-1155
Telephone Number:	(888) 598-7545 (TTY: 711)
Claims Fax Number:	(855) 321-2604

Plan Number:	Medicare Exchange HRA
Plan Year:	Plan Year 2022; effective July 1, 2021 – June 30, 2022
Plan Origination:	July 1, 2011

Introduction

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

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

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

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

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

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

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

It is important to stay informed of the most up to date information regarding your health care benefits. It is your responsibility to know and follow the requirements as described in PEBP's Master Plan Documents.

Medicare Exchange Health Reimbursement Arrangement Plan (HRA)

Purpose of the Medicare Exchange HRA

The HRA or reimbursement account is initially set up on behalf of Eligible Retirees. The HRA is funded based on an amount determined by the Plan Administrator. Eligible Retirees receive a monthly allocation to their individual HRA based upon the monthly funding amount set by the Plan Administrator, the retiree's years of service, and retirement date. The HRA can be used by Eligible Retirees to request reimbursement of HRA-Qualified Medical Expenses incurred by the retiree, retiree's spouse, or the retiree's IRS-qualified tax dependent(s).

The HRA is established on behalf of Eligible Retirees coincident with their coverage effective date in an individual health insurance policy (Medicare Plan) through Via Benefits; or on behalf of Eligible Retirees with Tricare for Life and Medicare Parts A and B. The HRA is funded solely by the Plan Administrator. Reimbursement payments from the Medicare Exchange HRA are not includible in the retiree's gross income and are not taxable to the retiree.

Medicare Exchange HRA Eligibility

Eligible Retiree

To qualify for the Medicare Exchange HRA, an Eligible Retiree must meet the following requirements:

1. Enroll in Medicare Parts A and B coverage under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code, and;
2. Enroll in an individual health insurance policy (Medicare Plan) through Via Benefits[1]; and
3. Retain coverage in an individual health insurance policy (Medicare Plan) through Via Benefits; or
4. Enroll in TRICARE for Life, Medicare Parts A and B, and submit copies of the Tricare for Life and Medicare Parts A and B cards to the Plan Administrator; and
5. Complete any enrollment form (which may be electronic) or any enrollment procedures as specified by the Plan Administrator.

Termination of the Medicare Exchange HRA

Participation in the Medicare Exchange HRA plan will end:

1. On the date the Eligible Retiree ceases to be an Eligible Retiree for any reason, including but not limited to:

[1] Any eligible retiree who does not enroll in and maintain an individual health insurance policy through the Via Benefits WILL LOSE their PEBP sponsored benefits (i.e. Medicare Exchange HRA funding, life insurance, dental insurance, etc.)

a. Enrollment in the CDHP, LD PPO, Premier Plan or Health Plan of Nevada (HMO) coverage, if eligible;
b. Enrollment in other employer group coverage that may preclude enrollment in an individual Medicare plan through Via Benefits;
c. Upon obtaining employment as an active employee of the State of Nevada or a participating local government;
d. Ineligibility or declination Medicare Parts A and/or B coverage under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code;
e. Failure to pay for Medicare Part B coverage resulting in termination of Medicare Part B coverage;
f. Any change to a retiree's Medicare Supplement (Medigap), Medicare Advantage Plan, Medicare Advantage Plan with Prescription Drug Plan, etc., resulting in the removal of Via Benefits as the Agent of Record. For example, if a retiree knowingly or unknowingly enrolls in a medical plan directly with an insurance carrier which results in a change of Via Benefits as the Agent of Record. **Important!** To avoid the loss of HRA funding and other PEBP-sponsored benefits, retirees should always contact Via Benefits for assistance regarding questions related to their Medicare plans. This includes questions about plan options, including changing plans if moving to another city, state or county, premiums, etc.;
g. Due to the death of the Eligible Retiree.

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

Loss of Coverage

When coverage through Via Benefits is terminated by the Eligible Retiree, PEBP, the insurance carrier (due to the Eligible Retiree's death, non-payment of premiums or Via Benefits is no longer the "Agent of Record", the retiree shall receive no further Medicare Exchange HRA funding, and;

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

B. the Eligible Retiree may submit claims for reimbursement for HRA-Qualified Medical

Expenses incurred prior to his or her loss of coverage (e.g. break in coverage, loss of eligibility, etc.), provided the Eligible Retiree files such claims within one hundred eighty (180) days of loss of coverage. This means, when an Eligible Retiree's coverage is terminated, he or she will have one hundred eighty days (6 months) from the date coverage ends to file a claim for reimbursement for qualified medical expenses incurred during the eligible coverage period.

COBRA

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event to elect coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). If a proceeding in bankruptcy is filed with respect to the State of Nevada PEBP 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.

Funding

Medicare Exchange HRA Plan Funding

The benefits described in this document are provided by the Plan Administrator out of its assets, and no assets shall be segregated or earmarked for the purpose of providing benefits, nor shall any person have any right, title or claim to such assets prior to the submission and acceptance of a claim for eligible medical expenses. As such, each Medicare Exchange HRA is established pursuant to the Medicare Exchange HRA Plan as a notional account which reflects a bookkeeping concept and does not represent assets that are set aside for the exclusive purpose of providing reimbursement of qualified expenses to the Eligible Retiree under the terms of the Medicare Exchange HRA Plan. In no event may any benefits under the Medicare Exchange HRA Plan be funded with retiree contributions.

Benefit Credits

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

Medicare Exchange HRA Carryover Limit

HRA balances in excess of $8,000 will be capped annually on May 31st. This means HRA funds may accumulate throughout the year; however, on May 31st of each year, any HRA balance which exceeds $8,000 will be returned to the Plan and will not be available for reimbursement. Once funding for balances over $8,000 are removed from the HRA they cannot be reinstated, even by means of an appeal. To avoid having HRA funds returned to the Plan, retirees are

encouraged to use their HRA dollars to request reimbursement for monthly insurance premiums such as Medicare Supplement (Medigap), Medicare Advantage, Part D prescription drug plans, Medicare Part B, dental, and vision plans. HRA funds may also be used for eligible out of pocket expenses such as copays, deductibles, and other qualifying out of pocket healthcare expenses. Timely claim submission is also recommended as retirees have one year from when the expense is incurred to have it submitted and processed for reimbursement. Claims submitted and processed for reimbursement more than one year after the incurrence date will automatically be denied.

HRA-Qualified Medical Expenses

Eligible Expenses

The Medicare Exchange HRA Plan is administered by Via Benefits for the purpose of reimbursing Eligible Retirees for HRA-Qualified Medical Expenses incurred by the retiree, the retiree's spouse, and eligible dependent(s) on a tax-free basis. IRS Tax Code 213(d) determines reimbursable expenses. View IRS Publication 502 (https://www.irs.gov/pub/irs-pdf/p502.pdf), Medical and Dental Expenses for detailed information and descriptions of qualified medical expenses.

Examples of HRA-Qualifying Medical Expenses:

- Premiums for Medicare Parts A, B and D coverage,
  Premiums for Medicare Plan coverage purchased through Via Benefits,
- Excess Medicare Part B charges,
- Premiums for medical, dental and vision care plans, which are not paid on a pre-tax basis through a Code section 125 plan ("cafeteria" plan),
- Premiums for coverage under a long-term care plan,
- Deductibles for Medicare Parts A and B, medical, dental and vision care plans,
- Co-payments under Medicare, Medicare Plans, medical, dental and vision care plans,
- Out-of-pocket expenses for prescription drug copayments,
- Charges in excess of reasonable and customary charges as determined under medical, dental and vision care plans,
- Hearing exams and hearing aids,
- Acupuncture fees, and, but not limited to
- Eye exams, prescription eyeglasses and contact lenses.
- Certain Over-the-Counter products in accordance with the CARES Act, passed by Congress on March 27, 2020, repealed a rule from the 2010 Affordable Care Act that disallowed tax-free reimbursement of over-the-counter drugs or medicines (collectively "OTC") without a prescription. With this change, HRAs can cover certain OTC products without prescriptions. Eligible OTC includes any drugs or medications that are primarily for treatment (not cosmetic or for general health), menstrual care products such as tampons, pads, liners, etc., and medical devices and supplies.

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

Amount of Reimbursement

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

Summary of Reimbursement Options and Requirements

Timely Filing of HRA reimbursement claims

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

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

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

Automatic Premium Reimbursement (APR) - Via Benefits Participating Plans

Automatic Premium Reimbursement (APR) is a service offered by Via Benefits that enables retirees to be reimbursed for their monthly insurance plan premiums without manually submitting a reimbursement request. Automatic Premium Reimbursement is available for most, but not all Via Benefits' plans. With Automatic Premium Reimbursement, the retiree pays their premium to the insurance carrier (Automatic Premium Reimbursement does not pay the premium). Once the premium has been paid, the insurance carrier transmits an electronic receipt for the payment to Via Benefits and Via Benefits reimburses the retiree for their premium, up to the available balance in the retiree's HRA. To find out which insurance carriers offer Automatic Premium Reimbursement, login to the Via Benefits portal or contact Via Benefits.

If Automatic Premium Reimbursement is not available, retirees may be able to use Recurring Premium Reimbursement.

Recurring Premium Reimbursement Request

The Recurring Premium Reimbursement Request is available for plans that do not offer automatic reimbursement. Submit the Recurring Premium Reimbursement Request only for recurring plan premiums that are scheduled and reoccur on a monthly basis. The Recurring Premium Reimbursement Request must be submitted once each calendar year to be reimbursed monthly. The request can be made online using the Via Benefits portal or by completing the *Recurring Reimbursement Claim Form*. You must also submit a copy of your annual policy statement or coupon book that is sent to you by your insurance carrier which shows your premium for the year and includes the following information.

- Name of insured
- Name of insurance company (e.g., AARP)
- Type of coverage (e.g., medical, dental)
- Date of coverage (e.g., 1/01/2018 thru 12/31/2018)
- Monthly premium amount (e.g., $125)

Medicare Part B Reimbursement

You can be reimbursed for your Medicare Part B premium by submitting the *Recurring Medicare Part B Reimbursement Request Form*. The recurring reimbursement request must be submitted once each calendar year to be reimbursed monthly. The request may be submitted online by logging into the Via Benefits portal or by using the *Recurring Medicare Part B Reimbursement Request Form*. In addition to the Recurring Medicare Part B Reimbursement Request, you must also submit a copy of your *Social Security Benefit Award Letter (Proof of Income Letter).* You can request a copy of this letter by the contacting Social Security Administration (SSA) at 1-800-772-1213 (TTY: 1-800-325-0778) or online at SSA.gov and searching for "*Request a Proof of Income Letter".* If you are not collecting Social Security, you can submit a copy of the quarterly coupon for Part B in place of the Awards Letter.

Prescription and/or Office Visit Copayments

Non-premium related expenses such as prescription and office visit copays may be reimbursed by submitting a Standard Reimbursement Request. This request can be made by logging into the Via Benefits portal or by using the *Standard Reimbursement Request Form*. You will need to include a receipt or third-party document that includes the following information:

- Provider name,
- Participant name,
- Date of service,
- Description of service or product, and
- Proof you paid for the service, or
- An Explanation of Benefits (EOB) from your insurance company which includes all the above information.

Expenses incurred in a foreign country

Qualified expenses incurred in a foreign country may be eligible for reimbursement. If the supporting documentation is in a foreign language, the five required elements (provider name, participant name, date of service, description of service or product, and proof of payment for the service) must be translated into English. The amount of the expense must be converted from the foreign currency to U.S. dollars using a current currency exchange rate.

Via Benefits will reimburse the Eligible Retiree for expenses that it determines are eligible expenses up to the balance in the retiree's HRA at such intervals as PEBP may deem appropriate (but not less frequently than monthly). Via Benefits reserves the right to verify that all claimed health care expenses satisfy the IRS 213D definition of Qualifying Medical Expenses prior to reimbursement.

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

Expenses eligible for coverage under any medical, HMO, dental, or vision care plans in which the Eligible Retiree or his or her eligible dependent(s) are enrolled must be submitted first to all appropriate claims administrators for such plans before submitting the expenses to the Third- Party Administrator for reimbursement under the HRA. An Eligible Retiree who is entitled to payment or reimbursement under a health care reimbursement account in a cafeteria plan under IRS Code Section 125 must receive his or her maximum annual reimbursement under the health care reimbursement account in the cafeteria plan before he or she is entitled to any reimbursement under this HRA.

Claim Review Timing

Claims will be paid in the order in which they are received by Via Benefits and will be charged to the HRA account of the eligible retiree who submits the claim. PEBP may establish such other rules as it deems desirable regarding the frequency of reimbursement of expenses, the minimum dollar amount that may be requested for reimbursement and the maximum amount available for reimbursement during any single month.

Via Benefits shall review received claims and respond within thirty (30) days of receipt. If the Via Benefits determines that an extension is necessary due to
matters beyond the control of the HRA, Via Benefits will notify the claimant within the initial thirty (30) day period that they will need up to an additional fifteen (15) days to review the claim. If such an extension is necessary because the claimant failed to provide the information necessary to evaluate the claim, the notice of extension will describe the information that the claimant will need to provide to Via Benefits. In accordance with NAC 287.610, all claims must be submitted

to Via Benefits within one year (12 months) from the date the service(s) were incurred. No HRA reimbursements/benefits will be paid for any claim submitted after this period.

Via Benefits Medicare HRA Claim Appeal Process

Notice of Claim Denial

Via Benefits will notify every claimant who is denied a claim for benefits (in whole or in part) the following in written or electronic notice:

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

Requests for appeal must be made in writing to the office where the claim was originally submitted or online at https://my.viabenefits.com/pebp within 180 days after receipt of the notice of denial. A participant or their designee cannot circumvent the claims and appeals procedures by initiating a cause of action against PEBP (or State of Nevada) in a court proceeding.

The appeal process works as follows:

Level 1 Appeal

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

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

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

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

Level 2 Appeal

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

To file a Level 2 claim appeal, PEBP encourages you to complete a claim appeal request form. To obtain a claim appeal request form, contact PEBP customer services or refer to the PEBP website. Your Level 2 appeal must include a copy of:

1. the Level 1 review request;
2. a copy of the decision made on review; and
3. any other documentation provided to the HRA Third-Party Administrator by the participant.

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

Definition of Terms

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

Agent of Record: An Agent of Record is a company or individual who has the legal authority to represent the insured in maintaining, servicing, and purchasing an insurance policy.

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

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

Death: Dependents shall NOT continue to receive benefit credits after the month of the eligible retiree's death.

Eligible Dependent[2]: A dependent who is:

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

Eligible Expenses: Eligible expenses that do not exceed the balance in your HRA can be reimbursed from your HRA if the expenses are incurred during the time you participate in the HRA. Expenses are eligible only to the extent that they are not paid for by your health care coverage. Eligible expenses are the costs associated with the diagnosis, cure, mitigation, treatment, or prevention of disease, and the costs for treatments affecting any part or function of the body. See also *Qualifying Medical Expenses*.

Eligible Retiree[2]: An eligible retiree is a retiree who:

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

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

HRA Contribution: Also referred to as a "benefit credit" is the amount of money determined by your years of service and retirement date that is deposited to your HRA account on a schedule determined by the Plan Administrator. Retired public employees enrolled in a medical plan through the Via Benefits may qualify for an HRA contribution based on the date of hire, date of

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

retirement, and total years of service credit earned with each Nevada public employer.

A. The following monthly amount will be credited on behalf of eligible retirees:
    1) For Eligible Retirees who retired prior to January 1, 1994, the dollar amount is equal to the base amount as determined by the Legislature during each legislative session. For detailed information regarding contribution amounts refer to the Plan Year 2021 Benefits Guide located on the PEBP website at www.pebp.state.nv.us or contact PEBP at 775-684-7000 or 800-326-5496 to request the Plan Year 2021 Benefits Guide.
    2) For Eligible Retirees who retired on or after January 1, 1994, the dollar amount is equal to the base amount as determined by the Legislature during each legislative session multiplied by the years of service credit (calculated pursuant to NAC 287.485) up to a maximum of 20 years of service. For detailed information regarding contribution amounts refer to PEBP's Master Plan Document located on the PEBP website at www.pebp.state.nv.us.
B. No amount will be credited for certain retirees who do not meet the requirements to receive a years of service Medicare Exchange HRA Plan contribution (pursuant to NRS 287.046).

HRA Contribution Eligibility: To receive the PEBP HRA contribution, an Eligible Retiree must enroll in an individual Medigap, Medicare Advantage with Prescription Drug or Medicare Advantage Plan and maintain individual Medicare Plan coverage through the Via Benefits. If the Eligible Retiree does not enroll and maintain medical coverage as described above, the Eligible Retiree will NOT receive the PEBP HRA contribution amount and will lose their PEBP sponsored benefits entirely including but not limited to life insurance and dental insurance.

Effective July 1, 2015, the policy described under "HRA Contribution Eligibility" does not apply to Eligible Retirees or their spouses who have health coverage under TRICARE for Life and Medicare Parts A and B. To receive the PEBP HRA contribution, these individuals must submit a copy of their Military ID card(s) and Medicare Parts A and B card to PEBP.

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

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

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

Medicare Exchange HRA: The HRA is provided to Eligible Retirees enrolled in a Medicare Plan through Via Benefits and Eligible Retirees who have Tricare for Life and Medicare Parts A and B.

The HRA Plan is an excepted benefit and not subject to the Patient Protection Affordable Care Act (PPACA) group market reforms.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Third-Party Administrator: Via Benefits; also referred to as the contracted Third-Party Administrator.

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

Years of Service: Years of service as calculated pursuant to NAC 287.485 and maintained in the eligibility records of PEBP. Retired public employees enrolled in a medical plan through Via

Benefits may qualify for an HRA contribution based on the date of hire, date of retirement, and total years of service credit earned with each Nevada public employer.