MEDICARE EXCHANGE
HEALTH REIMBURSEMENT ARRANGEMENT
SUMMARY PLAN DESCRIPTION

Plan Year 2025

(Effective July 1, 2024 – June 30, 2025)

Administered By:

VIA BENEFITS™

formerly OneExchange™ from Towers Watson

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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.

Updated for PY 2025:

- Incorporated key definitions into the body of the document.
- Removed key definitions that were not found in the body of the document.
- Consolidated duplicative language.

Plan Information:

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.
Plan Administrator:	State of Nevada Public Employee's Benefits Program (PEBP) 3427 Goni Road, Suite 109 Carson City, NV 89706 (775) 684-7000, (702) 486-3100, or (800) 326-5496
Tax Identification Number:	88-0378065
Third-Party Administrator:	Via Benefits formally Towers Watson's One Exchange 10975 Sterling View Drive, Suite A1 South Jordan, UT 84095 (888) 598-7545 https://my.viabenefits.com/PEBP

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 their 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.

The 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 Administrator.

Refer to the PEBP website for additional information regarding dental insurance, life insurance, PEBP enrollment and eligibility provisions, HIPAA[1] Privacy and Security, and Mandatory Notices. This information is located at www.pebp.state.nv.us.

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

[1] 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.

Medicare Exchange Health Reimbursement Arrangement Plan (HRA)

The HRA is provided to Eligible Retirees enrolled in a Medicare Plan through Via Benefits or who have Tricare for Life, and Medicare Parts A and B[2]. For those that are not eligible for Medicare Part A, they remain on a PEBP sponsored health plan. The HRA Plan is an accepted benefit and not subject to the Patient Protection Affordable Care Act (PPACA) requirements.

A 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).

A HRA is established on behalf of Eligible Retirees in conjunction 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.

A HRA or reimbursement account is initially set up on behalf of Eligible Retirees. To qualify for the Medicare Exchange HRA, an Eligible Retiree must meet the following requirements:

- Enroll in Medicare Parts A and B coverage under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code, and
- Enroll in an individual health insurance policy (Medicare Plan) through Via Benefits; and
- Retain coverage in an individual health insurance policy (Medicare Plan) through Via Benefits; or
- 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
- Complete any enrollment form (which may be electronic) or any enrollment procedures as specified by the Plan Administrator.

NOTES:

1) *Eligible Retirees who are not eligible for Medicare Part A; you must still enroll in Medicare Part B.*
2) *Any eligible retiree who does not enroll in and maintain an individual health insurance policy through Via Benefits WILL LOSE their PEBP sponsored benefits (i.e., Medicare Exchange HRA funding, life insurance, dental insurance, etc.*
3) *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*

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

contribution, these individuals must submit a copy of their Military ID card(s) and Medicare Parts A and B card to PEBP.

Eligible retirees may cover eligible dependents who are a spouse or other dependent of an eligible retiree as defined in PEBP's Eligibility and Enrollment Master Plan Document. 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.

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:
   a. Obtaining employment as an active employee of the State of Nevada or a participating local government;
   b. Enrollment in other employer group coverage that may preclude enrollment in an individual Medicare plan through Via Benefits;
   c. Ineligibility or declination Medicare Parts A and/or B coverage under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code;
   d. Failure to pay for Medicare Part B coverage resulting in termination of Medicare Part B coverage;
   e. 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.; or
   f. Death.

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 an approved Medicare Exchange HRA Plan.

4. On the date an Eligible Dependent 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.

Once the Medicare Exchange HRA plan ends, the Eligible Retiree shall receive no further Medicare Exchange HRA funding.

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

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.

Also referred to as a "benefit credit[3]" is the amount of money determined by your years of service [4] 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 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.

The benefit credit will be credited to Medicare Exchange HRA accounts on the first business day of each calendar month as determined by PEBP.

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 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 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.

No amount will be credited for certain retirees who do not meet the requirements to receive a

[3] The amount credited to an eligible retiree's Medicare Exchange HRA accounts for the provision of benefits under the Medicare Exchange HRA.

[4] 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.

years of service Medicare Exchange HRA Plan contribution (pursuant to NRS 287.046).

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** is 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 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 include, but are not limited to:

- 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.

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

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.

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 Patient Protection and Affordable Care Act (PPACA) requirements.

Reimbursement of HRA-Qualified Medical Expenses

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 their HRA account. If an expense exceeds the unused amount in their HRA account, the expense will be carried over to the next month or until there are sufficient funds to reimburse the expense.

The Eligible Retiree may submit claims for reimbursement for HRA-Qualified Medical Expenses within one year (12 months) from the date the service(s) was incurred pursuant to NAC 287.610. This also means, when an Eligible Retiree's coverage ends, they will have one year (12 months) from the date the service(s) was incurred to file a claim for reimbursement for qualified medical expenses incurred during the eligible coverage period. No HRA reimbursements will be paid for any claim submitted after one year (12 months) from the date the service(s).

Any retiree who enrolls in PEBP's PPO Dental Plan will automatically be reimbursed their 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 over to the next month or until there are sufficient funds to reimburse the expense.

Refer to Via Benefits for the following:

- Automatic Premium Reimbursement
- Recuring Premium Reimbursement
- Medicare Part B Reimbursement
- Prescription and/or Office Visit Copayments Reimbursement
- Reimbursement for expenses incurred in a foreign country

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 reimbursement requests and respond within thirty (30) days of receipt. If 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.

Via Benefits Medicare HRA Claim Appeal Process

Via Benefits will notify every claimant who is denied a claim for benefits (in whole or in part) in writing to include:

- 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.

There are two levels of appeal which must be completed in order. A level 1 appeal must be made directly to Via Benefits. Requests for appeal must be made in writing 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 a level 1 appeal must include:

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

Via Benefits will review your claim. If any additional information is needed to process your request for appeal, it will be requested promptly.

Via Benefits will provide you with a decision in writing within twenty (20) days after receiving 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 on 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.

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 a level 2 appeal request in writing to the Quality Control Officer of PEBP or their 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.

You are welcome to submit Level 2 Claim Appeals online through a form that can be found under the subheading "Filing an Appeal" under PEBP's contact us web page. Your Level 2 appeal must include a copy of:

- the Level 1 review request;
- a copy of the decision made on review; and
- 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 Quality Control Officer or their designee. If the appeal decision 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. An exception to Plan rules must be approved by the Executive Officer of PEBP pursuant to NAC 287.680. **A Level 2 appeal decision is final.**

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.