RETIREE
HEALTH REIMBURSEMENT ARRANGEMENT
SUMMARY PLAN DESCRIPTION
Plan Year 2026

(Effective July 1, 2025 – June 30, 2026)

Public Employees' Benefits Program
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.

Introduction

The Public Employees' Benefits Program (PEBP) contracts with a vendor, Via Benefits, to operate a Medicare Exchange and administer a health reimbursement arrangement ("HRA") for eligible retirees. PEBP is the HRA sponsor, i.e. Plan Administrator, and Via Benefits is the Third-Party Administrator.

Medicare is federal health insurance for anyone age 65 and older, and some people under 65 with certain disabilities or conditions as outlined in Subchapter XVIII of Chapter 7 of Title 42 of the United States Code[1] (Medicare Parts A and B).

A Medicare exchange is a marketplace where retirees can purchase supplemental Medicare insurance or other health benefits, typically using funds contributed by their employer. These exchanges can be online platforms or physical locations where individuals can compare different plans and choose the coverage that best suits their needs. The types of supplemental insurance or other health benefits include:

- 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.

A Health Reimbursement Arrangement (HRA) is an employer-funded account that helps employees cover qualified medical expenses, including those not covered by their health plan. It's essentially a benefit that employers offer to reimburse employees for eligible medical costs, such as premiums, copays, deductibles, and other healthcare expenses.

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 exceptional benefit and not subject to the Patient Protection Affordable Care Act (PPACA) group market reforms. The HRA is funded solely by the Plan Administrator. Each eligible retiree has an HRA account to hold their HRA Contribution, which will be discussed in this document. Reimbursement payments from the HRA are not includible in the retiree's gross income and are not taxable to the retiree.

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

The HRA is funded based on an amount determined by PEBP. Eligible retirees receive a monthly allocation to their individual HRA based upon a calculation involving:

- the monthly funding amount set by PEBP,
- the retiree's years of service, as calculated pursuant to NAC 287.485 and maintained in the eligibility records of PEBP, and
- and the retiree's retirement date.

This document outlines the specific criteria retirees must meet to be eligible for the HRA and how the HRA can be used. The Plan sponsor and its designee(s) will have discretionary authority to determine the applicability of and interpret the provisions within this document.

Note: References to "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, which is Via Benefits.

Health Reimbursement Arrangement (HRA) Eligibility

To qualify for the HRA, an eligible retiree must:

1. Enroll in Medicare Parts A and B coverage under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code;
2. Enroll in an individual Medigap, Medicare Advantage with Prescription Drug or Medicare Advantage Plan and maintain individual Medicare Plan coverage through Via Benefits. [2], or has TRICARE for Life; and
3. Complete any enrollment form (which may be electronic) or any enrollment procedures as specified by the Plan Administrator.

Note: If the eligible retiree does not enroll and maintain medical coverage as described in #2 above, the eligible retiree will NOT receive the 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 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.

A retiree is **an eligible retiree** if they have:

1. five or more years of service credit,
2. are eligible for retiree coverage based on date of hire,
3. their last employer is a participating PEBP entity, and
4. they are receiving retirement distributions from at least one of the following:
    - Public Employees Retirement System (PERS)
    - Legislators Retirement System (LRS)
    - Judges Retirement System (JRS)
    - Nevada System of Higher Education Retirement Plan Alternative (RPA).

The date of hire determines if a retiree qualifies for an HRA.

1. Hired prior to January 1, 2010: may participate and may quality for an HRA
2. Hired between January 1, 2010, and December 31, 2011: must have at least 15 YOS to qualify for an HRA.
3. Hired on or after January 1, 2012: does not qualify for an HRA.

[2] 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 retiree ceases to be an eligible retiree for any of the reasons indicated below:

1. Enrollment in the CDHP, LD PPO, Premier Plan, or Health Plan of Nevada (HMO) coverage, if eligible;
2. Enrollment in other employer group coverage that may preclude enrollment in an individual Medicare plan through Via Benefits;
3. Upon obtaining employment as an active employee of the State of Nevada or a participating local government;
4. Ineligibility or declination Medicare Parts A and/or B coverage under Subchapter XVIII of Chapter 7 of Title 42 of the United States Code;
5. Failure to pay for Medicare Part B coverage resulting in termination of Medicare Part B coverage;
6. 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.;
7. Due to the death of the Eligible Retiree.

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:

1. death of the eligible dependent;
2. divorce from the Eligible Retiree;
3. if the dependent is otherwise no longer considered a dependent pursuant to IRS Code 152; or
4. the cessation of participation of the Eligible Retiree.

Loss of Coverage

When coverage through Via Benefits is terminated 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 HRA funding.

1. Any expenses incurred after the loss of coverage date will not be reimbursed even if there are remaining funds in the retiree's HRA account.
2. Claims may be submitted for reimbursement for expenses incurred prior to the loss of coverage. Claims must be submitted within 12 months from the date coverage

ends to file a claim for reimbursement for qualified medical expenses incurred during the eligible coverage period.

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. For questions, please contact PEBP.

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 HRA

The HRA is 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 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 HRA Plan be funded with retiree contributions.

HRA Contribution

The Plan Administrator will credit each eligible retiree's HRA account through an HRA Contribution. An HRA Contribution, also referred to as a "benefit credit" is the amount of money determined by an eligible retiree's years of service and retirement date that is deposited to their HRA account on a schedule determined by the Plan Administrator. In essence, the amount of funds deposited into an HRA account is based on the eligible retiree's date of hire, date of retirement, and total years of service. 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.

Note: 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 Account Limit

HRA balances more than $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, it 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.

Eligible Expenses

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.

Eligible expenses that do not exceed the balance in of an eligible retiree's HRA account can be reimbursed if the expenses are incurred while the retiree is eligible. Expenses are eligible only to the extent that they are not paid for by 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 and 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.

- 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.

- Durable medical equipment
- Chiropractic services
- 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.

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

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.

Requesting 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.

Eligible retirees may request reimbursement for eligible dependents. Eligible dependents are a spouse or other dependent of an eligible retiree as defined in Internal Revenue Code (IRC) Section 152 (26 USC § 152.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.

Note: Eligible retirees must submit proof of the relationship with an eligible dependent they are requesting reimbursement for. Dependents **shall NOT** continue to receive benefit credits after the month of the eligible retiree's death.

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.

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.

Reimbursement Options and Requirements

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, the VIA Benefits Mobile App, or by completing the *Reimbursement Request Form*. Eligible retirees must also submit a copy of their annual policy statement or coupon book sent by their insurance carrier with the premiums for the year and include 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., 1/01/2025 thru 12/31/2025)
- Monthly premium amount (e.g., $125)

Medicare Part B Reimbursement

Medicare Part B premiums may be reimbursed without having to submit a *Reimbursement Request Form* or supporting documentation if the eligible retiree is enrolled in a "core Medicare Medical plan with Via Benefits. To activate this reimbursement type, the retiree can call Via Benefits or access their Mobil App account. It's important to note the following:

- Eligible retirees who have a Medicare Part B Premium that is greater or less than the standard premium amount, a claim form and supporting documentation is required.
- Eligible retirees who have a Tricare exception to qualify for the HRA, this reimbursement option is not available, and requests must be submitted manually.

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 *Reimbursement Request Form*.

In addition to the Reimbursement Request Form, eligible retirees must submit a copy of their *Social Security Benefit Award Letter (Proof of Income Letter).* A copy of this letter may be obtain by 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".* For those who are not collecting Social Security, they can submit a copy of the monthly or quarterly Medicare Premium Bill 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 *Reimbursement Request Form*. This request can be made by logging into the Via Benefits portal or by using the *Reimbursement Request Form*. A recipient must be included with the *Reimbursement Request Form.* The receipt should have the following:

- Provider name,
- Participant name,
- Date of service,
- Description of service or product, and
- Proof of payment, or
- An Explanation of Benefits (EOB) from the 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, eligible retirees certify that the information provided on the *Reimbursement Request Form* is correct and complete. Eligible retirees certify that the expenses were incurred for the an eligible retiree or an eligible dependent 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.

Via Benefits HRA Claim Appeal Process

Via Benefits will notify every claimant who is denied a claim for benefits (in whole or in part) the following written or electronic notice, referred to as an explanation of payment (EOP):

- 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.

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 court proceedings.

The appeal process works as follows:

Level 1 Appeal

If a HRA claim is denied, or the amount paid on a claim is thought to be incorrect, a Level 1 appeal may be filed, in writing, within 180 days of the date of receipt of the explanation of payment (EOP). Failure to request a Level 1 appeal within 180 days will be deemed as a waiver of any further rights to appeal. The Plan Administrator may override this timeframe on a case-by-case basis. 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 of why the claim is being appealed.

Eligible retirees may review applicable documents regarding the denial to prepare an appeal. Via Benefits will review appeals in the order they are received. If any additional information is needed to for Via Benefits to make a determination, it will be requested promptly.

Appeal decisions will be provided in writing within twenty (20) days of receipt of the request for appeal. Appeal denials will provide an explanation of the decision and include references to the applicable HRA provisions that support the denial. It will also explain the steps to file a Level 2 appeal if necessary.

Level 2 Appeal

Eligible retirees may file a Level 2 appeal if they are not satisfied with the Level 1 appeal decision. A Level 2 appeal must be submitted, in writing, to the Executive Officer of PEBP or his designee within 35 days of receipt of the Level 1 decision.

To file a Level 2 claim appeal, contact PEBP customer services or refer to the PEBP website. A Level 2 appeal must include a copy of:

- the Level 1 review request;
- the Level 1 decision; and
- any other documentation pertinent to the Level 2 appeal.

Appeal decisions will be provided, in writing. within 30 days of receipt of the Level 2 appeal. 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.