



**State of Nevada
Public Employees' Benefits Program**

**Master Plan Document for the
PEBP Consumer Driven Health Plan
for Medical, Prescription Drug, Wellness and Vision benefits
PEBP Self-Funded Dental PPO Plan
Summary of Benefits for
Health Savings Account, Health Reimbursement Account, Life Insurance and Long-Term
Disability Insurance**

**Plan Year 2014
July 1, 2013 – June 30, 2014**

www.pebp.state.nv.us

(775) 684-7000

Or

(800) 326-5496

Any amendments, changes or updates to this document will be listed here in the Amendment Log. The amendment log will include what sections are amended and where the changes can be found in the PEBP Master Plan Document.

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

As a PEBP participant, you may access whichever benefit plan (Consumer Driven Health Plan or HMO) is offered in your geographical area that best meets your needs, subject to specific eligibility and plan requirements. You are also encouraged to research plan provider access and quality of care in your service area.

The Consumer Driven Health Plan is a self-funded medical plan that is eligible for use with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA). All PEBP participants choosing the Consumer Driven Health Plan should examine this document to become more knowledgeable about their health benefits. PEBP participants who choose an HMO option should examine the eligibility, dental, life and Long Term Disability (LTD) sections. If you choose an HMO option, you should review their respective Evidence of Coverage documents available on the PEBP website at www.pebp.state.nv.us.

The Master Plan Document is a comprehensive description of the benefits available to you. Relevant statutes and regulations are noted throughout this document for reference. In addition, helpful material is available from PEBP or any PEBP vendor listed in the Participant Contact Guide.

PEBP encourages you to stay informed of the most up to date information regarding your health care benefits. It is your responsibility to know and follow the requirements as described in this Master Plan Document (MPD).

Sincerely,

Public Employees' Benefits Program

NOTE: Headings, font and style do not modify plan provisions. The headings of sections and subsections and text appearing in bold or CAPITAL LETTERS and font and size of sections, paragraphs and subparagraphs are included for the sole purpose of generally identifying the subject for the convenience of the reader. The headings are not part of the substantive text of any provision, and they should not be construed to modify the text of any substantive provision in any way.

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Introduction

This Master Plan Document describes the consumer driven health plan (also referred to as the CDHP, the self-funded CDHP or the self-funded PPO CDHP) for medical and dental benefits for employees and certain retirees, and their eligible dependents, participating in the Public Employees' Benefits Program, hereafter referred to as PEBP. Additional benefits are also described in this document.

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

The plan described in this document is effective July 1, 2013, and replaces all other Self-funded PPO medical and dental benefit plan documents/summary plan descriptions previously provided to you. This document will help you understand and use the benefits provided by the Public Employees' Benefits Program (PEBP). You should review it and also show it to members of your family who are or will be covered by the plan. It will give you an understanding of the coverage provided, the procedures to follow in submitting claims, and your responsibilities to provide necessary information to the plan. Be sure to read the Exclusions and Definitions sections. **Remember, not every expense you incur for health care is covered by the plan.**

All provisions of this document contain important information. If you have any questions about your coverage or your obligations under the terms of the plan, be sure to seek help or information. A Plan Contacts section will guide you to sources of help or information about the plan benefits.

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

This plan is not established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. The self-funded portions of this plan are funded with contributions from participating employers and eligible plan participants, held in an internal service fund. An independent Claims Administrator pays benefits out of the fund's assets.

- The **benefits offered** are the self-funded consumer driven health plan, prescription drug plan and the self-funded PPO dental plan, as described in this document. An independent Claims Administrator pays the claims for medical and dental benefits. An independent Claims Administrator pays the claims for prescription drug benefits. The self-funded consumer driven health plan also provides Health Savings Accounts (HSA) and Health Reimbursement Arrangement (HRA) benefits.

- The **fully insured benefits offered** include the HMO options (whose benefits are not described here but are discussed in documents provided to you by those HMO insurance companies), Life Insurance, and Long Term Disability (LTD) Insurance as described in this document. **For more information about the fully insured benefits, contact PEBP or visit the PEBP website.**

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 eligibility and benefits. We encourage you to pay particular attention to the following:

- **Review the Table of Contents.** The **Table of Contents** provides you with an outline of the sections.
- **Become familiar with PEBP vendors** and the services they provide by reviewing the **Plan Contacts section**.
- Review the **Participant Rights and Responsibilities section** located in the introduction section of this document.
- The **Definitions** section explains many technical, medical and legal terms that appear in the text.
- **Review the Medical Expense, Schedule of Medical Benefits and Medical Exclusions sections.** These describe your benefits in more detail. There are examples, charts and tables to help clarify key provisions and details of the Plan benefits.
- **Read the Preventive/Wellness section** to see the variety of preventive services covered under the Plan to help you proactively manage your personal health.
- **Refer to the General Provisions and Notices section** for information regarding your rights and general provisions of the Plan.
- **Refer to the Claims Information section** to find out what you must do to file a claim, and how to seek a review (appeal) if you are dissatisfied with a claims decision.
- **The COBRA section** discusses your options if coverage ends for you, a covered Spouse/domestic partner or Dependent Child.

The section on Coordination of Benefits discusses situations where you have coverage under more than one health care plan including Medicare. This section also provides you with information regarding how the plan subrogates with a third party who wrongfully caused an injury or illness to you.

IMPORTANT NOTICE

Certain documents (or certified copies) such as a marriage certificate, birth certificate, divorce decree, etc., will be necessary for enrollment in this plan, or if you change coverage.

Failure to promptly notify the Plan Administrator of any qualifying event within the designated period may cause you or your dependents to lose certain rights under the plan.

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.
- Voice complaints 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 and dental care.
 - Understand the prevention/wellness benefits offered by the Plan.
 - Visit your health care provider(s) as recommended.
- Choose in-network participating provider(s) to provide your medical and dental 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 in order 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 of the Plan's guidelines, provisions, policies and procedures.
- Inform PEBP if you experience any life changes such as a name change, change of address or changes to your coverage status because of marriage, divorce, domestic partnership, birth of a child(ren) or adoption of a child(ren).
- Provide PEBP with accurate and complete information needed to administer your health benefit plan, including if you or a covered dependent has other health benefit coverage.
- Retain copies of the documents provided to you from PEBP and PEBP's vendors. These documents include but are not limited to:
 - Copies of the Explanation of Benefits (EOB) from PEBP's third party claims administrator. Duplicates of your EOB's may not be available to you. It is important that you store these documents with your other important paperwork.
 - Copies of your enrollment forms submitted to PEBP.
 - Copies of your medical, vision and dental bills.
 - Copies of your HSA contributions, distributions and tax forms.

The Plan is committed to:

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

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Participant Contact Guide

General Contacts:	Service
<p>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</p>	<p>Plan Administrator</p> <ul style="list-style-type: none"> • Enrollment and change of status • Certificate of creditable coverage • COBRA information and premium payments • Level 2 claim appeals • External Review coordination
<p>Office for Consumer Health Assistance 555 E. Washington Avenue, Suite 4800 Las Vegas, NV 89101 Customer Service: (702) 486-3587 or (888) 333-1597 www.govcha.state.nv.us</p>	<p>Consumer Health Assistance</p> <ul style="list-style-type: none"> • Concerns and problems related to coverage • Provider billing issues • External Review information
Consumer Driven Health Plan Medical, Vision and Dental Contacts:	Service
<p>PEBP Statewide PPO Network Administered by Hometown Health Providers and Sierra Health Care Options Customer Service: (800) 336-0123 www.pebp.state.nv.us</p>	<p>In-state PPO Medical Network</p> <ul style="list-style-type: none"> • Network providers • Provider directory • Additions/deletions of providers
<p>National Network Providers First Health Network/HealthSCOPE Benefits P. O. Box 91603 Lubbock, TX 79403-1603 800-226-5116 www.myfirsthealth.com</p>	<p>National Medical Network/Outside of Nevada</p> <ul style="list-style-type: none"> • Network providers • Provider directory (website only) • Additions/deletions of providers <p>The National Medical Network is available to participants who reside outside of Nevada, or who live in Nevada but choose to seek medical treatment out of state.</p>

Consumer Driven Health Plan Medical, Vision and Dental Contacts:	Service
<p>Diversified Dental Services and Principal Financial Group P O Box 36100 Las Vegas, NV 89133-6100 Customer Service: Northern Nevada: (866) 270-8326 Southern Nevada: (800) 249-3538 www.ddsppo.com</p>	<p>Self-funded Dental PPO Network</p> <ul style="list-style-type: none"> • Diversified Dental Services PPO dental providers in Nevada and Principal Preferred Provider Dental network for all other states
<p>HealthSCOPE Benefits Claims Submission: HealthSCOPE Benefits P O Box 91603 Lubbock, TX 79490-1603 Appeal of Claims HealthSCOPE Benefits P O Box 2860 Little Rock, AR 72203 Group Number: NVPEB Customer service: (888) 763-8232 www.healthscopebenefits.com</p>	<p>Claims Administrator/ Third Party Administrator</p> <ul style="list-style-type: none"> • Claim submission • Claim status inquiries • Level 1 claim appeals • Verification of eligibility • Plan benefit information • PPO Plan ID Cards • Health Savings Account (HSA) Administrator • Health Reimbursement Arrangement (HRA) Administrator • ID Cards • National medical PPO provider information • Organ and tissue transplant PPO provider information • PPO medical providers located in Utah
<p>Hometown Health Providers (HTH) Utilization Management (888) 323-1461 www.stateofnv.hometownhealth.com</p>	<p>Medical Management</p> <ul style="list-style-type: none"> • Pre-certification, for example: <ul style="list-style-type: none"> ○ Inpatient hospital admissions ○ Certain outpatient procedures ○ All spinal surgeries ○ All bariatric (weight loss) surgeries • Large Case Management, for example <ul style="list-style-type: none"> ○ Complex disease management ○ High dollar disease management

Consumer Driven Health Plan Medical, Vision and Dental Contacts:	Service
<p>US Preventive Medicine (USPM) NVision Health and Wellness Customer Care Center 12740 Gran Bay Parkway West, Suite 2400 Jacksonville, FL 32258 (877) 800-8144 www.nvision.pebp.state.nv.us</p>	<p>Wellness and Disease Management</p> <ul style="list-style-type: none"> • Wellness: <ul style="list-style-type: none"> ○ Health Assessment Questionnaire ○ Prevention Plan • Disease Management for Diabetes • Disease Management for Obesity

Consumer Driven Health Plan Prescription Drug Plan Contacts:	Service
<p>Retail Pharmacy Services: Catamaran Customer Service and Prior Authorization (702) 869-4600 or (800) 799-1012 www.catamaranrx.com You will need to create a User ID and Password</p> <p>Mail Order Services Walgreens Mail Order P O Box 29061 Phoenix, AZ 85038-9061 Customer Service: (866) 845-3590</p> <p>Mail Order forms and online ordering: www.catamaranrx.com You will need to create a User ID and Password</p> <p>Specialty Drug Services Briova Rx (866)-618-6741</p>	<p>Prescription Drug Plan Administrator</p> <ul style="list-style-type: none"> • Prescription Drug Information • Retail Network Pharmacies • Prior Authorization • Non-network Retail Claims Payment • Price and Save tool • Mail Order Service and Mail Order Forms <ul style="list-style-type: none"> • Specialty Drug Services Provider
<p>Diabetic Sense – Catamaran Rx Customer Service: (877) 852-3512</p>	<p>Diabetic Mail Order Program</p> <ul style="list-style-type: none"> • Diabetic Supplies

Fully Insured Product Contacts:	Service
<p>Standard Insurance Company 920 SW Sixth Avenue Portland, OR 97204 Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html</p>	<p>Basic Life Insurance</p> <ul style="list-style-type: none"> • Benefits • Filing a life insurance claim • Beneficiary financial counseling • MEDEX travel assistance

Fully Insured Product Contacts:	Service
<p>Standard Insurance Company 920 SW Sixth Avenue Portland, OR 97204 Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html</p>	<p>Long-term Disability (LTD)</p> <ul style="list-style-type: none"> • Benefits • Filing a long-term disability claim
<p>Hometown Health Plan HMO Customer Service: (775) 982-3232 or (800) 336-0123 www.stateofnv.hometownhealth.com</p>	<p>Northern Nevada Health Maintenance Organization (HMO)</p> <ul style="list-style-type: none"> • Medical claims • Pre-authorization • Provider network
<p>Health Plan of Nevada HMO Customer Service: (702) 242-7300 (800) 777-1840 www.stateofnv.healthplanofnevada.com</p>	<p>Southern Nevada Health Maintenance Organization (HMO)</p> <ul style="list-style-type: none"> • Medical claims • Pre-authorization • Provider network
<p>Extend Health – Medicare Exchange 10975 Sterling View Drive, Suite A1 South Jordan, UT 84095 Customer Service: (888) 598-7545 TTY: (866) 508-5123 www.ExtendHealth.com/PEBP</p> <p>PayFlex – Health Reimbursement Arrangement P.O. Box 3039 Omaha, NE 68103-3039 Customer Service: (800) 284-4884 General Fax: (402) 231-4300 Claims Fax: (402) 231-4310 www.payflex.com</p>	<p>Medicare Exchange and Health</p> <ul style="list-style-type: none"> • Reimbursement Arrangement For Retirees and covered dependents with Medicare Parts A and B. • Health Reimbursement Arrangement for Retirees with Medicare Parts A and B. • Premium reimbursement

Voluntary Product Contacts:	
<p>Standard Insurance Company 920 SW Sixth Avenue Portland, OR 97204 Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html</p>	<p>Life Insurance – Additional Voluntary life insurance benefits</p>
<p>Standard Insurance Company 920 SW Sixth Avenue Portland, OR 97204 Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html</p>	<p>Short-term Disability Insurance Voluntary short-term disability benefits</p>
<p>Liberty Mutual Customer Service: (800) 637-7026 Gary.bishop@libertymutual.com</p>	<p>Home and Auto Insurance</p> <ul style="list-style-type: none"> • Voluntary homeowners and auto insurance • Voluntary RV insurance
<p>HealthSCOPE Benefits Claims Submission: HealthSCOPE Benefits P.O. Box 3627 Little Rock, AR 72203 Customer Service: (888) 763-8232 Fax: (877)-240-0135</p> <p>Email: pebphsahra@healthscopebenefits.com Online Claims Submission: www.healthscopebenefits.com Click Member Type PEBP as the company name Click Flexible Spending Account (FSA) Status Login to your Member Dashboard</p>	<p>Flexible Spending Accounts</p> <ul style="list-style-type: none"> • Limited Scope Flexible Spending Account • Dental expenses • Dependent Care Flexible Spending Account
<p>Liberty Dental Plan</p>	<p>Voluntary Buy Up Dental Insurance</p> <ul style="list-style-type: none"> • Orthodontia coverage

Summary of Benefit Options

	Full-Time Employees			Active Legislator	Retirees (non Medicare)			Survivors of Retirees (non Medicare)		COBRA
	State	Non- State	NSHE		State	Non- State	Reinstated (State or Non- State)	Spouse	Dependent Child	
Medical Options										
Consumer Driven Health Plan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hometown Health Plans (HHP) HMO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health Plan of Nevada (HPN) HMO	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Other Options										
Self-funded PPO Dental	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Basic Life	✓	✓	✓	✓	✓	✓				
Long-Term Disability (LTD)	✓	✓	✓	✓						
					Retirees eligible for Medicare Parts A and B			Survivors of Retirees		
Medicare Exchange for Medicare eligible retirees and their covered Medicare eligible dependents					✓	✓	✓	✓		
Voluntary Products										
Short-Term Disability	✓	✓	✓	✓						
Home and Auto	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Flex Plan (Section 125 pre-tax)	✓									
Additional Life	✓	✓	✓	✓	✓	✓				
Buy Up Dental Insurance	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Eligibility

This section explains which individuals are eligible for coverage under the Public Employees' Benefits Program (PEBP). Information on enrollment, termination procedures, time limits, supporting documentation, and payment are all detailed below. The Executive Officer or his designee makes all final determinations concerning eligibility (NAC 287.313).

Any individual that is eligible for coverage as both a primary participant and a dependent shall be enrolled as a primary participant.

Eligibility Determinations

Eligibility for PEBP coverage is determined in accordance with the NRS 287, NAC 287 and the provisions outlined in this document. All eligibility decisions are final and are not subject to appeal. Individuals have the right to request information as to why a determination was made. However, unless evidence supports that the decision does not coincide with the eligibility terms in this document, the original determination will not be reversed.

Enrollment

Enroll Online

Log on to the PEBP website at www.pebp.state.nv.us and click on e-PEBP Online Enrollment Tool and 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 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 and social security number of any dependent that the participant chooses to cover under the Plan.

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 can be obtained from PEBP. Please note enrollment forms must be completed in blue or black ink and the original must be submitted to PEBP. PEBP will not accept copies, faxes, or scanned forms sent via email in place of the original form.

State Employees and Nevada System of Higher Education (NSHE) Employees

The following employees who work a minimum of 80 hours per month are eligible to participate in PEBP:

- Employees of a State agency,
- NSHE classified employees, and
- NSHE employees under a letter of appointment with benefits (temporary, part-time faculty employees who are employed half-time or more for a period of 90 consecutive days or more, but less than twelve months).

Except as noted below for NSHE employees/professionals under annual contract, coverage for NSHE employees is effective on the first day of the month concurrent with or following 90 days of full-time employment¹. Pursuant to Senate Bill 433 (2009), furlough leave is to be considered a work day (or portion of a work day) for all purposes except salary. If an employee has a reduction in hours below 80, as a result of the furlough, the employee's health coverage would continue as usual.

NSHE employees/professionals under annual contract are eligible on the first day of the month concurrent with or following the effective date of the annual contract.

Active State Legislators

Members of the Nevada Senate or Assembly whose term of office has not expired are eligible to participate in PEBP health care coverage on the first day of the month concurrent with or following 90 days of start of their term. Pursuant to NRS 287.044, members of the Senate or Assembly must pay the full, unsubsidized cost of coverage.

Biennial Employee

An employee whose position of employment is only authorized for 4 to 6 months every other year and who maintains COBRA coverage during the entire break in employment is eligible to reinstate active employee coverage the first day of the month concurrent with or following the rehire date.

Seasonal or Casual Labor Employee

Seasonal or casual labor employees who work a minimum of 80 hours per month and who satisfy the eligibility waiting period for a new hire, reinstatement, or rehire may enroll in PEBP coverage.

Employee Rehires

If an employee terminates employment or has a permanent reduction in hours and returns to full-time employment with the same or a different state agency after more than 12 months, the employee is considered a "rehire" and is subject to the new hire initial enrollment process.

¹ For purposes of this document, "80 hours per month" is used interchangeably with "full-time employment". A person who works at least 80 hours per month for three consecutive months is considered to have worked 90 days of full-time employment.

Employee Reinstatements

If an employee terminates employment or has a permanent reduction in hours and subsequently returns to full-time employment within 12 months of his/her termination date, the employee will be considered a "reinstated employee" if he/she was eligible for benefits at the time of his/her termination. The waiting period for benefits is waived and coverage will begin on the first day of the month concurrent with or following the return to full-time employment.

NOTE: An employee who terminates employment from a state agency to accept a position with a non-state agency (or vice versa) will be treated as a new hire (not as a reinstatement) and, as such, must satisfy the new hire waiting period, regardless of their previous enrollment in PEBP.

Non-State Employees

Employees of a participating public employer who work a minimum of 80 hours per month are eligible to participate in PEBP. Coverage is effective on the first day of the month concurrent with or following 90 days of full-time employment.

New hire, Rehire and Reinstatement rules for state employees described above also apply to non-state employees.

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

Eligible retirees can change their tier and medical plan option upon retiring or re-retiring. If the retiree does not enroll within 60 days of their retirement date as determined by PERS or NSHE, the retiree will not be eligible to elect coverage through PEBP until the PEBP annual Open Enrollment (see NRS 287.0475). A retired public officer or employee of the State or NSHE or his or her surviving spouse/domestic partner, can reinstate insurance 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 defined individuals will only have one opportunity to rejoin the PEBP Plan following retirement.

Retiree Coverage for Employees 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.

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 Coverage for Employees hired with a PEBP participating agency on or after January 1, 2012

Retired public officers and retired employees with an initial date of hire on or after January 1, 2012 may participate in the program but will not be eligible for a subsidy or Exchange HRA contribution upon retirement.

A retiree who returns to active work status with a PEBP participating agency may risk losing the years of service subsidy or Exchange years of service contribution at re-retirement as follows:

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.

State Retirees

Retirees who satisfy the above criteria and 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 who satisfy the above criteria and 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 disenrolled 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 as long as they continue to pay their premiums.

Medicare Eligible Retirees

Medicare Part A

At age 65 years, PEBP requires retirees and covered dependents to enroll in premium-free Medicare Part A if deemed eligible by the Social Security Administration (SSA).

Most people age 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 at age 65 years 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 at 1-800-772-1213.

If You Are Entitled to Premium-Free Medicare Part A

If you **are eligible** for premium-free Part A, PEBP will require you to enroll in Part A coverage approximately three months before your 65th birthday.

If You Are Not Entitled to Premium-Free Medicare Part A

If you are **not entitled** to premium-free Part A, PEBP will require a copy of the Part A denial letter issued by the SSA.

Submit a copy of the Part A card or the Part A denial letter to the PEBP office as follows:

- For birthdays occurring on the first day of the month, the Part A card or denial 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, the Part A card or denial letter must be received no later than the last day of the month, following the 65th birthday month.
- For newly retiring employees, the Part A card or denial letter must be received within 60 days of the retirement coverage effective date.

Failure to provide proof of either Medicare Part A enrollment (through submission of the Medicare card) or proof of ineligibility (through submission of a denial letter provided by the SSA) will result in termination of coverage for the retiree and any covered dependents.

Medicare Part B

At age 65 years, retirees and dependents are required to purchase Medicare Part B. To purchase Medicare Part B, contact the SSA at 1-800-772-1213.

If you are a retiring active employee (or a dependent of a retiring active employee) age 65 years or older, you will be required to enroll in Medicare Part B.

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 newly retiring employees, the Part B card must be received within 60 days of the retirement coverage effective date.

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 who are not eligible for premium-free Medicare Part A may remain on the PEBP CDHP or HMO plan.

Note: Retirees who subsequently become eligible for premium-free Medicare Part A will be required to enroll in a medical plan through Extend Health.

Retirees who are eligible for premium-free Medicare Part A must enroll in a medical plan through Extend Health and will be required to maintain medical coverage through Extend Health 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 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 plan.

Medicare Retirees Covered through Extend Health

Retirees who are eligible for premium-free Medicare Part A must enroll in a medical plan through Extend Health 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 Extend Health will become effective concurrent with the retiree's medical plan effective date through Extend Health.

Dependents are not eligible for a Health Reimbursement Arrangement contribution through Extend Health.

Disenrollment (or break) in Medical Coverage for Medicare Retirees Covered Through the Medicare Exchange

Retirees who experience a break in medical coverage or who terminate medical coverage through Extend Health will also terminate the years of service HRA contribution, PEBP dental coverage, \$5,000 Basic Life Insurance, and Voluntary Life Insurance (if applicable). See the Retiree Late Enrollment section for re-enrollment rights.

Note: Plan rules require retirees with Medicare Parts A and B to retain medical coverage through Extend Health to receive years of service HRA contributions, PEBP dental coverage, \$5,000 Basic Life Insurance, and Voluntary Life Insurance (if applicable).

Medicare Retirees Covered under the CDHP or HMO

Retirees who are not eligible for premium-free Medicare Part A and who purchases Medicare Part B and/or cover one or more non-Medicare eligible dependents may remain on the PEBP CDHP or HMO plan.

Note: A retiree/survivor covered under the PEBP CDHP or HMO that experiences a qualifying event that changes their eligibility status to participant only, must enroll in a medical plan through Extend Health.

Medicare Part B Premium Credit

Retirees who are covered under the PEBP CDHP 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.

Medicare Part D Coverage

Retirees and covered dependents enrolled in the PEBP CDHP who enroll in Medicare Part D prescription coverage will lose CDHP prescription drug coverage for the remainder of that Plan Year. There will be no reduction in premium cost and PEBP's prescription drug coverage will not be reinstated until the next plan year with proof of disenrollment of Medicare Part D.

Health Reimbursement Arrangement (HRA) for Retirees Covered Through Extend Health

Extend Health HRA accounts are employer-owned accounts established on behalf of eligible retirees covered in a medical plan through Extend Health.

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 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 Extend Health HRA Summary Plan Document available on the PEBP website.

Health Savings Account (HSA) for CDHP Participants

Health Savings Accounts are similar to Individual Retirement Accounts (IRAs), but for health care. However, unlike an IRA, HSA distributions are tax-exempt when used to pay qualifying health care expenses. The account earns interest and investment options may be available once the account balance reaches a certain limit. Unused dollars in the account carry over from year to year while the account value increases through tax free earned interest and investment growth. Employee contributions are optional through pre-tax payroll deductions. HSAs are also portable.

To qualify for the HSA you:

- must be an active employee enrolled in the CDHP;
- may have secondary coverage that is also a high deductible health plan as defined by the Internal Revenue Service (IRS);

You are not eligible for the HSA if:

- you are enrolled in Medicare, Tricare, Tribal coverage, etc. (non-high deductible health plan);
- you are a retiree;
- you are claimed as a dependent on another person's tax return (excludes joint returns);
- you and/or your spouse has a Medical Flexible Spending Account (FSA); or
- you are enrolled in COBRA.

Additional HSA provisions are available in Publication 502 and 969 at www.irs.gov.

Health Reimbursement Arrangement (HRA) for CDHP Participants

Health Reimbursement Arrangement (HRA) accounts are employer-owned accounts available to retirees and certain active employees (who are ineligible for the HSAs) enrolled in the CDHP.

HRA funds may be used to pay for qualified health care expenses for the participant and members of the participant's tax-family. HRAs are funded by PEBP; participant contributions are not allowed. HRA funds may only be used while the participant is covered under the CDHP. If a participant changes health plans or coverage ends, all remaining funds in the HRA are returned to PEBP.

Additional HRA provisions are available in Publication 502 and 969 at www.irs.gov.

Years of Service Premium Subsidy

Retired public employees enrolled in the CDHP 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 employer.

Years of Service HRA Contribution for Medicare Retirees Enrolled in a Medical Plan Through Extend Health

Retired public employees enrolled in a medical plan through Extend Health 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 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 employer, 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.

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 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.

Dependent Eligibility

Eligible dependents may be enrolled as long as:

- benefit coverage is in effect for the active employee or retiree on that day; and
- any required supporting documents are received in the PEBP office within 60 days of the Qualifying Event; or within 30 days following the last day of open enrollment; or
- within 30 days after the first day of employment, or no later than the date coverage is scheduled to become 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 Extend Health will have the option to enroll in the CDHP 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 Extend Health.

When Coverage Becomes Effective for Eligible 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, or
- if added during an open enrollment period, the first day of the new plan year.

Your Spouse

The participant's spouse, 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 are typically not eligible for coverage under the PEBP Plan. If your spouse's employer-sponsored health coverage satisfies PEBP's definition of "significantly inferior coverage" and you comply with the items listed in the Exception section below, you may be able to enroll or continue your spouse's coverage under PEBP. Definition of "significantly inferior coverage" is provided in the definition section of this document.

The Plan requires proof of the legal marital relationship and an authorization declaring that the spouse is not eligible for an employer group health plan. A divorced spouse of a participant is not an eligible dependent under this Plan.

Your Domestic Partner

The participant's domestic partner, as determined by the laws of the State of Nevada, is eligible for coverage under the PEBP Plan. Domestic partners that are eligible for health coverage 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 section listed below, you may be able to continue your domestic partners coverage under PEBP. Definition of "significantly inferior coverage" is provided in the definition section of this document.

The Plan requires a copy of the Domestic Partner Certification from the Nevada Secretary of State and a signed affidavit 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 eligible for coverage after termination of the domestic partnership.

Exception: 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, age 25 years or younger, are eligible for coverage on:

- the day the participant becomes eligible for coverage,
- the day the participant acquires the eligible dependent by birth, adoption or placement for adoption,
- 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.

To enroll dependent children, the participant must complete online enrollment, or submit a completed Benefit Enrollment and Change Form, including the child's social security number, and a copy of the child's birth certificate. In the case of a stepchild or domestic partner's child, a marriage certificate or certification of domestic partnership will also be required.

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 under permanent legal guardianship turns age 26 years;
- the end of the month in which the dependent child turns 26 years of age unless proof of disabled dependent child status has been provided to and approved by PEBP.

Your Newborn Child(ren)

Newborn dependent child(ren) 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) (see NRS 689B.033). If the dependent 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 this document.

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 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.

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.

Guardianship

Health care coverage is available for a minor individual under age 19 years who is under a participant's permanent legal guardianship. Coverage may be continued up to age 26 for an individual who was under permanent legal guardianship at the time the minor individual was 18 or 19, as applicable, pursuant to NRS 159.191.

Enrollment must be completed within 60 days of the issuance of the legal guardianship court order signed by the judge or during a future open enrollment period if initial enrollment is not completed within 60 days of the issuance of the legal guardianship court order signed by the judge. PEBP will require a copy of the legal guardianship court order, signed by the judge, the individual's social security number and a copy of the individual's certified birth certificate.

An individual under permanent legal guardianship over age 26 years is not eligible for coverage; refer to the COBRA section of this document for additional coverage options.

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:

1. Name of the issuing authority;
2. Name and mailing address (if any) of an individual who is a primary participant under the Plan;
3. 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
4. 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 usually results from a divorce that has been received by the plan, and 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 manner in which 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 an 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 of 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. For additional information regarding the procedures for payment of claims under a QMCSO/NMSN, see the Claims Information section of this document. Also 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 also 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.

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

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 may require proof of support and maintenance, e.g., a copy of income tax returns showing the child was claimed as a dependent on IRS tax forms in compliance with the IRS Code 152 (a) without regard to the gross income test.

PEBP may 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.

A disabled individual who was under permanent legal guardianship at the time the minor individual was 18 or 19, as applicable, pursuant to NRS 159.191 may continue coverage under this provision subject to the terms outlined above.

Grandchildren

Grandchildren are not eligible for coverage unless they are under a 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, dependent child(ren) and individuals under permanent legal guardianship up to age 26 who were covered under the participant's medical plan on the date of the participant's death.

Coverage for a surviving dependent will end on the last day of the month of the participant's death. To continue coverage the surviving dependent(s) must enroll within 60 days of the date of death of the employee or retiree.

Basic Life Insurance coverage and years of service subsidy is not available to survivors.

Survivors of Active Employees

If an active employee dies with 10 or more years of service credit, the employee's covered dependents are eligible to continue PEBP coverage as surviving dependents. Any dependent not enrolled for coverage on the date of the employee'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 employee's death. Surviving dependents include an employee's spouse or domestic partner, dependent child(ren) and individuals under permanent legal guardianship up to age 26 years who were covered 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

Survivors of retirees 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 participant's death.

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

Pursuant to NRS 287.021 and 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 Public Employees' Benefits Program 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 surviving spouse and any surviving child of a volunteer firefighter who was killed in the line of duty and who was officially a member of a volunteer fire department in this State is eligible to

join the Public Employees' Benefits Program. If such a dependent elects to join the Public Employees' Benefits Program, the dependent or legal guardian of the child must notify the Board in writing within 60 days after the date of death of the volunteer 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 Public Employees' Benefits Program for the surviving dependent of a volunteer 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 or individual under permanent legal guardianship is eligible to receive coverage pursuant to this section until the child reaches age 26 years.

Unsubsidized Dependents

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 Extend Health. Termination of a primary participant's coverage will result in termination of the unsubsidized dependents.

Unsubsidized dependents can only be added to or removed from coverage during Open Enrollment or as a result of a Qualifying Event.

Enrollment

Initial Enrollment for Active Employees

Employees must enroll or decline coverage online at www.pebp.state.nv.us or by completing by the Employee Benefit Enrollment and Change Form and submitting any required supporting documents (if adding dependents) to the PEBP office. Enrollment must be completed within 30 days after the first day of employment or no later than the date coverage is scheduled to become effective.

Default Enrollment

Employees who fail to enroll within the required timeframe will be defaulted as self-only on the Consumer Driven Health Plan (CDHP) and a Health Reimbursement Arrangement (HRA). Employees enrolled in the CDHP will pay a monthly premium for that coverage.

Initial Enrollment for Retirees

Retirees must enroll by completing the Retiree Benefit Enrollment and Change Form (RBECEF) and the Years of Service Certification Form that may be obtained from PEBP. The completed forms must be submitted to PEBP within 60 days of the date of retirement. Eligible dependents must be enrolled at the same time as the retiree.

Initial Enrollment for Survivors

Survivors who wish to be covered under PEBP must complete and submit the Retiree Benefit Enrollment and Change Form (RBECE) within 60 days of the date of death of the employee or retiree.

Open Enrollment

Open Enrollment is typically held May 1 – May 31 and any changes made during open enrollment will become effective on July 1.

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.

Note: If a medical plan option is discontinued and the covered participant does not make a plan election for the new Plan Year, the participant and any covered dependents will be defaulted to the CDHP Plan (default plan).

Qualifying Events

Federal regulations generally require that plan coverage remain in effect, without change, throughout the plan year unless a qualifying event occurs during the year (mid-year).

Qualifying events include the birth of a child, marriage, divorce, etc. (for a detailed list of qualifying events, see the Qualifying Events Quick Reference Table in this document). Any change made to health care benefits must be determined by PEBP to be necessary, appropriate, and consistent with the change in status. The plan must be notified in writing within 60 days of the qualifying event; otherwise, the request will not be accepted and the change cannot be made until the subsequent Open Enrollment period. As a result of a qualifying event, only those changes that are consistent with the change of status will be allowed. Generally, only coverage for an individual who has lost eligibility from a group health plan as a result of a change of status (or who has gained eligibility and enrolled in coverage from a group health plan) can be added or dropped mid-year from this Plan.

Any qualifying event that creates a situation in which the retiree/survivor and all remaining covered dependents are eligible for premium-free Medicare Part A creates a requirement that the retiree/survivor and all remaining covered dependents choose coverage through Extend Health. Failure to enroll in a medical plan through Extend Health will result in termination of coverage.

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, 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 be in compliance 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 one of the PEBP-sponsored Health Maintenance Organizations (HMOs), 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.

Rescissions

This Plan will cause a Rescission of Coverage due to fraud or an intentional misrepresentation of a material fact. A Plan participant may have the right to appeal a Rescission. See the Claim Appeal Process to learn how to initiate an appeal.

Summary of Supporting Eligibility Documents								
Dependent Type	Social Security Number	Marriage Certificate	Birth Certificate	Hospital Birth Confirmation	Adoption Decree	Nevada Certification of Domestic Partnership	Legal Permanent guardianship signed by a judge	Physician's Disability Certification
Newborn Child	✓		✓	✓				
Child: Birth-Age 26 Yrs	✓		✓					
Adopted Child	✓		✓		✓			
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	✓					✓		

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. In all cases, required supporting documentation must be submitted to PEBP within the same timeframe.

Employees in declined coverage status and who experience a change in number of dependents may opt to enroll for coverage mid-year if adding a newly acquired dependent.

Qualifying Events Quick Reference Table			
Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends
<p>Employee Hire:</p> <ul style="list-style-type: none"> • New Hire • Rehire • Reinstatement • University Professional 	<ul style="list-style-type: none"> • Within 30 days after the first day of employment, or; • No later than the date coverage is scheduled to become effective. 	<p>If adding spouse or domestic partner:</p> <ul style="list-style-type: none"> • SSN and a copy of the marriage certificate or Nevada domestic partnership certificate <p>If adding dependent child(ren):</p> <ul style="list-style-type: none"> • SSN and a copy of child(ren)'s birth certificates <p>If adding an individual under legal guardianship to age 19 years:</p> <ul style="list-style-type: none"> • Copy of legal guardianship papers (signed by a judge) • SSN and copy of birth certificate • If not the primary insured's child, a copy of the marriage certificate or domestic partnership certificate <p>If adding a stepchild(ren):</p> <ul style="list-style-type: none"> • SSN • Copy of certified birth certificate(s) • Copy of the marriage certificate or domestic partnership certificate 	<p>New Hire - Employees who work a minimum of 80 hours per month for three (3) consecutive months are eligible for coverage on the first day of the month concurrent with or following 90 days of full-time employment</p> <p>Rehire - Employees who work a minimum of 80 hours per month for three (3) consecutive months are eligible for coverage on the first day of the month concurrent with or following 90 days of full-time employment</p> <p>Reinstatement - Reinstated employees are defined as an employee who terminates employment or has a permanent reduction in hours and subsequently returns to full-time employment within 12 months of his/her termination date. The employee will be considered a reinstated employee if he/she was eligible for benefits at the time of his/her termination. Coverage becomes effective on the first day of the month concurrent with or following the date of reinstatement</p> <p>University Professional - Coverage effective on the first day of the month concurrent with or following the date of the annual contract</p>

Qualifying Events Quick Reference Table				
Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based Upon the Event
Employee retires	End of month following the date the employee retires	<ul style="list-style-type: none"> • RBECE • Years of Service Certification Form • If age 65 years or older, copy of Medicare card • If age 65 years or older, letter (if applicable) from the Social Security Administration indicating individual is not eligible for premium-free Medicare Part A 	Retiree coverage effective on the first day of the month concurrent with or following the employee's date of retirement	<ul style="list-style-type: none"> • May add dependent(s) • May select a new health plan option • If retiree is eligible for free Medicare Part A, may be required to enroll for coverage through the Medicare exchange

Qualifying Events Quick Reference Table				
Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based Upon the Event
Adoption or placement for adoption (more than 60 days after the child's date of birth)	Within 60 days of the event date	<ul style="list-style-type: none"> • Copy of legal adoption papers (signed by a judge), followed by final adoption papers within 60 days of issuance • SSN and copy of birth certificate (within 120 days of the adoption) • If not the primary insured's child, a copy of the marriage certificate or domestic partner certificate 	Coverage effective on the first day of the month in which child is adopted or placed for adoption, whichever date is earlier	May add the designated adopted child(ren) and other eligible dependent(s) in the family unit
<ul style="list-style-type: none"> • Birth; or • Adoption or placement for adoption of a newborn child less than 60 days from the child's date of birth 	Within 60 days of the event date	<ul style="list-style-type: none"> • Copy of hospital birth confirmation • SSN and copy of birth certificate (within 120 days of date of birth) • If not the primary insured's child, a copy of the marriage certificate or domestic partner certificate 	<ul style="list-style-type: none"> • Newborns will automatically be covered for 31 days following the date of birth. To continue coverage beyond 31 days, the child must be added to the participant's plan within 60 days of the date of birth. Any changes in premium cost become effective on the first day of the month concurrent with or following the newborn's 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 newborn child and other eligible dependent(s) in the family unit

Qualifying Events Quick Reference Table				
Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based on Event
Disabled Child age 26 years or older	Within 30 days of the dependent child turning age 26 years	<ul style="list-style-type: none"> • Certification of Disabled Dependent Child (completed by primary participant and child's physician) • SSN • If not the participant's child, copy of the marriage or domestic partner certificate • If disabled child is age 26 years or older, verification that the child has had continuous health insurance since the age of 26 years 	<ul style="list-style-type: none"> • 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
Permanent Guardianship of an individual	Within 60 days of the event date	<ul style="list-style-type: none"> • Copy of legal guardianship papers (signed by a judge) • SSN • Copy of birth certificate • If not the primary insured's child, a copy of the marriage certificate or domestic partnership certificate 	<p>Coverage effective on the first day of the month concurrent with or following the legal guardianship papers signed by a judge</p> <p>Coverage is provided only up to age 26 years.</p>	May add the child(ren) to age 19 years and other eligible dependent(s) in the family unit

Qualifying Events Quick Reference Table				
Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based on Event
Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)	Within 60 days of issuance of QMCSO or Release of QMCSO	Copy of QMCSO appropriately signed	<ul style="list-style-type: none"> • QMCSO: <u>First of the month concurrent with or</u> 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 	<p>Must add dependent(s) as stated in the QMCSO</p> <p>May add other eligible dependent(s) in the family unit</p>

Qualifying Events Quick Reference Table				
Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based Upon the Event
<p>Dependent Loses Coverage Spouse/domestic partner or eligible dependents experience a change of status resulting in a loss of eligibility from another group health plan</p>	<p>Within 60 days of the event date</p>	<ul style="list-style-type: none"> • HIPAA certificate(s) from other insurance carrier stating the insurance end date and identity of covered individual(s) for each dependent being added to your coverage • SSN for all dependent(s) being added • Copy of marriage or domestic partnership certificate • If adding dependent(s), a copy of the child(ren)'s birth certificates 	<p>Coverage effective on the first day of the month concurrent with or following the date of the loss of coverage</p>	<p>May add the spouse or domestic partner and all other eligible dependent(s) in the family unit who experienced a loss of coverage</p>
<p>Dependent Gains Coverage Spouse/domestic partner or eligible dependent experiences a change of status resulting in a gain of eligibility from another group health plan</p>	<p>Within 60 days of the event date</p>	<ul style="list-style-type: none"> • Confirmation of coverage letter from other insurance carrier stating the insurance effective date and identity of covered individual(s) for each dependent being deleted from your coverage 	<p>Coverage terminates on the last day of the month the event occurs</p>	<p>Must delete spouse or domestic partner if coverage is employer based; and may delete any dependent(s) that are being added to the group coverage</p>

Qualifying Events Quick Reference Table				
Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based Upon the Event
Marriage or Domestic Partnership	Within 60 days of the event date	<ul style="list-style-type: none"> • SSN • Copy of the marriage certificate or Nevada domestic partnership certificate • If adding dependent child(ren), a copy of the child(ren)'s birth certificates 	Coverage effective on the first day of the month concurrent with or following the date of marriage/registration of domestic partnership with the Nevada Secretary of State's office	May add spouse or domestic partner and other eligible dependent(s) in the family unit
Divorce, Annulment or; Termination of Domestic Partnership	Within 60 days of the event date	<ul style="list-style-type: none"> • Copy of the divorce/annulment decree signed by the judge (all pages) • Copy of the termination of domestic partnership filed with the Nevada Secretary of State's office 	<ul style="list-style-type: none"> • Coverage terminates on the last day of the month in which divorce decree is signed by the judge or Termination of DP is filed with the Secretary of State's office • 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 DP 	Must delete ex-spouse or ex-domestic partner and all other ineligible dependent(s)

Qualifying Events Quick Reference Table				
Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based Upon the Event
Employer of Spouse/Domestic Partner Offers an Open Enrollment Period	Within 60 days of the event date	<ul style="list-style-type: none"> • Proof of Open Enrollment from the employer • Confirmation of coverage letter from the insurance carrier stating the effective date of new coverage and the identity(ies) of the newly covered individual(s) 	<ul style="list-style-type: none"> • If deleting dependent child(ren) from that other employer's 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 	<ul style="list-style-type: none"> • 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
PEBP's Open Enrollment Period	Typically May 1- May 31 of each year	<ul style="list-style-type: none"> • If adding a dependent, refer to the Summary of Supporting Document Requirements in this document • Required supporting documents are due by June 30 	Coverage effective July 1	May add or delete dependents, change plan options or decline coverage
Participant death	Within 60 days of the event date	Original death certificate	<ul style="list-style-type: none"> • 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 the Master Plan Document

Qualifying Events Quick Reference Table				
Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based Upon the Event
Dependent Death	Within 60 days of the event date	Copy of death certificate	Coverage for decedent terminates on the date of death	Must delete the decedent from coverage and any ineligible dependent(s)
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	<ul style="list-style-type: none"> • Copy of Medicare card • Letter (if applicable) from the Social Security Administration (SSA) indicating individual is not eligible for premium-free Part A • BECF (only if Medicare entitlement includes Parts A and B and changing health plans to the Medicare exchange) 	Coverage under Medicare Exchange becomes effective within 60 days of Medicare effective date or retirement date, whichever is later	<ul style="list-style-type: none"> • 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 person in the family is not eligible for free Part A, the entire family may continue PEBP CDHP or HMO coverage or the Part A individual may choose coverage through the exchange • Note: If the Medicare retiree covers a non-Medicare spouse/DP and the retiree enrolls through the exchange, the spouse/DP cannot decline coverage until open enrollment

Qualifying Events Quick Reference Table				
Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based Upon the Event
Dependent declines coverage due to Medicare or Medicaid entitlement	Within 60 days of the event date	<ul style="list-style-type: none"> • Copy of Medicare card • HIPAA certificate of creditable coverage from Medicaid 	Coverage terminates on the last day of the month preceding the Medicare or Medicaid coverage effective date	May delete the dependent who becomes entitled to Medicare or Medicaid
Medicare Part B Premium Credit	No later than the end of the month prior to the Part B effective date	<ul style="list-style-type: none"> • Copy of Medicare Part B card; or • Copy of the Medicare Part B award letter 	Part B premium credit starts on the first of the month following receipt of required supporting document	Premium credit will only apply to primary retirees covered under the Consumer Driven Health Plan or an HMO Plan
Survivor	Within 60 days of the primary participant's date of death		Coverage for eligible survivors 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

Qualifying Events Quick Reference Table				
Event Type	Notification Period	Required Supporting Documents	When Coverage Begins or Ends	Allowable Changes Based Upon the Event
Survivor of Police/Firefighter	Within 60 days of the police officer's or firefighter's date of death	<ul style="list-style-type: none"> • RBECF • Written notification to employer of the Survivor's intent to enroll in Survivor's coverage • Copy of death certificate • SSN and copy of marriage certificate • If adding dependent(s), a copy of child(ren)'s birth certificate(s) 	Coverage for eligible survivors 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
Settlement Agreement	Within 60 days of Settlement Agreement	Copy of Hearing Officer's decision	<ul style="list-style-type: none"> • Retroactive to date established by the Hearing Officer decision under the CDHP; 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 	<ul style="list-style-type: none"> • Employee may re-enroll in coverage; or • Decline coverage

Dependent Loses Other Group Health Care Coverage

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

- loss of eligibility as a result 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 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 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, 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 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 employer-based coverage. Notification after 60 days will result in coverage terminating at the end of the month PEBP receives proof of other employer 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 and the order of benefit determination rules as described in the Coordination of Benefits section of this document will establish which plan is the primary plan (pays first) and which is secondary (pays second).

Significantly Inferior Coverage

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 with 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 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.

If your spouse/domestic partner cannot decline coverage from their employer until the annual 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.

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 a Benefit Enrollment and Change Form (BECF) 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.

Declining Active Employee Coverage

An employee may decline coverage at initial enrollment, during PEBP’s annual open enrollment or during the spouse’s/domestic partner’s open enrollment period (see Open Enrollment for Employer of Spouse or Domestic Partner section). An employee will not receive 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, \$5,000 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.

Disenrollment (or break) in Medical Coverage for Medicare Retirees Covered Through Extend Health

Retirees who experience a break in medical coverage or who terminate medical coverage through Extend Health will also terminate the years of service HRA contribution, PEBP dental

coverage, \$5,000 Basic Life Insurance, and Voluntary Life Insurance (if applicable). See the Retiree Late Enrollment section for re-enrollment rights.

Note: Plan rules require retirees with Medicare Parts A and B to retain medical coverage through Extend Health to receive the years of service HRA contributions, PEBP dental coverage, \$5,000 Basic Life Insurance, and Voluntary Life Insurance (if applicable).

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 an 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 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.

Retiree Late Enrollment

A retired public officer or employee of the State, NSHE, a participating local government, or his or her surviving spouse, can reinstate insurance during an annual Open Enrollment 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 defined individuals will only have one opportunity to rejoin the PEBP Plan following retirement. To take advantage of the retiree late enrollment, the retiree should contact PEBP between April 1 and May 31 of any calendar year. A reinstated retiree will not be eligible for basic or voluntary life insurance through PEBP.

When Coverage Ends

In all cases of death, coverage ends on the date of death of the employee, retiree, or dependent.

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.

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); or
- the Plan is discontinued.

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);
- the Plan is discontinued.

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); or
- the Plan is discontinued.

Coverage for an unsubsidized dependent ends 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; or
- the Plan is discontinued.

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 General Provisions.

Certificates of Creditable Coverage

PEBP shall issue certificates of creditable coverage (HIPAA Certificates) to a covered person: (a) whose coverage terminates; and (b) to individuals upon their written request while the individual is covered under the plan and within 24 months of the date of coverage termination, as required by federal law. Procedures for requesting certificates of creditable coverage may be obtained from PEBP. See the COBRA section for an explanation of when and how those certificates of coverage will be provided.

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 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 <http://dop.nv.gov/FMLAOverview.pdf>.

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.

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 similar to 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.

Workers' 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 worker's 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 Worker's Compensation leave, unless the employee selected different coverage during an Open Enrollment period.

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 800-326-5496). Survivors, dependents, legislators and employees on leave without pay 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 in order 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 or HMO only.

Premiums for CDHP or HMO coverage are automatically deducted from the participant's paycheck or pension. Each monthly premium pays for coverage for that same month. In the following circumstances, premiums shall be paid directly to PEBP on a monthly basis:

- 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 survivor's 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 such time as the account is paid in full.

Participants may 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 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 enrollment and eligibility 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.

Consumer Driven Health Plan Overview

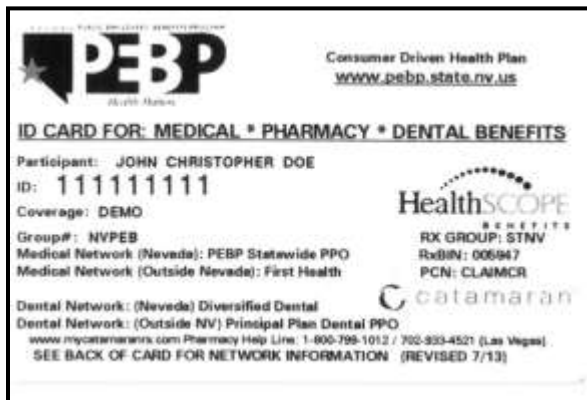
Identification Cards (Medical, Pharmacy and Dental Benefits)

The PEBP CDHP Medical, Pharmacy and Dental ID card contains important coverage information and should be carried at all times. ID cards are issued under the Plan Participant's name and unique ID number only. This card will not be issued to employees and retirees who elect HMO coverage.

PEBP Dental coverage only ID card is issued to the following:

- Medicare retirees covered under the Medicare Exchange program who elect the PEBP self-funded PPO Dental Plan.
- Members who elect HMO medical coverage.

Under normal circumstances only two ID cards are issued. Eligible dependents will not receive individual ID cards. ID cards are issued under the Plan Participant's name and unique ID number only. If additional cards are needed, please contact HealthSCOPE Benefits. Information regarding HealthSCOPE is located in this document under the section titled "Participant Contact Guide." If you notice that any coverage information is not correct, please contact PEBP.



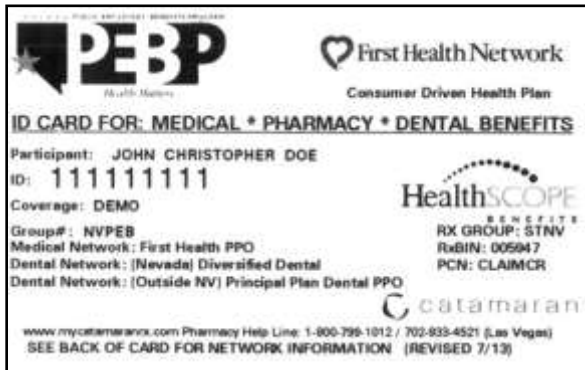
PEBP Consumer Driven Health Plan ID card - Front

This card is issued to participants who reside in Nevada and who may need medical, pharmacy or dental services in Nevada or outside of Nevada



PEBP Consumer Driven Health Plan ID card - Back

Summary of Consumer Driven Health Plan Components

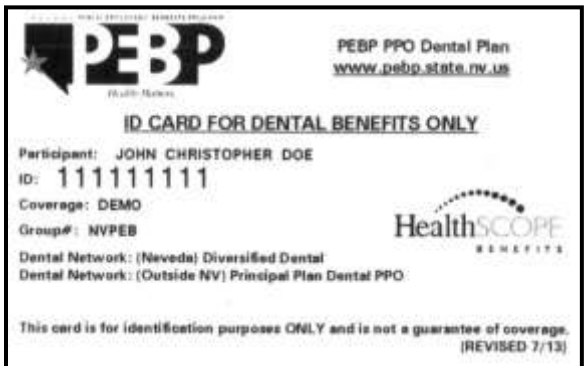


PEBP Consumer Driven Health Plan ID card - Front

This card with the First Health Network logo is issued to participants who reside outside of Nevada



PEBP Consumer Driven Health Plan ID card - Back



Dental Only ID Card - Front

This card is issued to retirees covered under the Medicare Exchange who elect the PEBP self-funded Dental Plan and to active employees who elect one of the medical HMO options.



Dental Only ID Card - Back

Summary of Self-funded Plan Components

Deductibles - Medical and Retail, Specialty and Mail Order Prescription Drugs

Each plan year, before the plan begins to pay benefits, you are responsible for paying your entire eligible medical and prescription drug expenses up to the plan year deductible. Eligible medical and prescription drug expenses are applied to the deductibles in the order in which claims are received by the plan. Only eligible medical and prescription drug expenses can be used to satisfy the plan's deductibles. Non-eligible medical and prescription drug expenses described in the following sections do not count toward the deductibles. Deductibles accumulate on a plan year basis and reset to zero at the start of each new plan year. Deductible credit is based on the date of service for the medical or prescription drug expense and not when the medical or prescription drug expense is received by the plan.

In-Network

Deductible Type	Individual (self coverage only)	Individual (when two or more family members are covered)	Family (when two or more family members are covered)
Annual Medical and Prescription Drug	\$1,900.00	\$2,500.00	\$3,800.00

Out-of-Network

Deductible Type	Individual (self coverage only)	Individual (when two or more family members are covered)	Family (when two or more family members are covered)
Annual Medical and Prescription Drug	\$1,900.00	\$2,500.00	\$3,800.00

Medical Plan (including outpatient prescription drugs) - Annual Deductible

- Medical deductibles, for individual or family coverage, accumulate separately for in-network provider expenses and out-of-network provider expenses. If both in-network and out-of-network providers are used, the deductible will have to be met separately, meaning a separate deductible for in-network utilization and a separate deductible for out-of-network utilization.
- Family coverage means employee/retiree plus one or more other covered individuals.
- The family deductible could be met by any combination of eligible medical and prescription drug expenses from *two or more* members of the same family coverage unit. The family deductible may be satisfied cumulatively. For the family coverage deductible, under no circumstances will a single individual be required to pay more than \$2,500.00 toward the deductible.

Example

1. Family member #1 incurs \$2,600 in eligible in-network medical expenses, of which \$2,500 is applied to the individual in-network deductible and \$2,500 is also applied to the family deductible of \$3,800. In this example, the individual has met his in-network deductible and the remaining in-network family deductible is \$1,300. The remaining \$100 is paid at the appropriate coinsurance rate.
 2. Family member #2 incurs \$2,000 in eligible in-network medical expenses: \$1,300 is applied toward the remaining family in-network deductible, which satisfies the \$3,800 annual family in-network deductible amount. The remaining \$700 is paid at the appropriate coinsurance rate.
- Certain preventive medical expenses are not subject to deductibles. See the Schedule of Medical Benefits to determine when eligible medical expenses are not subject to deductibles.
 - Eligible medical and prescription drug expenses paid from a Health Savings Account or Health Reimbursement Arrangement account accumulate toward the deductible.

NOTE FOR PERSONS WHOSE STATUS CHANGES FROM EMPLOYEE/RETIREE TO DEPENDENT OR FROM DEPENDENT TO EMPLOYEE:

As long as the person is continuously covered under this plan before, during and after the change in status, credit will be given for portions of the medical, prescription drug and dental deductibles already met, and benefit maximum accumulators (e.g. medical out of pocket maximums, dental frequency maximums and annual benefit maximum) will continue without interruption.

Coinsurance

Once you have met your plan year deductible (individual or family), the plan generally pays a percentage of the eligible medical expenses and you are responsible for paying the rest. The part you pay is called the coinsurance. If you use the services of a health care provider who is a member of the plan's PPO network, you will be responsible for paying less money out of your pocket. This feature is described in more detail in the Medical Network section of this document. In-Network, the Plan generally pays 75% of the provider's contracted in-network rate and you pay the remaining 25%. Out-of-Network, the Plan generally pays 50% of Usual and Customary (U&C) charges and you pay the remaining 50%. Out-of-Network providers can also bill you directly for any difference between their billed charges and the U&C charges allowed by the Plan.

NOTE FOR WHEN YOU DO NOT COMPLY WITH UTILIZATION MANAGEMENT PROGRAMS:

If you fail to follow certain requirements of the plan's Utilization Management Program (as described in the Utilization Management section of this document), the plan may pay a smaller percentage of the cost of those services and you will have to pay a greater percentage of those costs. The additional amount you will have to pay is in addition to your deductibles or out-of-pocket maximums described in the following tables.

Plan Year Out-of-Pocket Maximums

Medical and Retail, Specialty and Mail Order Prescription Drugs

The Plan limits the amount a participant might pay each plan year. The out-of-pocket maximums accumulate separately for in and out-of-network providers. After an individual or family has paid eligible medical and prescription drug expenses exceeding the deductible and coinsurance amounts up to the maximum out-of-pocket cost, no further coinsurance or deductible will apply to covered eligible medical and prescription drug expenses for the remainder of the current plan year. As a result, after the out-of-pocket maximum has been reached, the plan will pay 100% of all covered eligible medical and prescription drug expenses that are incurred during the remainder of the plan year. The out of pocket maximum accumulates on a plan year basis and resets to zero at the start of each new plan year. Accumulation of the out of pocket maximum is based on the date of service for the medical or prescription drug expense and not when the medical or prescription drug expense is received by the plan. Only expenses where the plans coinsurance is applied are eligible for the out of pocket maximum. The out-of-pocket maximums are as follows:

Coverage Tier	In-Network:	Out-of-Network:
Participant Only	\$3,900/individual	\$10,600/individual
Family Tier when two or more family members are covered	\$7,800/family	\$21,200/family

The out-of-pocket maximums are a combination of covered out-of-pocket expenses, including deductible and coinsurance and excluding the out-of-pocket expenses listed below. Family out-of-pocket maximums can be met by an individual covered family member or by any combination of expenses incurred by the covered family members.

NOTE: In- and out-of-network maximums are **not** combined to reach your plan year out of pocket maximum. A participant who uses both in and out-of-network providers could pay a total of \$14,500 for participant only or \$29,000 for family coverage.

Example

1. Family member #1 incurs \$2,600 in eligible in-network medical expenses, of which \$2,500 is applied to the individual in-network deductible and \$2,500 is also applied to the family deductible of \$3,800. In this example, the individual has met his in-network deductible and the remaining in-network family deductible is \$1,300. The remaining \$100 of incurred eligible medical expenses is paid at the appropriate coinsurance rate (75%). The remaining family out of pocket maximum is reduced from \$7,800 to \$5,275.
2. Family member #2 incurs \$2,000 in eligible in-network medical expenses: \$1,300 is applied toward the remaining family in-network deductible, which satisfies the \$3,800 annual family in-network deductible amount. The remaining \$700 is paid at the appropriate coinsurance rate (75%). The remaining family out of pocket maximum is reduced from \$5,275 to \$3,800.
3. Family member #3 incurs \$25,000 in eligible in-network medical expenses. The in-network family deductible has been satisfied by the previous family members and the remaining

family out of pocket maximum is \$3,800. In this example, the family member is responsible for 25% of covered eligible medical expenses up to \$3,800 and the Plan would pay 100% of all remaining covered medical expenses, in this case \$21,200. For the remainder of the plan year, the in-network family deductible and the in-network family out of pocket maximum have been satisfied and the plan will pay 100% of all eligible medical and prescription drug expenses for all the covered members of the family.

The in-network and out-of-network out-of-pocket maximums are **not** interchangeable, meaning you may not use any portion of an in-network out-of-pocket maximum to meet an out-of-network out-of-pocket maximum, and vice versa.

Expenses That Do Not Accumulate Towards Your Deductible and Out-of-pocket

The plan never pays benefits equal to all the medical expenses you may incur. You are always responsible for paying for certain expenses for medical services and supplies yourself. The following services **do not** accumulate toward the deductible or out-of-pocket maximum and you will be responsible for paying these expenses out of your own pocket (This list is not all inclusive):

- All expenses for medical services or supplies that are not covered by the plan, to include but not limited to expenses that exceed the PPO provider contract rate, services listed in the exclusions section of this document and dental expenses (unless deemed medical as described in this document).
- All charges in excess of the Usual and Customary charge determined by the plan.
- Any additional amounts you have to pay because you failed to comply with the Utilization Management Program described in the Utilization Management section of this document.
- Benefits exceeding those services or supplies subject to Limited Overall Maximums for each covered individual for certain eligible medical expenses. The services or supplies that are subject to Limited Overall Maximum Plan Benefits and the amounts of the Limited Overall Maximum Plan Benefits are identified in the Schedule of Medical Benefits.
- Certain wellness or preventive services that are paid by the plan at 100% do not accumulate towards the out of pocket maximum.

Self-Funded CDHP/ PPO Medical Benefits

Eligible Medical Expenses

You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called “eligible medical expenses”, and they are limited to those that are:

- determined by the Plan Administrator or its designee to be “medically necessary” (unless otherwise stated in this Plan), but only to the extent that the charges are “Usual and Customary (U&C)” (as those terms are defined in the Definitions section of this document); and
- not services or supplies that are excluded from coverage (as provided in the Exclusions section of this document); and
- services or supplies; the charges for which are not in excess of the Limited Overall and/or Plan Year Maximum Benefits shown in the Schedule of Medical Benefits.

Generally, the plan will not reimburse you for all eligible medical expenses. Depending on the plan you select, usually you will have to satisfy some deductibles, pay some coinsurance toward the amounts you incur that are eligible medical expenses. However, once you have incurred a maximum coinsurance out-of-pocket cost, no further coinsurance will be applied for the balance of the plan year. There are also maximum plan benefits applicable to each plan participant.

Non-eligible Medical Expenses

For any expenses that are not eligible medical expenses, you are responsible for paying the full cost of all expenses that are:

- not determined to be medically necessary (unless otherwise stated in this plan);
- determined to be in excess of the Usual and Customary charges;
- not covered by the plan,
- in excess of a maximum plan benefit, or
- payable on account of a penalty for failure to comply with the plan’s Utilization Management requirements,
- non-eligible medical expenses do not contribute to the deductible or out of pocket maximums as determined by the Plan for your specific coverage tier.

PPO Network Health Care Provider Services

If you receive medical services or supplies from an in-network PPO provider, you will be responsible for paying less money out of your pocket. Health care providers who are members of the PPO network have agreed to accept the PPO network negotiated amounts in place of their standard charges for covered services. You are responsible for any applicable plan deductible and/or coinsurance requirements as outlined in this document, and are described in more detail in the schedule of medical benefits. Out-of-network providers may bill the plan participant their standard charges and any balance that may be due after the plan payment. It is the participant’s responsibility to verify the in-network status of a chosen provider.

NOTE: In accordance with NRS 695G.164, if you are seeing a provider that is in network and that provider leaves the network, and you are actively undergoing a medically necessary course of treatment and you and your provider agree that a disruption to your current care may not be in your best interest or if continuity of care is not possible immediately with another in network provider, PEBC will pay that provider at the same level they were being paid while contracted

with PEBP's PPO network, if the provider agrees. If the provider agrees to these terms, coverage may continue until:

- the 120th day after the date the contract is terminated; or
- if the medical condition is pregnancy, the 45th day after:
 - The date of delivery; or
 - If the pregnancy does not end in delivery, the date of the end of the pregnancy.

Out-of-Country Medical and Vision Purchases

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

Please contact PEBP's third party administrator before traveling or moving to another country to discuss any criteria that may apply to a medical or vision service reimbursement request.

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

PEBP will require a written notice from you or your designated representative explaining why you received the medical services from an out of country provider and why you were unable to travel to the United States for these services. This provision applies to elective and emergency services. For emergency services, PEBP provides benefits for transportation back to the United States.

- If you are a state of Nevada active employee or a dependent of an active employee, this benefit is provided by Medex, a subcontractor for Standard Insurance. For more information about this program please refer to the website and telephone number for Standard Insurance provided in the Participant Contact Guide located in the front section of this document.
- If you are a retiree or a dependent of a retiree with life insurance through Standard Life Insurance Company, this benefit is available through Medex, a subcontractor for Standard Insurance. For more information about this program please refer to the website and telephone number for Standard Insurance provided in the Participant Contact Guide located in the front section of this document.
- If you are not eligible for transportation services provided by Medex, PEBP may provide benefits through the self-funded PPO plan for the purposes of medical transportation. Refer to PEBP's third party administrator, listed in the Participant Contact Guide, for more information.

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

- Proof of payment from you to the provider of service (typically your credit card invoice)
- Itemized bill to include complete description of the services rendered and admitting diagnosis(es)
- Itemized bill must be translated to English
- Reimbursement request must be converted to United States dollars
- Any foreign purchases of medical care and services will be subject to Plan limitations such as:
 - deductibles
 - coinsurance
 - frequency maximums
 - annual benefit maximums
 - medical necessity
 - FDA approval
 - Usual and Customary (U & C)

If the provider will accept payment directly from PEBP you must also provide the following:

- Assignment of Benefits signed by you or an individual with the authority to sign on your behalf such as a legal guardian or Power of Attorney (POA).

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

Autism Spectrum Disorders

This Plan provides coverage for the screening of, diagnosing of and treatment of Autism Spectrum Disorders effective July 1, 2011. To be covered, services must be provided after July 1, 2011. Any services provided before this date may be denied. Autism Spectrum Disorder is defined in the Definitions section of this document. For benefit exclusions and limitations, please refer to the Schedule of Medical Benefits section of this document.

NRS 689B.0335 provides the language specific to Autism Spectrum Disorder coverage and is provided below for clarification:

To be covered the treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavior therapy or therapeutic care that is:

- (a) Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and
- (b) Provided for a person diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician, psychologist or behavior analyst.
- (c) "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

(d) "Autism spectrum disorders" means a neurobiological medical condition including, without limitation, autistic disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified.

(e) "Behavioral therapy" means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or certified autism behavior interventionist.

(f) "Certified autism behavior interventionist" means a person who is certified as an autism behavior interventionist by the Board of Psychological Examiners and who provides behavior therapy under the supervision of:

- (1) A licensed psychologist;
- (2) A licensed behavior analyst; or
- (3) A licensed assistant behavior analyst.

(g) "Evidence-based research" means research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.

(h) "Habilitative or rehabilitative care" means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.

(i) "Licensed assistant behavior analyst" means a person who holds current certification or meets the standards to be certified as a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Board of Psychological Examiners and who provides behavioral therapy under the supervision of a licensed behavior analyst or psychologist.

(j) "Licensed behavior analyst" means a person who holds current certification or meets the standards to be certified as a board certified behavior analyst or a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, and who is licensed as a behavior analyst by the Board of Psychological Examiners.

(k) "Prescription care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

(l) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

(m) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

(n) "Screening for autism spectrum disorders" means medically necessary assessments, evaluations or tests to screen and diagnose whether a person has an autism spectrum disorder.

(o) "Therapeutic care" means services provided by licensed or certified speech pathologists, occupational therapists and physical therapists.

(p) "Treatment plan" means a plan to treat an autism spectrum disorder that is prescribed by a licensed physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst.

Schedule of Medical Benefits

A schedule of the PPO Medical Plan benefits appears on the following pages in a chart format. Explanations and limitations that apply to each of the benefits are shown in the second column.

Specific differences in the benefits when they are provided in-network (when you use PPO network providers) and out-of-Network (when you use non-network Non-PPO Providers) are shown in the subsequent columns, if applicable.

The benefits are listed in alphabetical order. To determine the extent to which limitations apply to the benefits that are payable for any health care services or supplies you receive, you should also check to see if those services are listed separately in the Schedule of Medical Benefits, even if they seem to be included in Hospital Services or Physician and Health Care Practitioner Services, and you should also check the Exclusions section of this document.

<p>Schedule of Medical Benefits Plan Year 2014 This chart explains the benefits payable by the CDHP. All benefits are subject to the deductible except where noted. See also the Exclusions and Definitions sections of this document for important information.</p>			
Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Acupuncture</u> Acupuncture and acupressure</p>	<p>Covered if performed by a licensed MD, DO, Acupuncturist (as defined in this plan), Oriental Medicine Doctor.</p> <p>Maintenance services are not a covered benefit.</p>	<p>75% PPO after plan year deductible (PPO= Preferred Provider Organization negotiated fee schedule)</p>	<p>50% U&C after plan year deductible (U&C= Usual and Customary fee schedule)</p>
<p><u>Allergy Services</u> Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast</p> <p>Desensitization and hyposensitization (allergy shots given at periodic intervals)</p> <p>Allergy antigen solution</p>	<p>Allergy testing subject to pre-certification. See the Utilization Management section for details.</p> <p>Allergy services are covered only when ordered by a physician.</p>	<p>Allergy testing, shots and antigen: 75% PPO after plan year deductible</p>	<p>Allergy testing, shots and antigen: 50% of U&C or 110% of the Medi Span AWP, after plan year deductible</p>

<p align="center">Schedule of Medical Benefits Plan Year 2014 This chart explains the benefits payable by the CDHP. All benefits are subject to the deductible except where noted. See also the Exclusions and Definitions sections of this document for important information.</p>			
Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Ambulance Services</u> Ground vehicle transportation to the nearest appropriate health care facility as medically necessary for treatment of a medical emergency, acute illness or inter-health care facility transfer Air transportation to the nearest appropriate health care facility, only as medically necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status</p>	<p>In the event of a life-threatening emergency in which a participant uses an out-of-network provider, benefits will be paid at the in-network benefit level. "Life threatening emergency" means the sudden onset of a medical condition with symptoms severe enough to cause a prudent person to believe that lack of immediate medical attention could result in serious jeopardy to his/her health, jeopardy to the health of an unborn child, impairment of a bodily function or dysfunction of any bodily organ or part.</p>	<p>75% PPO after plan year deductible</p>	<p>75% U&C after plan year deductible</p>

Schedule of Medical Benefits Plan Year 2014 This chart explains the benefits payable by the CDHP. All benefits are subject to the deductible except where noted. See also the Exclusions and Definitions sections of this document for important information.			
Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Autism Spectrum Disorders</u></p> <p>Treatment of any neurobiological medical condition including, without limitation, autistic disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified.</p>	<p>A maximum annual individual benefit of \$36,000 per year for applied behavior analysis treatment as it relates to Autism Spectrum Disorders.</p> <p>Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription drug care, psychiatric care, psychological care, behavior therapy or therapeutic care that is:</p> <p>(a) Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and</p> <p>(b) Provided for a person diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician, psychologist or behavior analyst.</p> <p>Does not include coverage for: Reimbursement to an early intervention agency or school for services delivered through early intervention or school services.</p>	<p>75% PPO after plan year deductible</p>	<p>50% U&C after plan year deductible</p>

Schedule of Medical Benefits Plan Year 2014 This chart explains the benefits payable by the CDHP. All benefits are subject to the deductible except where noted. See also the Exclusions and Definitions sections of this document for important information.			
Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Behavioral Health Services</u> (Mental Health and Substance Abuse Treatment)</p> <p>Behavioral Health services payable by this plan include:</p> <ul style="list-style-type: none"> • Outpatient visits • Inpatient admission • Partial day care • Day treatment • Psychological testing 	<p>See the specific exclusions related to Behavioral Health Services, including mental retardation and learning disability, in the Exclusions section. Benefits are payable only for services of Behavioral Health Care Practitioners listed in the Definitions section.</p> <p>The following behavioral health practitioners are payable under the plan: psychiatrist (MD or DO), psychologist (Ph.D.), Master's prepared counselors (e.g., MSW), licensed associate in social work, social worker, independent social worker or clinical social worker.</p> <p>Outpatient prescription drugs for behavioral health payable under Drugs in this Schedule of Medical Benefits.</p>	<p>Inpatient Admission, Inpatient Partial and Day Treatment: 75% PPO after plan year deductible</p> <p>Outpatient: 75% PPO after plan year deductible</p> <p>Psych Testing: 75% PPO after plan year deductible</p>	<p>Inpatient Admission, Inpatient Partial and Day Treatment: 50% U&C after plan year deductible</p> <p>Outpatient Services including Psych Testing: 50% U&C after plan year deductible</p>
<p><u>Blood Transfusions</u> Blood transfusions, blood products and equipment for its administration</p>	<p>Covered only when ordered by a physician.</p> <p>Expenses related to autologous blood donation (patient's own blood) are covered.</p>	<p>75% PPO after plan year deductible</p>	<p>50% U&C after plan year deductible</p>
<p><u>Breastfeeding Support</u></p>	<p>Pregnant and postpartum women will have access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment in conjunction with each birth.</p>	<p>Preventive/Wellness: 100% No deductible.</p>	<p>50% U & C after plan year deductible</p>

Schedule of Medical Benefits Plan Year 2014 This chart explains the benefits payable by the CDHP. All benefits are subject to the deductible except where noted. See also the Exclusions and Definitions sections of this document for important information.			
Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Chemotherapy</u> Chemotherapy drugs and supplies administered under the direction of a physician in a hospital, health care facility, physician's office or at home</p>	<ul style="list-style-type: none"> • Covered only when ordered by a physician. • Chemotherapy must be pre-certified 	75% PPO after plan year deductible	50% of U&C or 110% of the Medi Span AWP, after plan year deductible
<p><u>Chiropractic Services</u> Office visit and spinal manipulation services</p>	<ul style="list-style-type: none"> • Covered if performed by a licensed MD, DO, or chiropractor. • Maintenance services are not a covered benefit. • X-rays performed in conjunction with chiropractic services are payable under the Radiology Services section of this Schedule of Medical Benefits. 	75% PPO after plan year deductible	50% U&C after plan year deductible
<p><u>Clinical Trials</u> For example: Cancer or Chronic Fatigue syndrome clinical trials</p>	<ul style="list-style-type: none"> • Nevada law allows some clinical trials taking place in Nevada to be covered if certain criteria are met. • See "Experimental and /or Investigational" in the Definitions section. • Pre-certification must be obtained from PEBP's utilization management company. 	75% PPO after plan year deductible	50% U&C after plan year deductible

Schedule of Medical Benefits Plan Year 2014 This chart explains the benefits payable by the CDHP. All benefits are subject to the deductible except where noted. See also the Exclusions and Definitions sections of this document for important information.			
Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Corrective Appliances (Prosthetic & Orthotic Devices, Other Than Dental)</u></p> <p>Prosthetics such as limbs and ocular</p> <p>Orthotics such as casts, splints and other orthotic devices used in the reduction of fractures and dislocations; colostomy or ostomy (orthotic) supplies, hearing aid (with limitations)</p> <p>Initial contact lens or eyeglasses required following cataract surgery. Soft lenses or sclera shells intended as corneal bandages for patients without the lens of the eye (aphakic)</p> <p>Hearing aids</p>	<p>Coverage is provided for certain corrective appliances that are medically necessary and FDA approved. Plan pays for purchase of standard models at the option of the Plan. Repair, adjustment or servicing of the device or, replacement of the device due to a change in the covered person's physical condition that makes the original device no longer functional or if the device cannot be satisfactorily repaired.</p> <p>See the exclusions related to Corrective Appliances in the Medical Exclusions section. To help determine what prosthetic or orthotic appliances are covered, see the definitions of "Prosthetics" and "Orthotics" in the Definitions section.</p> <p>Corrective appliances are covered only when ordered by a physician or health care practitioner.</p> <p>Orthopedic shoes and foot orthotics are not a covered benefit unless the shoe or foot orthotic is permanently attached to a brace.</p> <p>Hearing aids payable if participant has at least 50% loss in one ear.</p> <p>You must submit a copy of your payment receipt from the hearing aid provider to receive credit towards your or your family annual out of pocket maximum. If you do not submit a payment receipt to PEBP's third party claims administrator, you will not receive credit towards your or your family annual out of pocket maximum.</p>	<p>Hearing Aids: 50% PPO after plan year deductible</p> <p>All other Corrective Appliances: 75% PPO after plan year deductible</p>	<p>Hearing Aids: 50% U&C after plan year deductible</p> <p>All other Corrective Appliances: 50% U&C after plan year deductible</p>

Schedule of Medical Benefits Plan Year 2014 This chart explains the benefits payable by the CDHP. All benefits are subject to the deductible except where noted. See also the Exclusions and Definitions sections of this document for important information.			
Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Diabetes Education Services</u> Diabetes training and education services are payable when requested by a physician and medically necessary for the self-care and self-management of a person with diabetes</p>	<p>Services must be provided by a Certified Diabetes Educator or a health care practitioner. Included in this benefit is retraining due to new techniques for the treatment of diabetes or when there has been a significant change in the person's clinical condition or symptoms that requires modification of self-management techniques.</p> <p>Some diabetic supplies are payable under the Prescription Drug section of this Schedule of Medical Benefits. Please contact the Prescription Drug Plan Administrator for more information.</p> <p>If a participant or their spouse/domestic partner or covered dependent child(ren) diagnosed with diabetes is actively engaged in the Diabetes Care Management Program some of their laboratory tests and office visits, prescription drugs and diabetic supplies are eligible for a copayment and are not subject to deductible. See the Diabetes Care Management section of this document for more information.</p>	75% PPO after plan year deductible	Not covered
<p><u>Dialysis</u> Hemodialysis or peritoneal dialysis and supplies</p>	<p>Covered when ordered by a physician and administered in a hospital, health care facility, physician's office or at home.</p> <p>Outpatient, Inpatient or Home Dialysis must be pre-certified by PEBP's Utilization Management vendor. (See the Utilization Management section for details).</p>	75% PPO after plan year deductible	50% U&C after plan year deductible

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Durable Medical Equipment (DME)</u> rental only up to the allowed purchase price of the durable medical equipment;</p> <p>purchase of standard models at the option of the Plan to include equipment maintenance agreements;</p> <p>repair, adjustment or servicing or medically necessary replacement of the durable medical equipment due to a change in the covered person's physical condition, or if the equipment cannot be satisfactorily repaired</p> <p>Coverage is provided for medically necessary oxygen, along with the medically necessary equipment and supplies required for its administration</p>	<p>See the exclusions related to Corrective Appliances and Durable Medical Equipment in the Exclusions section. To help determine what durable medical equipment is covered, see the definition of "Durable Medical Equipment" in the Definitions section.</p> <p>Durable medical equipment is covered only when its use is medically necessary and it is ordered by a physician or health care practitioner.</p> <p>Certain blood glucose monitors are eligible for benefits through PEBP's Prescription Drug Program, see the Prescription Drug Schedule of Benefits and the Diabetes Care Management sections of this document for more information.</p> <p>Rental is payable for certain durable medical equipment but only up to the allowed purchase price of certain corrective appliances such as oxygen concentrators.</p> <p>If the need for a certain durable medical device or appliance is expected to be for a life time, the Plan encourages you to arrange for the purchase of the equipment as opposed to renting the equipment. Some examples of lifelong durable medical equipment are oxygen concentrators, CPAP or BiPAP machines or electric wheelchairs for paralysis. Please check with PEBP's third party administrator or utilization management company for assistance.</p> <p>Contact PEBP's third party administrator for the internet purchase of certain DME such as: CPAP machines or breast pumps.</p>	<p>75% PPO after plan year deductible</p>	<p>50% U&C after plan year deductible</p>

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Emergency Room & Urgent Care Services</u> Hospital emergency room (ER) for a medical emergency</p> <p>Use of an urgent care facility</p> <p>Ancillary charges (such as lab or x-ray) performed during the ER or urgent care visit</p> <p>See also the Ambulance section of this schedule</p>	<p>In-network and out-of-network expenses for emergency room services are covered at the in-network benefit level only when those services are for a medical emergency, as that term is defined below:</p> <p>“Medical emergency” means the sudden onset of a medical condition with symptoms severe enough to cause a prudent person to believe that lack of immediate medical attention could result in serious jeopardy to his/her health, jeopardy to the health of an unborn child, impairment of a bodily function or dysfunction of any bodily organ or part.</p> <p>In the event of a medical emergency in which a participant uses an out-of-network provider, benefits will be paid at the in-network benefit level.</p>	<p>Emergency Room:</p> <ul style="list-style-type: none"> • Medical Emergency: 75% PPO after plan year deductible <p>Urgent Care Facility: 75% PPO after plan year deductible</p>	<p>Emergency Room:</p> <ul style="list-style-type: none"> • Medical Emergency: 75% U&C after plan year deductible <p>Urgent Care Facility: 50% U&C after plan year deductible</p>

Schedule of Medical Benefits Plan Year 2014 This chart explains the benefits payable by the CDHP. All benefits are subject to the deductible except where noted. See also the Exclusions and Definitions sections of this document for important information.			
Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Family Planning/Contraceptives (Females Only)</u></p> <p>Surgical sterilization- Females Only (e.g. tubal ligation)</p> <p>Prescription contraceptives including oral birth control pills, injectables (e.g., Depo-Provera), Intrauterine devices (IUD), diaphragms, implantable birth control devices and services (e.g., Norplant)</p> <p>Follow up visits for side effect management, compliance and maintenance and removal of any device or implant contraceptives covered under these guidelines is also covered at 100% as Preventive/Wellness as long as provided by in network facilities and providers.</p>	<p>All FDA approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. The FDA requires the services to be “prescribed” by a physician even for covered over the counter methods. The following is a list of the FDA approved female contraceptive methods:</p> <ul style="list-style-type: none"> • Sterilization surgery for women; • Surgical sterilization implant for women; • Intrauterine devices (“IUDs”) or implant contraceptives; • Shots or injections; • Oral contraceptives (generic only); • Patches; • Vaginal contraceptive rings; • Diaphragm with spermicide; • Sponge with spermicide; • Cervical Cap with spermicide; • Female condoms; • Spermicide; and • Emergency contraceptives if primary method of birth control fails. 	<p>Preventive/Wellness: 100% No deductible.</p>	<p>50% U & C after plan year deductible</p>

<p align="center">Schedule of Medical Benefits Plan Year 2014 This chart explains the benefits payable by the CDHP. All benefits are subject to the deductible except where noted. See also the Exclusions and Definitions sections of this document for important information.</p>			
Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Fertility, Sexual Dysfunction Services and Male Contraception</u></p> <p>Only diagnosis of fertility and infertility is payable for the employee and spouse</p> <p>Medical or surgical treatment of sexual dysfunction</p> <p>Male Contraception</p> <p>Male Surgical Sterilization</p>	<p>No coverage for the treatment of fertility or infertility. See the specific exclusions related to Drugs, Medicines and Nutrition; Fertility and Infertility; Maternity Services; and Sexual Dysfunction Services in the Exclusions section.</p> <p>Diagnostic procedures for fertility and infertility are subject to the plan year deductible.</p> <p>There are some limits on sexual dysfunction drugs such as Viagra or Muse (max 6 pills or injections/month) and are subject to the plan year deductible.</p> <p>Procedures related to sexual dysfunction as a result of a medical diagnosis or procedure to treat a medical diagnosis may be covered. See the Exclusions section of this document for more information.</p> <p>Male contraception such as condoms are not covered</p> <p>Subject to plan year deductible and coinsurance</p>	<p>75% PPO after plan year deductible</p>	<p>50% U&C after plan year deductible</p>

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Genetic Testing and Counseling</u></p> <ul style="list-style-type: none"> • amniocentesis, • chorionic villus sampling (CVS), • alphafetoprotein (AFP), • BRCA1 and BRCA2 • apo E <p>Notes</p> <ul style="list-style-type: none"> • Contact the Utilization Management company listed in the Contact Guide for coverage details and precertification for covered genetic testing. • For precertification and payment for types of genetic testing and/ or counseling not listed above, contact PEBP's third party administrator prior to receiving the service for determination of medical necessity. 	<p>See the Definitions section and the Exclusions section for definitions and exclusions relating to Genetic Testing and Counseling, including non-payment for pre-parental genetic testing.</p> <p>Amniocentesis, chorionic villus sampling (CVS), and alphafetoprotein (AFP) analysis in pregnant women only if the procedure is medically necessary as determined by the Plan Administrator or its designee.</p> <p>Genetic Counseling when provided before and/or after amniocentesis, chorionic villus sampling (CVS), alphafetoprotein (AFP) analysis. BRCA1 and BRCA2 counseling for individuals already diagnosed with breast and/or ovarian cancer.</p> <p>BRCA1 and BRCA2 genetic test for individuals already diagnosed with breast and/or ovarian cancer where results may affect the course of treatment of the covered PEBP participant. BRCA1 and BRCA 2 testing may be covered under the preventive/wellness benefit. Please refer to the preventive/wellness section of this document for a description of the benefit and the criteria for coverage.</p> <p>Apo E genetic test to help physicians identify those individuals at highest risk for heart disease and determine the most appropriate dietary and fitness program for the covered PEBP participant.</p>	<p>75% PPO after plan year deductible</p>	<p>50% U&C after plan year deductible</p>
<p><u>Hearing Aids</u></p>	<p>See the Corrective Appliances section of this chart. Hearing aids are considered orthotic devices under this plan.</p>		

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Home Health Care and Home Infusion Services</u> Part-time, intermittent skilled nursing care services and medically necessary supplies to provide home health care or home infusion services, subject to the maximum plan benefits shown in the Explanations and Limitations column</p> <p>Home services other than skilled nursing care are not covered</p> <p>Enteral formulas for use at home</p>	<p>See the exclusions related to Home Health Care and Custodial Care (including personal care and childcare) in the Exclusions section of this document.</p> <p>Home health care and home infusion services are covered only when ordered by a physician or health care practitioner.</p> <p>The maximum plan benefit for skilled nursing care services and supplies to provide home health care and home infusion services is 60 visits per person per plan year. A home health care visit will be considered a periodic visit by a nurse or therapist, or four (4) hours of home health services.</p> <p>Charges are covered for private duty nursing by a licensed nurse (RN or LVN/LPN) only when care is medically necessary and not custodial in nature. Outpatient private duty nursing care on a 24-hour shift basis is not covered.</p> <p>Enteral formula (including parenteral nutrition and nutritional supplements) are payable for use as mandated by law.</p>	<p>75% PPO after plan year deductible</p>	<p>50% of U&C or 110% of the Medi Span AWP, after plan year deductible</p>

<p align="center">Schedule of Medical Benefits Plan Year 2014 This chart explains the benefits payable by the CDHP. All benefits are subject to the deductible except where noted. See also the Exclusions and Definitions sections of this document for important information.</p>			
Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Hospice</u> Hospice services and supplies are payable when the patient meets the criteria for receiving hospice care as described under Hospice in the Definitions section to include:</p> <ul style="list-style-type: none"> • Inpatient hospice care • Home hospice services 	<p>Bereavement counseling services provided by a licensed social worker or a licensed pastoral care counselor for the patient's immediate family (covered spouse and/or dependent children) as provided as part of the hospice service. Bereavement counseling beyond that included as part of the hospice program is payable under the behavioral health benefits of this Plan.</p>	<p>75% PPO after plan year deductible</p>	<p>75% U&C after plan year deductible</p>

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Hospital Services (Inpatient)</u> Room & board facility fees in a semiprivate room with general nursing services</p> <p>Specialty care units (e.g., intensive care unit, cardiac care unit)</p> <p>Lab/x-ray/diagnostic services</p> <p>Related medically necessary ancillary services (e.g., prescriptions, supplies)</p> <p>Newborn care and circumcision</p>	<p>Elective hospitalization is subject to pre-certification. All hospitalization is subject to concurrent review. See the Utilization Management section.</p> <p>Private room is payable at the semi-private rate unless it is determined that a private room is medically necessary or the facility does not provide semi-private rooms.</p> <p>Under certain circumstances (listed below) the medical plan will pay for the facility fees and anesthesia associated with medically necessary dental services if the utilization review firm determines that hospitalization is medically necessary to safeguard the health of the patient during performance of dental services.</p> <ul style="list-style-type: none"> • Patient is a child under age seven (7) years and has been diagnosed with extensive dental decay substantiated by x-rays and narrative provided by treating dentist, or • Patient has a documented illness, such as hemophilia or prior tissue or organ transplant requiring a hospital environment to monitor vital signs; or • Patient has a documented mental or physical impairment requiring general anesthesia in a hospital setting for the safety of the patient. • No payment is extended toward the dentist or any assistant dental provider under this medical plan. Refer to the dental benefits described in this document. 	<p>75% PPO after plan year deductible</p>	<p>50% U&C after plan year deductible</p>

Schedule of Medical Benefits Plan Year 2014 This chart explains the benefits payable by the CDHP. All benefits are subject to the deductible except where noted. See also the Exclusions and Definitions sections of this document for important information.			
Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<u>Hospital Services (Inpatient) cont.</u>	See the Eligibility section for how to properly enroll Newborns. Outpatient surgery with an observation period that lasts more than 23 hours will be considered and paid as an inpatient confinement under this medical plan. No coverage for non-emergency hospital admission: No coverage for care and treatment billed by a hospital for a non-medical emergency admission on a Friday or Saturday unless surgery is performed within 24 hours of the admission. Inpatient private duty nursing by a licensed nurse (RN, LVN/LPN) is covered only when care is medically necessary and not custodial, and the hospital's intensive care unit is filled or the hospital has no intensive care unit.	75% PPO after plan year deductible (PPO= Preferred Provider Organization negotiated fee schedule)	50% U&C after plan year deductible (U&C= Usual and Customary fee schedule)

Schedule of Medical Benefits Plan Year 2014 This chart explains the benefits payable by the CDHP. All benefits are subject to the deductible except where noted. See also the Exclusions and Definitions sections of this document for important information.			
Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Laboratory Services (Outpatient)</u> Technical and professional fees Pre-admission testing</p>	<p>Covered only when ordered by a physician or health care practitioner.</p> <p>Inpatient laboratory services are covered under the Hospital Services section of this Schedule of Medical Benefits.</p> <p>Pre-admission testing: Laboratory tests performed on an outpatient basis 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury for which admission or surgery is planned.</p> <p>Outpatient laboratory services such as but not limited to cholesterol screening, glucose and PSA must be provided at a contracted free standing laboratory facility.</p> <p>Outpatient laboratory services (except for pre-admission testing, urgent care facility or emergency room) performed at an acute care hospital facility will not be covered unless an exception is warranted and approved by the Plan Administrator or its designee.</p> <p>If an outpatient laboratory facility or draw station is not available to you within 50 miles of your residence, you may use an acute care hospital facility to receive your outpatient laboratory services.</p> <p>Refer to the wellness/preventive section for information regarding benefits for screening tests and other preventive laboratory testing.</p>	<p>75% PPO after plan year deductible</p>	<p>50% U&C after plan year deductible</p>

Schedule of Medical Benefits Plan Year 2014 This chart explains the benefits payable by the CDHP. All benefits are subject to the deductible except where noted. See also the Exclusions and Definitions sections of this document for important information.			
Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Maternity Services</u> Hospital and birth (birthing) center charges and physician and midwife fees for medically necessary maternity services</p> <p>Termination of pregnancy - See the Genetic Testing section of this Schedule of Medical Benefits for additional information</p> <p>See the Section under Breastfeeding Support for information and benefits related to this type of service.</p>	<ul style="list-style-type: none"> • See the exclusions related to Maternity Services in the Exclusions section. • See the Eligibility section on how to enroll a Newborn Dependent Child(ren). <p>Pregnancy-related care is covered for a female employee or spouse only. No coverage is provided for maternity or delivery expenses of Dependent Children, except for complications of the Dependent Child's pregnancy (see the definition of Complications of Pregnancy in the Definitions section of this document). Hospital length of stay for childbirth: This plan complies with federal law that prohibits restricting benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a health care practitioner to obtain authorization from the plan or its UM Company for prescribing a length of stay not in excess of those periods. However, federal law generally does not prohibit the mother's or newborn's attending health care practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable).</p> <p>Coverage for newly born and adopted children and children placed for adoption consists of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, within the limits of the policy, necessary transportation costs from place of birth to the nearest specialized treatment center under major medical policies, and with respect to basic policies to the extent such costs are charged by the treatment center.</p> <p>Termination of Pregnancy is covered only when the attending physician certifies that the mother's health would be endangered if the fetus were carried to term.</p>	<p>75% PPO after plan year deductible</p>	<p>50% U&C after plan year deductible</p>

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Medical Foods for Inherited Metabolic Disorders</u> Medical Foods (also called “special food products”) are payable for persons with “inherited metabolic disorders” (as those terms are defined in the Definitions section of this document) subject to certain conditions</p>	<p>Medical foods (defined in this plan) are payable for persons with inherited metabolic diseases/disorders (a disease caused by an inherited abnormality of the body chemistry of a person) to a maximum of \$2,500 per person per plan year subject to the following provisions, as determined by the Plan Administrator or its designee:</p> <p>Must be prescribed by a physician to treat a diagnosis of “inherited metabolic disorder”.</p> <p>Documentation to substantiate the presence of an inherited metabolic disorder and that the products purchased are “special food products” may be required before the plan will reimburse the participant for costs associated with this benefit.</p>	<p>75% PPO after plan year deductible is met, to the benefit maximum.</p>	<p>50%U&C after plan year deductible, to the benefit maximum.</p>

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Nondurable Supplies</u> Coverage is provided for up to a 31-day supply per month of:</p> <ul style="list-style-type: none"> • Sterile surgical supplies used immediately after surgery • Supplies needed to operate or use covered durable medical equipment or corrective appliances • Supplies needed for use by skilled home health or home infusion personnel, but only during the course of their required services <p>Diabetic supplies are also payable under the Prescription Drug benefit, see the section on Prescription Drug Benefits in this document for more information</p>	<p>To determine what Nondurable Medical Supplies are covered, see the definition of “Nondurable Supplies” in the Definitions section.</p> <p>Please see the Participant Contact Guide for information regarding the Diabetic Sense mail order program.</p>	<p>75% PPO after plan year deductible</p>	<p>50% of U&C or 110% of the Medi Span AWP, after plan year deductible</p>

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<u>Oral and Craniofacial Services</u> Injury to Sound and Natural Teeth Oral and/or craniofacial surgery	<p>See the exclusions related to Dental Services in the Exclusions section.</p> <p>Treatment of injury to sound and natural teeth must be provided by a dentist or physician and is limited to restoration of sound and natural teeth to a functional level, as determined by the Plan Administrator or its designee (see the definition of “Sound and Natural Teeth” in the Definitions section).</p> <p>Oral or craniofacial surgery is limited to cutting procedures to remove tumors, cysts, abscess including dental abscess and cellulitis, or for acute injury.</p> <p>No coverage for dental services such as removal of wisdom teeth, root canal, gingivectomy and periodontal disease, preparing the mouth for the fitting of or use of dentures, or services related to orthodontia. Under no circumstances are services related to orthodontia covered under this Plan. Orthodontia is a specific plan exclusion.</p> <p>Temporomandibular joint (TMJ) services are payable when medically necessary but not if treatment is recognized as a dental procedure, involves extraction of teeth or application of orthodontic devices (e.g., braces) or splints.</p>	75% PPO after plan year deductible TMJ related services: 50% PPO after plan year deductible	50% U&C after plan year deductible TMJ related services: 50% U&C after plan year deductible

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Outpatient Surgery Facility</u> Ambulatory (outpatient) surgical facility (e.g., surgicenter)</p> <p>Physician fees payable under the Physician services section of this Schedule of Medical Benefits</p>	<p>Outpatient surgery with an observation period that lasts more than 23 hours will be considered and paid as an inpatient confinement under this medical plan.</p> <p>Under certain circumstances the medical plan will pay for the facility fees and anesthesia associated with medically necessary dental services performed in an outpatient surgical facility if the following criteria is met:</p> <p>Patient is a child under age seven (7) years and has been diagnosed with extensive dental decay substantiated by x-rays and narrative provided by treating dentist</p> <p>Patient has a documented illness, such as hemophilia or prior tissue or organ transplant that requires a hospital environment to monitor vital signs</p> <p>Patient has a documented mental or physical impairment that requires general anesthesia in a hospital setting for the safety of the patient</p> <p>No payment is extended toward the dentist or any assistant dental provider fees under this medical plan.</p>	<p>75% PPO after plan year deductible</p>	<p>50% U&C after plan year deductible</p>
<p><u>Prosthetics</u></p>	<p>See the benefit in this Schedule entitled "Corrective Appliance."</p>		

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Physician and Other Health Care Practitioner Services</u> Physician and health care practitioner's professional fees for services provided in a hospital, emergency room, urgent care center, a health care practitioner's office or at home, except as otherwise indicated in this Schedule of Medical Benefits. Payable physician and health care practitioners include:</p> <ul style="list-style-type: none"> • Surgeon; • Assistant surgeon (if medically necessary); • Anesthesia by physicians and Certified Registered Nurse Anesthetists (CRNA); • Pathologist; Radiologist; • Physician Assistant; Nurse Practitioner; Nurse Midwife; • Homeopathic physicians; • Christian Science Practitioners; • Oriental Medicine Doctor (OMD) only for acupuncture 	<p>"Primary Care Physician (PCP)" means a physician in family practice, internal medicine, obstetrics and gynecology and pediatrics.</p> <p>"Specialist" means a physician with advanced education and training in clinical medicine or surgery who is not a primary care physician as defined under this Plan. Many specialists are licensed or certified in their area of clinical specialty.</p> <p>Carpal Tunnel surgery and foot surgery subject to pre-certification. See the Utilization Management section for details.</p> <p>The Plan Administrator or its designee will determine if multiple surgical or other medical procedures will be covered as separate procedures or as a single procedure based on the factors in the definition of "Surgery" in the Definitions section.</p> <p>Assistant surgeon fees will be reimbursed for medically necessary services to a maximum of 20% of the eligible expenses payable to the primary surgeon. A Certified Surgical Assistant (as that term is defined by this plan in the Definitions section) is payable as an assistant surgeon.</p> <p>No coverage is provided for Prophylactic Surgery or Treatment as defined in the Definitions section and as explained in the Exclusions section. No coverage for homeopathic treatments, supplies, remedies or substances.</p>	<p>PCP Office Visit: 75% PPO after plan year deductible</p> <p>Specialist Office Visit: 75% PPO after plan year deductible</p> <p>All Other Services 75% PPO after plan year deductible</p>	<p>PCP or specialist services inpatient or outpatient: 50% U&C after plan year deductible</p>

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Radiology (X-Ray), Nuclear Medicine & Radiation Therapy Services (Outpatient)</u></p> <p>Technical and professional fees associated with diagnostic and curative services, including radiation therapy</p> <p>Pre-admission testing</p>	<p>Covered only when ordered by a physician or health care practitioner.</p> <p>Refer to the wellness/preventive section of this document for information regarding benefits for screening radiology services other preventive radiology testing.</p> <p>Pre-admission testing: Radiology tests performed on an outpatient basis 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury for which admission or surgery is planned.</p>	<p>75% PPO after plan year deductible</p>	<p>50% PPO after plan year deductible</p>
<p><u>Reconstructive Services and Breast Reconstruction After Mastectomy</u></p> <p>This plan complies with the Women's Health and Cancer Rights Act, any covered individual who is receiving benefits from a mastectomy who elects breast reconstruction in connection with it, coverage is provided for:</p> <ul style="list-style-type: none"> • reconstruction of the breast on which the mastectomy was performed 	<p>See the exclusions related to Cosmetic Services (including Reconstructive Surgery) in the Exclusions section.</p> <p>Treatment of leaking breast implant is covered; however, replacements of the implants are payable only if the reason for the implant(s) was due to a condition covered by the Women's Health and Cancer Rights Act.</p> <p>Prophylactic Surgery is covered under certain circumstances:</p> <ul style="list-style-type: none"> • Must be pre-certified by PEBP's utilization management vendor • Women diagnosed with breast cancer at 45 years of age or younger; <i>or</i> 	<p>75%PPO after plan year deductible</p>	<p>50% U&C after plan year deductible</p>

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<ul style="list-style-type: none"> • surgery and reconstruction of the other breast to produce a symmetrical appearance • prostheses and physical complications for mastectomy, including lymphedemas Reconstructive surgery if such procedures are intended to improve bodily function or to correct deformity from disease, infection, trauma, congenital anomaly, or results from a covered therapeutic procedure.	<ul style="list-style-type: none"> • Women who are at increased risk for specific mutation(s) due to ethnic background (for instance: Ashkenazi Jewish descent) and who have one or more relatives with breast cancer or ovarian cancer at any age; <i>or</i> • Women who carry or have a first-degree relative who carries a genetic mutation in the TP53 or PTEN genes (Li-Fraumeni syndrome and Cowden and Bannayan-Riley-Ruvalcaba syndromes); <i>or</i> • Women who possess BRCA1 or BRCA2 mutations confirmed by molecular susceptibility testing for breast and/or ovarian cancer; <i>or</i> • Women who received radiation treatment to the chest between ages 10 and 30 years, such as for Hodgkin disease; <i>or</i> • Women with a first or second degree male relative with breast cancer*; <i>or</i> • Women with a first or second degree relative with a BRCA1 or BRCA2 mutation; <i>or</i> • Women with multiple primary or bilateral breast cancers in a first or second degree blood relative; <i>or</i> • Women with multiple primary or bilateral breast cancers; <i>or</i> • Women with one or more cases of ovarian cancer AND one or more first or second degree blood relatives on the same side of the family with breast cancer; • Women with three or more affected first or second degree blood relatives on the same side of the family, irrespective of age at diagnosis. 		

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<p><u>Rehabilitation Services (Cardiac)</u> Cardiac rehabilitation is available to those individuals who have had cardiac (heart) surgery or a heart attack (myocardial infarction or M.I.)</p>	<p>Cardiac rehabilitation programs must be ordered by a physician.</p> <p>See also the definition of Cardiac Rehabilitation in the Definitions section of this document.</p>	75% PPO after plan year deductible	50% U&C after plan year deductible
<p><u>Rehabilitation Services (Physical, Occupational, and Speech Therapy)</u> Short term active, progressive rehabilitation services (occupational, physical, or speech therapy) performed by licensed or duly qualified therapists as ordered by a physician</p> <p>Inpatient rehabilitation services in an acute hospital, rehabilitation unit or facility or skilled nursing facility for short term, active, progressive rehabilitation services that cannot be provided in an outpatient or home setting.</p>	<p>Inpatient rehabilitation admission requires pre-certification (see the Utilization Management section for details).</p> <p>Maintenance rehabilitation and coma stimulation services are not covered (see specific exclusions relating to Rehabilitation Therapies in the Exclusions section).</p> <p>Rehabilitation services are covered only when ordered by a physician.</p> <p>Speech therapy is covered if the services are provided by a licensed or duly qualified speech therapist to restore normal speech or to correct dysphagia or swallowing defects and disorders lost due to illness, injury or surgical procedure. Speech therapy is payable following surgery to correct a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy), an injury, or sickness that is other than a learning or mental disorder. Speech therapy for functional purposes (including but not limited to a speech impediment, stuttering, lisping, tongue thrusting, stammering, conditions of psychoneurotic origin), learning disorder or childhood developmental speech delays and disorders are excluded from coverage.</p>	<p>Inpatient or Outpatient: 75% PPO after plan year deductible</p>	<p>Inpatient or Outpatient: 50% U&C after plan year deductible</p>

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Second Physician Opinion</u> Includes only one office visit per opinion</p>	<p>For your second opinion, you may choose any in-network, Board-certified specialist who is not an associate of the attending physician.</p>	<p>75% PPO after plan year deductible</p>	<p>50% U&C after plan year deductible</p>
<p><u>Skilled Nursing Facility (SNF) and Subacute Care Facility</u></p>	<p>Admission to a Skilled Nursing Facility or Subacute Care Facility requires pre-certification (see the Utilization Management section of this document).</p> <p>Services must be ordered by a physician.</p> <p>Skilled Nursing Facility (SNF) confinement or Subacute Care Facility confinement: payable up to 60 days per plan year for all confinements related to the same cause.</p>	<p>75% PPO after plan year deductible</p>	<p>50% U&C after plan year deductible</p>

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Transplants (Organ and Tissue):</u></p> <ul style="list-style-type: none"> Coverage is provided only for eligible services directly related to non-experimental transplants of human organs or tissue, along with the facility and professional services, FDA-approved drugs, and medically necessary equipment and supplies. Coverage is provided for the donor when the receiver is a participant under this plan. Coverage is provided for organ or tissue procurement and acquisition fees, including surgery, storage, and organ or tissue transport costs directly related to a living or nonliving donor (transport within the U. S. or Canada only). When the donor has medical coverage, his/her plan will pay first and benefits under this plan will be reduced by that payable under the donor's plan. 	<p>Transplantation-related services require pre-certification (see the Utilization Management section of this document for details).</p> <p>See the specific exclusions related to Experimental and Investigational Services and Transplants in the Exclusions section.</p> <p>Expenses incurred by a PEBP plan participant who donates an organ or tissue are not covered unless the person who receives the donated organ/tissue is also a participant covered by this plan.</p> <p>Participants and their covered dependents are required to use a Center of Excellence for organ and tissue transplants. An appropriate Center of Excellence facility will be identified by PEBP's National PPO Network or PEBP's third party claims administrator.</p> <p>This Plan provides for reimbursement of certain costs associated with travel and hotel accommodations for the patient and one additional individual person (spouse/domestic partner, family member or friend) when associated with medical treatment for organ and tissue transplants performed at a Center of Excellence. Please refer to the section titled "Organ and Tissue Transplants" for additional information. Expenses incurred for travel and hotel accommodations for organ and/or tissue transplants not performed at a Center of Excellence are not covered.</p> <p>PEBP does not provide advance payment for travel expenses related to organ or tissue transplants.</p>	<p>75% PPO after plan year deductible</p>	<p>50% U&C after plan year deductible</p>

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<p><u>Vision Care*</u></p>	<p>One vision exam per plan year subject to deductible and coinsurance. Hardware such as but not limited to, contact lenses, lenses and frames are not covered.</p> <p>*PEBP does not maintain a Vision Network, therefore, any vision provider selected will be considered at the same rate, 75% after plan year deductible and Usual and Customary (U & C) applies.</p>	75% of U & C after plan year deductible	
<p><u>Preventive/Wellness Benefit</u> For Example:</p> <ul style="list-style-type: none"> • Physical exam, screening lab and x-rays • Well Child visits and services • HPV vaccination • Prostate screening • Routine sigmoidoscopy or colonoscopy • Adult immunizations • Screening mammogram (in the absence of a diagnosis) • Pelvic exam and Pap smear lab test • Osteoporosis screening • Hypertension screening • Skin Cancer screening • Routine hearing exam 	<p>Preventive/Wellness benefits are healthcare services that are not provided as a result of illness, injury, or congenital defect. Your physician may recommend a service that is not listed. Please contact the third-party administrator listed in the Participant Contact Guide for coverage information or refer to the preventive/wellness section of this document.</p> <p>Deductible does not apply to these preventive/wellness benefits. Unless coverage is mandated by law, you are responsible for any expenses incurred that are not listed in this documents or do not meet the definition of preventive/wellness services.</p> <p>Benefits are payable for medically supervised weight loss treatment programs. Does not include programs such as Weight Watchers, Jenny Craig, Slim Fast or the rental/purchase of exercise equipment. Refer to the weight management exclusion in the Exclusions section of this document. Weight loss program benefits are not payable if provided out-of-network.</p>	Preventive/Wellness: 100% No deductible.	Not covered

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Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<ul style="list-style-type: none"> • Weight Loss program, medically supervised • Stress management programs <p><u>For an expanded list of covered preventive/wellness services, please refer to the preventive/wellness section of this document.</u></p>	<p>Outpatient newborn, Well Child visits and routine childhood immunizations (<i>e.g.</i> DPT, Polio, MMR, HIB, hepatitis, chicken pox, tetanus). See also, the Special Rule for Coverage of Newborn Dependent Children in the Eligibility section.</p> <p>Prescription and over-the-counter tobacco/smoking cessation products are covered under the Prescription Drug program. Over-the-counter smoking cessation products must be accompanied by a prescription written by a physician. Benefits for over-the-counter products are limited to recommendations by the Surgeon General, located in the Preventive/Wellness section of this document.</p>		

Medical Provider (PPO) Networks

The Plan's Preferred Provider Organizations (PPO) are networks of hospitals, physicians, medical laboratories and other health care providers located within a service area who have agreed to provide health care services and supplies at negotiated discount fees to plan participants. When a participant uses the services of a PPO network (in-network) health care provider, the participant is responsible for paying the applicable deductible and coinsurance on the discounted fees for medically necessary services or supplies, subject to the limitations and exclusions of the plan. If you receive medically necessary services or supplies from an in-network provider, you will pay a lower coinsurance than if you received those services or supplies from a health care provider who is not in the PPO network. In-network providers have agreed to accept the plan's payment (plus any applicable coinsurance you are responsible for paying) as payment in full. The in-network health care Provider generally deals with the plan directly for any additional amount due.

Out-of-network (non-network) health care providers have no agreements with the plan and are generally free to set their own charges for the services or supplies they provide. The plan will reimburse the participant for the Usual and Customary Charge (as defined in this document) for medically necessary services or supplies, subject to the plan's deductibles, coinsurance (on non-discounted services), limitations and exclusions. Non-network health care providers may bill the participant for any balance that may be due in addition to the amount paid by the plan (called balance billing). You can avoid potential balance billing by always using in-network providers.

Plan participants may obtain health care services from in-network or non-network health care providers. Because providers are added and dropped from the PPO network periodically throughout the year, it is the participant's responsibility to verify provider participation BEFORE seeking services by contacting the PPO network. The PPO network's telephone number and website are listed in the Participant Contact Guide section of this document and are available on the PEBP website (www.pebp.state.nv.us).

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

- In the event of a life-threatening emergency in which a participant uses a non-network provider, benefits will be paid at the in-network benefit level.
- For medically necessary services or supplies from non-network providers when such services or supplies are not available from in-network providers within 50 miles of the participant's residence. This includes services provided for preventive/wellness, or a second opinion. (This exception only applies to those individuals who live in a service area covered by an eligible PPO network.)
- If a participant travels to an area ***not*** serviced by an eligible PPO network, benefits for a non-network provider will be paid at the in-network level.
- If a participant travels to an area serviced by one of the plan's eligible PPO networks, the participant must use an in-network provider in order to receive benefits at the in-network benefit level.
- If a participant traveling to an area serviced by an eligible PPO network experiences an urgent but not life-threatening situation and cannot access an in-network provider, benefits ***may*** be paid as in-network for use of an out-of-network urgent care facility.

- If there is a specialty not available inside the participant's eligible PPO network, benefits may be paid as in-network.

When a participant uses the services of a non-network provider in the circumstances defined above, charges by the non-network provider will be subject to the Plan's Usual and Customary charge (as defined in this document). Non-network health care providers may bill the participant for any balance that may be due in addition to the amount paid by the plan (called balance billing).

In-State Preferred Provider Organizations (PPO Network)

You should access the in-state PPO network:

- if you reside in the State of Nevada; or,
- if you reside outside the State of Nevada and travel into Nevada for medical services.

Information regarding the in-state PPO network is located in the Participant Contact Guide section of this document and is available on the PEBP website (www.pebp.state.nv.us).

Out-of State Preferred Provider Organizations (PPO Network)

You should access the out-of-state PPO network:

- if you reside outside of Nevada and require medical services outside of Nevada (within the United States); or,
- if you reside in the State of Nevada and require medical services available in another state.

Information regarding the out-of-state PPO network is located in the Participant Contact Guide section of this document and is available on the PEBP website (www.pebp.state.nv.us).

Service Area

A "service area" is a geographic area serviced by in-network health care providers. If you and/or your covered dependent(s) live more than 50 miles from the nearest in-network health care provider whose services or supplies are determined by the Plan Administrator or its designee as being appropriate for the condition being treated, the plan will consider that you live outside the service area. In that case, your claim for medically necessary services or supplies from a non-network health care provider will be treated as if the services or supplies were provided in-network.

Directories of Network Providers

At least once each year, the PPO networks will generate an updated Directory of Health Care Providers who are members of their network. The directory will be made available to you at no cost. You can obtain a directory by calling the applicable PPO network at the telephone number shown in the Participant Contact Guide section of this document. You can also view the Directory of Health Care Providers on the PEBP website (www.pebp.state.nv.us).

Physicians and health care providers who participate in the plan's networks are added and deleted periodically during the year. You can find out if a health care provider is a member of your network by calling the applicable PPO network at the telephone number listed in the Participant Contact Guide section of this document or by accessing the provider directory on the PEBP website. Participants are encouraged to confirm the in-network participation status of a provider prior to receiving services.

Utilization Management (UM)

Purpose of the Utilization Management Program

The plan is designed to provide you and your eligible family members with financial protection from significant health care expenses. To enable the plan to provide coverage in a cost-effective way, it has adopted a utilization management program designed to help control increasing health care costs by avoiding unnecessary services, directing participants to more cost effective treatments capable of achieving the same or better results and managing new medical technology and procedures. If you follow the procedures of the plan's utilization management program, you may avoid some out-of-pocket costs. However, if you don't follow these procedures, plan benefits are reduced and you will be responsible for paying more out of your own pocket.

What is the Utilization Management Program

The plan's utilization management program is administered by an independent professional utilization management company operating under a contract with the plan (hereafter referred to as the UM company). The name, address and telephone number of the UM company appears in the Participant Contact Guide section of this document. The health care professionals in the UM company focus their review on the necessity and appropriateness of hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical or surgical services. In carrying out its responsibilities under the plan, the UM company has been given discretionary authority by the Plan Administrator to determine if a course of care or treatment is medically necessary with respect to the patient's condition and within the terms and provisions of this plan.

Elements of the Utilization Management Program

The plan's utilization management program consists of:

- Pre-certification review – the review of proposed health care services before the services are provided;
- Concurrent (continued stay) review - the ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or skilled nursing/sub-acute facility;
- Case management - a process whereby the patient, the patient's family, physician and/or other health care providers work together with PEBP under the guidance of the plan's independent UM company to coordinate a quality, timely and cost-effective treatment plan. Case management services may be particularly helpful for patients who require complex, high-technology medical services and who may therefore benefit from professional assistance to guide them through the maze of choices of health care services, providers and practices.

Just because your physician recommends surgery, hospitalization, confinement in a skilled nursing/sub-acute facility, or your physician or other health care provider proposes or provides any medical service or supply does not mean the recommended services or supplies will be considered medically necessary for determining coverage under the medical plan.

The utilization management program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of plan benefits. The UM company's certification that a service is medically necessary doesn't mean a benefit payment is guaranteed.

Eligibility for and actual payment of benefits are subject to the terms and conditions of the plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered, or if the services were not covered, either in whole or in part, by an exclusion in the plan.

All treatment decisions rest with you and your physician or other health care provider. You should follow whatever course of treatment you and your physician, or other health care provider, believe to be the most appropriate, even if:

- the UM company does not certify a proposed surgery or other proposed medical treatment as medically necessary; or
- the plan will not pay regular benefits for a hospitalization or confinement in a skilled nursing/sub-acute facility because the UM company does not certify a proposed confinement

However, the benefits payable by the plan may be affected by the determination of the UM company.

PEBP, the Claims Administrator and the UM company are ***not*** engaged in the practice of medicine and none of them take responsibility for the quality of health care services actually provided (even if they have been certified by the UM Company as medically necessary), or for the outcomes if the patient chooses not to receive health care services that have not been certified by the UM company as medically necessary.

Pre-Certification Review

Pre-certification review is a procedure administered by the UM company to assure health care services meet or exceed accepted standards of care. It also includes the determination of whether or not the admission and length of stay in a hospital or skilled nursing/sub-acute facility, surgery or other health care services are medically necessary. When services are required to be pre-certified (see list below), they must be approved before they are provided. Failure to obtain pre-certification ***may*** result in your benefits being reduced (see the Failure to Follow Required Utilization Management Procedures section).

What Services Must Be Pre-certified:

- All elective inpatient hospital admissions, including planned use of a hospital for a dental purpose. (Exception: a pregnant mother does not need to notify the UM company about the admission for delivery unless the stay will exceed 48 hours for a vaginal delivery or 96 hours for a C-section).
- All admissions to a skilled nursing facility or sub-acute facility
- All admissions to any hospital or rehab facility for rehabilitation therapy
- All organ/tissue pre-transplantation related expenses, including the admission for transplantation services
- Foot surgeries such as bunionectomy, correction of hammer toes, or corrective procedures on metatarsals, phalanges (toes), metatarsophalangeal joint, and interphalangeal joint
- Carpal tunnel surgery
- Genetic testing and/ or counseling for:
 - amniocentesis, chorionic villus sampling (CVS), alphafetoprotein (AFP),
 - apo E

- For other types of genetic testing and/ or counseling, contact PEBP's third party administrator listed in the Participant Contact Guide
- Weight-loss surgery (see more Plan restrictions for this service in the section below)
- All spinal surgeries, inpatient or outpatient, to include but not limited to: laminotomy, discectomy, stereotaxis and neurostimulators
- Dialysis- Inpatient and Outpatient
- Cardiac Pace Makers
- Illnesses requiring chemotherapy
- Any procedure that might be deemed to be experimental and/or investigational. See the Definition Section for information regarding experimental and/or investigational procedures.
- Durable medical equipment when the cost is expected to exceed \$1,000.00.

In compliance with NRS 695G.170, precertification is not required for medically necessary emergency services when a medical condition that manifests itself by symptoms of such sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:

- Serious jeopardy to the health of an insured;
- Serious jeopardy to the health of an unborn child;
- Serious impairment of a bodily function; or
- Serious dysfunction of any bodily organ or part.

Even though a precertification may not be required for some services, like those listed above, the hospital or facility is still required to comply with the Plan's provisions regarding utilization management, such as concurrent (continued stay) review.

How to Request Pre-certification

It is your responsibility to ensure that pre-certification occurs when it is required by this plan. Any penalty for failure to obtain pre-certification is your responsibility, not the health care provider's. You or your physician must call the UM company at the telephone number shown in the Participant Contact Guide section of this document or available on the PEBP website (www.pebp.state.nv.us).

Calls for elective services should be made at least 14 days before the expected date of service. The caller should be prepared to provide all of the following information:

- the employer's name
- employee's name
- patient's name, address, phone number and social security number/ or PEBP unique ID
- physician's name, phone number or address
- the name of any hospital or outpatient facility or any other health care provider that will be providing services
- the reason for the health care services or supplies
- the proposed date for performing the services or providing the supplies.

If additional information is needed, the UM company will advise the caller. The UM company will review the information and provide a determination to you, your physician, the hospital or other health care provider, and the Claims Administrator as to whether or not the proposed health care services have been certified as medically necessary. While industry and accreditation

standards require a pre-certification determination within 15 calendar days for a non-urgent case, the UM company will usually respond to your physician or other health care provider by telephone within 3 business days of receipt of the request and any required medical records and/or information. The determination will then be confirmed in writing.

If your admission or service is determined not to be medically necessary, you and your physician will be given recommendations for alternative treatment. You may also pursue an appeal (see the section regarding Appealing a UM Determination).

Concurrent (Continued Stay) Review

When you are receiving medical services in a hospital or other inpatient health care facility, the UM company will monitor your stay by contacting your physician or other health care providers to assure that continuation of medical services in the health care facility is medically necessary. The UM company will also help coordinate your medical care with benefits available under the plan.

Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services, and/or advising your physician or other health care providers of various options and alternatives for your medical care available under this plan.

If, at any point, your stay is found ***not*** to be medically necessary and care could be safely and effectively delivered in another environment (such as through home health or in another type of health care facility), you and your physician will be notified. This does not mean that you must leave the hospital, but if you choose to stay, all expenses incurred after the notification will be your responsibility. If your hospital stay is determined not to be medically necessary, no benefits will be paid on any related hospital, medical or surgical expense. You may also appeal the determination (see the section regarding Appealing a UM Determination).

Emergency Hospitalization

You are not required to obtain a pre-certification before you obtain services for a Medical Emergency. Further, if a Medical Emergency occurs, there may be no time to contact the UM company before you are admitted to the hospital. However, the UM company must still be notified of the hospital admission within 1 business day so that the UM company can conduct a concurrent (continued stay) review. You, your physician, the hospital, a family member or friend can call the UM company. If you don't follow the required UM process, benefits payable for the services may be reduced by 50% of the allowable charges. This provision applies to both in-network and non-network medical expenses. Expenses related to the penalty will not be counted to meet your plan year deductible or out-of-pocket maximum.

Case Management

Case management is a voluntary process administered by the UM company. Its medical professionals work with the patient, family, caregivers, health care providers, Claims Administrator and PEBP to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly and/or high-technology services, or when assistance is needed to guide the patient through a maze of potential health care providers (see the section titled Restrictions and Limitations of the Utilization Management Program).

The Case Manager of the UM company will work directly with your physician, hospital and/or other health care provider to review proposed treatment plans and to assist in coordinating services and obtaining discounts from health care providers as needed. From time to time, the Case Manager may confer with your physician or other health care providers, and may contact you or your family to assist in making plans for continued health care services or obtaining information to facilitate those services.

You, your family, or your physician may call the Case Manager at any time to ask questions, make suggestions or offer information. The Case Manager can be reached by calling the UM company at the telephone number shown in the Participant Contact Guide section of this document or on the PEBP website (www.pebp.state.nv.us).

Weight Loss Surgeries- Plan Restrictions

Weight loss surgeries must be performed at an in-network (PPO) outpatient or inpatient Center of Excellence facility. There is no payment if services are provided at an out of network facility or out of network surgeon or other ancillary providers are used. PEBP or its designee will determine the in-network Center of Excellence facility.

Participants are limited to one obesity related surgical procedure of any type in an individual's lifetime while covered under the PEBP CDHP (or previous PEBP PPO Plans) plan. For example, a participant cannot have lap band surgery and subsequently seek benefits for gastric bypass. The first service related to surgical weight loss will be considered payable under this plan, any others will not. If a participant had coverage under a different plan previously and subsequently had a bariatric surgery, they are still eligible to have one bariatric procedure paid for under the PEBP CDHP Plan, provided that all precertification criteria are met.

For lap band adjustments, the Plan will consider any adjustments made in the 12 months following surgery as long as the participant remains compliant with their post-surgical agreement as verified by PEBP's UM company. Any adjustments to the lap band after the first 12 months post-surgery will be subject to precertification by PEBP's Utilization Management vendor.

It is the responsibility of the PEBP participant to ensure that their providers and facilities chosen to provide these services are in network in order for benefits to be paid. Participants can verify the network status of any provider or facility by calling PEBP's third party administrator.

The PEBP participant must receive treatment in an Obesity Surgery Center of Excellence. An Obesity Surgery Center of Excellence provider has met with the requirements outlined by the Surgical Review Corporation (SRC) in collaboration with the American Society for Metabolic and Bariatric Surgery (ASMBS). The certification identifies providers who consistently deliver excellent care and positive outcomes. The ASMBS Bariatric Surgery Center of Excellence (BSCOE) designation helps identify providers with whom a participant should expect to receive safer and more effective surgical treatment. These BSCOE providers adhere to a multidisciplinary surgical preparatory regimen to include but not be limited to the following:

1. Behavior modification program supervised by a qualified professional; *and*
2. Consultation with a dietician or nutritionist; *and*

3. Documentation in the medical record of the participant's active participation and compliance with the multidisciplinary surgical preparatory regimen at each visit. A physician's summary letter, without evidence of concurrent oversight is not sufficient documentation. Documentation should include medical records of the physician's initial assessment of the participant, and the physician's assessment of the participant at the completion of the multidisciplinary surgical preparatory regimen; *and*
4. Exercise regimen (unless contraindicated) to improve pulmonary reserve prior to surgery, supervised by an exercise therapist or other qualified professional; *and*
5. Program must have a substantial face-to-face component (must not be entirely delivered remotely); *and*
6. Reduced-calorie diet program supervised by dietician or nutritionist.

This Plan allows for the reimbursement of certain travel and hotel accommodation expenses for the patient and one additional individual person (spouse/domestic partner, family member or friend) when associated with medical treatment for obesity surgery that is performed at a Center of Excellence. See the section regarding travel expenses for more information.

If a participant has started any type of program to meet the pre-surgery criteria outlined below with an out of network facility/ provider, those services will NOT be considered to be a part of the Plan's mandatory precertification requirements. In order for the Plan to consider your bariatric surgery at the in network benefit level; you will have to begin the precertification process again with the appropriate providers.

All services, pre and post-surgery must be at an in network facility, with in network providers AND be at a certified center of excellence for bariatric weight loss.

Pre-certification/ Pre-Surgery Criteria for Weight-Loss Surgery

The participant or their physician must contact PEBP's UM company to begin the process toward surgical intervention for obesity. The initial contact will include:

- Notification to the participant that the precertification process begins with the initial contact to the UM company.
- Notification to the participant that precertification requests presented to PEBP's UM company before the clinical criteria listed below has been completed will be denied. A precertification request may be reconsidered upon completion of the clinical criteria.
- Informing the participant of the requirement to access and participate in a weight management and nutrition program.
- Documenting participant completion of the associated assessments required to be considered for the procedure.
- Educating the participant on how to access wellness services and how to proceed with meeting the Clinical Indications listed below.
- PEBP's UM company can advise participants of Centers of Excellence in Bariatric Surgery providers in their geographic area.

Note: The PEPB participant will sign a contract of agreement to attend support monthly meetings for 1 year post surgery (provided by participating providers). The Program will allow

online waiver for patients residing 50 miles or more from the obesity surgeon's facility where the support meetings are held.

Clinical Criteria for Weight Loss Surgeries

- Treatment indicated by ANY ONE of the following:
 - Patient has a BMI exceeding 40 kg/m².
 - Patient's BMI is greater than 35 kg/m² and two or more clinically serious conditions exist (e.g., obesity hypoventilation, sleep apnea, diabetes, hypertension (high blood pressure), cardiomyopathy, musculoskeletal dysfunction, joint replacement, GERD, hypertriglyceridemia or hypercholesteremia, back pain, urinary incontinence, renal failure, arthritis).
- Surgical intervention indicated because patient has met all of following criterion:
 - Patient is well-informed and motive and has failed previous non-surgical weight loss attempts
 - No thyroid disorder (excluding thyroid problems currently being successfully treated) found by your physician [e.g., an endocrine (hormone) disorder]
 - Must have obtained full growth and be over the age of 18 years
 - Documentation of a pre-operative psychological evaluation by a licensed clinical psychologist or psychiatrist within the last 90 days to determine if the patient has the emotional stability to follow through with the medical regimen that must accompany the surgery
 - Physician-supervised nutrition and exercise program: Participant has complied for at least 6 months (without a gap) within the 12 month period prior to the scheduled surgical intervention in a physician-supervised nutrition and exercise program (including dietician consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record at each visit. The physician-supervised nutrition and exercise program must meet all of the following criteria:
 - Participation in a physician-supervised nutrition and exercise program must be documented in the medical record by an attending physician who supervised the member's participation. The nutrition and exercise program may be administered as part of the surgical preparative regimen, and participation in the nutrition and exercise program may be supervised by the surgeon who will perform the surgery or by some other physician. Note: A physician's summary letter is not sufficient documentation. Documentation should include medical records of the physician's concurrent assessment of the patient's progress throughout the course of the nutrition and exercise program. For participants who participate in a physician-administered nutrition and exercise program (e.g., MediFast, OptiFast), program records documenting the participants participation and progress may substitute for physician medical records; *and*
 - Nutrition and exercise program must be supervised and monitored by a physician working in cooperation with dieticians and/or nutritionists, with a substantial face-to-face component (must not be entirely remote); *and*
 - Nutrition and exercise program(s) must be for a cumulative total of 6 months or longer in duration and occur within the 12 month period prior to the scheduled surgical intervention.

Note: The PEPB participant will sign a contract of agreement to attend support monthly meetings for 1 year post surgery (provided by participating providers). The Program will allow an online waiver for patients residing 50 miles or more from the obesity surgeon's facility where the support meetings are held.

Contraindications to weight loss surgery

Requests for weight loss surgery will be denied if any one or more of the following conditions are present:

- Untreated major depression or psychosis
- Binge-eating disorders
- Current Drug or alcohol abuse
- Severe cardiac disease with prohibitive anesthetic risks
- Severe coagulopathy
- Inability to comply with nutritional requirements including life-long vitamin replacement

Failure to Follow Required Utilization Management Procedures

If you don't follow the required Pre-certification Review process described in this section, benefits payable for the services you failed to pre-certify will be reduced by 50% of the allowable charges. This provision applies to both in-network and non-network medical expenses. Expenses related to the penalty will not be counted to meet your plan year deductible or out-of-pocket maximum.

If you wish to appeal a decision made by the Utilization Management company, please refer to the section called "Appealing a UM Determination" in the Self-Funded Claims Administration section of this document.

Travel expenses for Organ and/or Tissue Transplant and Obesity Surgery Services

This Plan requires participants to use a PPO Center of Excellence for organ and tissue transplants and obesity surgery. To locate a PPO Center of Excellence, please contact or have your physician contact PEPB's National PPO Network or Third Party Claims Administrator.

This Plan allows for the reimbursement of certain travel and hotel accommodation expenses for the patient and one additional individual person (spouse/domestic partner, family member or friend) when associated with medical treatment for organ and tissue transplants or bariatric weight loss surgery performed at a Center of Excellence. This benefit is subject to certain conditions, as described below.

This Plan incorporates the travel expense reimbursement guidelines established in the Nevada State Administrative Manual (SAM) 0200 as well as the guidelines adopted by the PEPB Board and outlined in the PEPB Board Duties, Policies and Procedures manual.

In State Travel (Nevada) – SAM 0212

Travel expenses incurred may be reimbursed at a rate comparable to the rates established by the [US General Services Administration](#) (GSA) for the State of Nevada. Maximum per diem reimbursement rates for Nevada's lodging, meals and incidental expenses are established by city/county and vary by season. Receipts are required for all lodging expenses. In addition to the

reimbursable lodging rates, participants may be reimbursed for lodging taxes and fees. Lodging taxes are limited to the taxes on reimbursable lodging costs. For example, if the maximum lodging rate is \$50 per night, and you elect to stay at a hotel that costs \$100 per night, you can only claim the amount of taxes on \$50 which is the maximum authorized lodging amount. Meals will be reimbursed in accordance with the meals and incidental expense (M&IE) allowance. Receipts are not required for the M&IE allowance. Participants should refer to the GSA's website <http://gsa.gov> and the link "Per Diem Rates" for the most current rates.

Participants are required to use the least expensive method of transportation. Participants who use their personal vehicle to travel to a Center of Excellence will be compensated for miles to and from the Center of Excellence (based on an objective source such as Google Maps) at the standard mileage reimbursement rate for which a deduction is allowed for travel for federal income tax or the personal convenience mileage reimbursement rate depending on the circumstances and the cost of other methods of travel.

Out of State (Nevada) travel – SAM 0214

Travel expenses incurred may be reimbursed at a rate comparable to the rates established by the US General Services Administration (GSA) for the primary destination. Maximum per diem reimbursement rates for lodging, meals and incidental expenses are established by city/county and vary by season. Receipts are required for all lodging expenses. In addition to the reimbursable lodging rates, participants may be reimbursed for lodging taxes and fees. Lodging taxes are limited to the taxes on reimbursable lodging costs. For example, if the maximum lodging rate is \$50 per night, and you elect to stay at a hotel that costs \$100 per night, you can only claim the amount of taxes on \$50 which is the maximum authorized lodging amount. Meals will be reimbursed in accordance with the meals and incidental expense (M&IE) allowance for the primary destination. Receipts are not required for the M&IE allowance. Participants should refer to the GSA's website <http://gsa.gov> and the link "Per Diem Rates" for the most current rates.

Participants are required to use the least expensive method of transportation. Participants who use their personal vehicle to travel to a Center of Excellence will be compensated for miles to and from the Center of Excellence (based on an objective source such as Google Maps) at the standard mileage reimbursement rate for which a deduction is allowed for travel for federal income tax or the personal convenience mileage reimbursement rate depending on the circumstances and the cost of other methods of travel.

The Board Duties, Policies and Procedures of PEBP outline when meals are eligible for reimbursement:

- Reimbursement for meals while traveling must meet the following guidelines:
 - Breakfast – must depart before 7:00a.m. or return after 9:00a.m.
 - Lunch- must depart before 11:00 a.m. or return after 1:00 p.m.
 - Dinner- must depart before 5:00 p.m. or return after 7:00 p.m.

The PEBP Board has adopted the following additional restrictions relating to travel associated with medical treatment for organ and tissue transplants or bariatric weight loss surgery performed at a Center of Excellence:

- Travel expenses are covered only when the distance to the Center of Excellence is 100 miles or more from the participant's residence.
- Travel expenses are covered when incurred in conjunction with the patient's transplant or bariatric surgery (does not include pre-surgery evaluations) and for one year after surgery for follow-up visits as required by the patient's surgeon. Travel expenses incurred on or after one year are not eligible for reimbursement.
- Travel expenses related to an organ or tissue transplant or bariatric surgery scheduled or performed at a facility or other provider type that is not a Center of Excellence as determined by PEBP or its designee will not be covered. There are no exceptions.
- Eligible travel expenses includes:
 - Flight expenses for commercial air (regular coach rate).
 - Mileage reimbursement for personal vehicle.
 - Travel meals (for patient and travel companion only).
 - Hotel accommodations.
 - Parking or vehicle storage fees for private automobiles and commercial transportation costs (i.e., taxi, shuttle, etc.).
 - Rental car expense.
- Receipts are required for reimbursement for all expenses except for meals which are based on the number of days and time of travel.
- The following are specifically excluded from reimbursement under any circumstances (other expenses not included below may be denied if they are not preapproved):
 - Alcoholic beverages
 - Car maintenance
 - Vehicle insurance
 - Flight insurance
 - Cards, stationery, stamps
 - Clothing
 - Dry cleaning
 - Entertainment (cable televisions, books, magazines, movie rentals)
 - Flowers
 - Household products
 - Household utilities, including cell phone charges, maid, baby-sitter or day care services
 - Kennel fees
 - Laundry services
 - Security deposits
 - Toiletries
 - Travel expenses related to a facility or provider that is not a certified Center of Excellence
- Travel expenses are subject to the annual deductible and coinsurance amount.
- If the travel companion is another PEBP participant, reimbursement or deductible credit will not be credited to PEBP participant who is not the recipient of the organ or tissue transplant.
- PEBP does not provide advance payment for travel expenses.

Pre-approval of your travel expenses

Unless there are extenuating circumstances, travel expenses must be preapproved by PEBP or its designee. Travel expenses not preapproved by PEBP or its designee will not be eligible for reimbursement.

If the participant is unable to obtain pre-approval by PEBP or its designee because the organ or tissue transplant required immediate travel, the participant may submit all associated travel costs to PEBP or its designee after the transplant surgery for consideration. The participant should make arrangements for someone to notify PEBP or its designee regarding the emergency travel and the circumstances surrounding such travel. Travel claims must be submitted within 12 months of the date of surgery to be considered eligible.

Pre-approval will provide an approximation of your travel reimbursement. Final reimbursement will be based on actual expenses using the actual number of days and travel times and may differ from the pre-approved approximation. PEBP has provided a pre-approval "Travel Expense Request" form on its website at www.pebp.state.nv.us.

Submitting your travel expense receipts

A claim for travel expense reimbursement must be submitted to PEBP's third party claims administrator on a "Travel Expense Reimbursement" claim form. All relevant sections of the form must be completed including the start and end times, destination and purpose of trip. The claimant should sign the travel expense claim form attesting to the accuracy of the claim.

"Travel Expense Reimbursement" claims should be accompanied by original itemized receipts which include the name(s) of the person(s) incurring the expense. If the travel includes a commercial airline flight, an itinerary should be attached for meal justification.

Reimbursement of eligible travel expenses, including any eligible travel expenses relating to a travel companion, will be payable to the primary participant (employee or retiree) and not to the service vendor (credit card company, hotel, hospital, restaurant, etc.).

NOTE: PEBP has full authority to approve or deny all or part of your travel expenses. The denial of travel expenses cannot be appealed.

NVision Health and Wellness

Wellness Program

PEBP provides a comprehensive wellness program referred to as NVision Health or NVision Health and Wellness. This program is available to primary participants of the CDHP and the HMO plans (actives and eligible retirees) and their covered dependents.

The information described in this section provides a summary of the program. For more detailed information, please contact PEBP's wellness vendor. The wellness vendor's telephone number and website are listed in the Participant Contact Guide section of this document and are available on the PEBP website (www.pebp.state.nv.us).

NVision Health provides participants with a personalized, confidential wellness program that includes the tools, education and personal attention that can help maintain or improve health. The program includes an online Health Assessment Questionnaire (HAQ) and a comprehensive blood analysis to identify current and future health risks. It also includes a personalized plan with specifics information and recommendations about health.

The NVision Health and Wellness program has several components offering a multi-year approach to improving or maintaining health and wellness for participants.

Valuable Benefits Include:

- Online Health Assessment Questionnaire (HAQ) and comprehensive blood analysis that identifies your current and future health risks
- Personalized plan gives specific information and recommendations about your health
- More than 25 online education programs help you achieve your health goals
- Support from a personal Health Coach online or by phone (for CDHP participants with moderate or high risk levels)
- Preventive screening schedules and alerts based on age, gender and risks
- Confidential health records to store and manage your health information
- Online health tools to help reduce your health risks, including a robust health library, animations and an interactive symptom checker
- Personal Prevention score tracks your progress and keeps you motivated
- Results to share with your doctor
- 24/7 nurse help line
- Macaw application that allows you to take your health and wellness program anywhere
- Plan-wide challenges allow you to compete with other members by tracking healthy actions through Macaw or your online portal
- NVision Kids content about health and wellness

July 1, 2013 – June 30, 2014

Participants complete the following 4 steps between March and May, 2013:

1. Program registration or re-enrollment;
2. Health Assessment Questionnaire (HAQ);
3. Biometric screening
 - Body Mass Index (BMI)
 - Blood pressure
 - Triglycerides
 - HDL cholesterol
 - LDL cholesterol
 - Glucose
 - Non-tobacco use; and
4. Action Programs – Intervention
 - Physical examination
 - Teeth cleaning
 - Benefits 101 tutorials and pass the exam with a minimum score of 80%.

Primary CDHP and HMO participants who complete the 4 steps receive a premium credit based on the total points achieved. Point values earned in Year One are for premium credit effective July 1, 2013 through June 30, 2014.

Primary participants earning a final prevention score between 0 and 749 are not eligible for a premium credit. Participants earning a prevention score between 750 and 850 receive a \$25 monthly premium credit. Participants earning a prevention score between 851 and 1,000 points receive a \$50 monthly premium credit.

The following table describes the point values that may be earned for completing the four steps.

Point values earned for premium credit effective July 1, 2013 through June 30, 2014.

If your final Prevention Score falls between:	Your monthly premium credit will be:	
0 - 749	\$0	
750 - 850	\$25	
851 - 1,000	\$50	
Biometric Screening	Weighted %	Points
BMI	15.00%	150
Blood Pressure	10.00%	100
Triglycerides	10.00%	100
HDL Cholesterol	10.00%	100
LDL Cholesterol	10.00%	100
Glucose	10.00%	100
Non-Tobacco Use (via lab results)	10.00%	100
Total Biometric Assessment	75.00%	750
Action Program—Intervention	Weighted %	Points
Preventive Screening Visit		
<input type="checkbox"/> Physical exam—125 points	15.00%	150
<input type="checkbox"/> Teeth cleaning/exam—25 points		
Tutorial		
<input type="checkbox"/> Benefits 101 tutorial and exam	10.00%	100
Total Action Program—Intervention	25.00%	250
Total Prevention Score	100.00%	1,000

Disease Management (Diabetes and Obesity)

Diabetes Care Management

The Diabetes Care Management program is a disease management program open to all primary CDHP self-funded plan participants, their covered spouses or domestic partners and their covered dependent children diagnosed with diabetes.

When you join the Diabetes Care Management program, your effective date will be the 1st of the month following your enrollment in the program. The effective date will be determined by PEBP's wellness vendor and PEBP.

The information described in this section provides a summary of the program's functions. For more detailed information, please contact PEBP's wellness vendor or PEBP's third party administrator. Contact information for PEBP's wellness vendor and third party administrator is located in the Participant Contact Guide section of this document.

The Diabetes Care Management program is optional and considered an "opt-in" program.

Primary participants and their covered spouses or domestic partners are not considered actively engaged until they accept the following requirements:

- Regular telephonic engagement calls with PEBP's wellness vendor's coaches; and
- Maintenance of their prevention plan as prescribed by the participant's physician and coach.

Covered dependent children between the ages 1 - 18 are considered "actively engaged" when the following services are adhered to. Compliance will be monitored by PEBP's wellness vendor and/or third party administrator:

- At least 2 visits with their primary care physician or endocrinologist each plan year.
- Adherence to the diabetes medications prescribed by their physician. This will be monitored by PEBP's wellness vendor and/or third party administrator.
- Adherence to appropriate laboratory testing as prescribed by their physician.

Participants, their covered spouses or domestic partners and their covered adult (over age 18 years) dependent children diagnosed with diabetes who are actively engaged in the Diabetes Care Management program will receive the following benefits:

- Two physician office visits indicating a primary diagnosis of diabetes will be paid for under the preventive/wellness benefit annually;
- Two routine laboratory blood services such as the hemoglobin (A1c) test will be paid for under the preventive/wellness benefit annually;
- Diabetes related medications, such as insulin and Metformin, will be eligible for copayments and not be subject to the plan year deductible; and
- Diabetic supplies coordinated through the preferred mail order service are eligible for a copayment for each supply and are not subject to the plan year deductible. Diabetic

supplies that are less than the copayment, you will be charged the actual cost and not the copayment.

If, at any time, PEBP's wellness vendor or third party administrator deems a participant, covered spouse, covered domestic partner or covered dependent child(ren) to be non-compliant or no longer engaged, the participant, any covered spouse or covered domestic partner and any covered dependent child(ren) will return to the standard CDHP/PPO benefits where the annual deductible and coinsurance will apply to the medical services listed in this section of the MPD. The effective date of the return to the standard CDHP/PPO benefits will be the first day of the month following the non-compliance notification from PEBP's wellness vendor or third party administrator.

Diabetes Care Management Schedule of Benefits Plan Year 2014

This chart explains the benefits payable by the wellness benefit of the Self-funded Plan while engaged in Care Management.

All benefits are subject to the deductible except where noted.

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
Routine Office Visits and routine laboratory testing.	<ul style="list-style-type: none"> • Must be for physician office visits indicating a diagnosis of diabetes. • Must be actively engaged in the Diabetes Care Management program. • Limit of two routine office visits per year. • Limit of two routine laboratory blood services such as the hemoglobin (A1c) test will be paid for under the preventive/wellness benefit annually. • If a participant exceeds two routine office visits per year and two routine laboratory blood services per year, the annual deductible and coinsurance will apply to these services. 	100% of PPO contracted rate. No deductible. Limit of two visits per year.	Not covered under wellness benefit. Subject to 50% coinsurance and annual deductible.

Diabetes Care Management Schedule of Benefits Plan Year 2014

This chart explains the benefits payable by the wellness benefit of the Self-funded Plan while engaged in Care Management.

All benefits are subject to the deductible except where noted.

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
Diabetic Supplies Mail Order Benefit	<ul style="list-style-type: none"> • This is a preferred mail order service for diabetic supplies for participants. To enroll in this benefit, contact the diabetes mail order benefit program whose name and phone number is listed in the Participant Contact Guide section of this document. • You may receive up to a 90 day supply (with the exception of the blood glucose monitor) of each eligible diabetic supply item. • Diabetic supplies must be coordinated through the preferred mail order service to receive the benefit. • Diabetic supplies not coordinated through the preferred mail order service will be subject to normal plan benefits e.g. deductible and coinsurance. • Must be actively engaged in the Diabetes Care Management program. 	<p>\$50 copay applies to <u>each</u> diabetic supply item. If the actual cost is less than \$50, you will pay the actual cost.</p> <p>There is no cost to you for the blood glucose monitor.</p> <p>Once enrolled, you are able to receive up to a 90-day supply of the following items: blood glucose monitors, test strips, insulin syringes, alcohol pads, and lancets.</p>	<p>75% PPO contracted rate after plan year medical and prescription drug deductible.</p>

Diabetes Care Management Schedule of Benefits Plan Year 2014

This chart explains the benefits payable by the wellness benefit of the Self-funded Plan while engaged in Care Management.

All benefits are subject to the deductible except where noted.

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	
<p>Diabetes related medications such as insulin and Metformin</p>	<p>Diabetes related medications will be identified by PEBP's Prescription drug administrator.</p> <p>Other Limitations</p> <ul style="list-style-type: none"> • Copayments for diabetes related drugs are not applied to meet the medical and prescription drug deductible or out-of-pocket maximum. • This plan does not coordinate prescription drug plan benefits. • Must be actively engaged in the Diabetes Care Management program. • Copayment at 90 day supply retail: Subject to three times the listed 30 day retail copayment. <p>Specialty Medications: Specialty Medications are not covered under this program and are subject to the annual deductible and out of pocket maximums described in the Summary of Self-Funded Components section of this document. For more information about specialty medications, please contact the prescription drug plan administrator listed in the Participant Contact Guide.</p>	<p>In-Network Retail :</p> <ul style="list-style-type: none"> • Tier 1 Generic: \$5 copay • Tier 2 Preferred Brand: \$25 copay • Tier 3 Non Preferred Brand: 100% copay* <p>Mail Order Services</p> <ul style="list-style-type: none"> • Tier 1 Generic: \$15 copay • Tier 2 Preferred Brand: \$75 copay • Tier 3 Non Preferred Brand: 100% copay* <p>*Tier 3 Non-preferred name brand drugs: Participant is responsible for 100% of the Preferred Contract Rate. Deductible credit is not applied.</p>

Obesity and Overweight Care Management

The Obesity and Overweight Care Management program is open to all primary CDHP plan participants, their covered spouses or domestic partners and their covered dependent children who have been diagnosed as obese or overweight by their physician.

For enrollment information, please contact PEBP's third party administrator listed in this document under the Participant Contact Guide. When you enroll in the program, your effective date will typically be the 1st of the month following your enrollment in the program. The effective date will be determined by PEBP.

The information described in this section provides a summary of the program's functions. For more detailed information, please contact PEBP's wellness vendor or PEBP's third party administrator. Contact information for PEBP's wellness vendor and third party administrator is located in the Participant Contact Guide section of this document.

The Obesity and Overweight Care Management program is optional and considered an "opt-in" program. To be eligible for the enhanced wellness benefits, participants and/or their covered dependents must meet certain criteria and adhere to certain participation requirements.

Once you have met your final weight loss goal as determined by your weight loss provider at the onset of your participation in a medically supervised weight loss program, benefits under the Obesity and Overweight Care Management program will end. This plan does not provide benefits for ongoing maintenance care. If you choose to receive ongoing maintenance care, you will be responsible for the cost of receiving the services.

PEBP's third party administrator provides an Obesity Care Management participant program navigation guide on their website, see the Participant Contact Guide for more information.

Criteria for Obesity/Overweight weight loss benefits

➤ For adults 18 years and older:

Services must be provided by:

- An in-network provider who specializes in weight loss services according to PEBP's PPO provider network; or
 - An in-network provider who is certified by the American Board of Bariatric Medicine (ABBM); or
 - An in-network provider who is in training to become certified by the American Board of Bariatric Medicine (ABBM); or
 - If no provider as described above is available within 50 miles of a member's residence, any in-network provider.
2. The patient's BMI must be greater than 30 kg/m², with or without any co-morbid conditions present, or greater than 25 kg/m² (or waist circumference greater than 35 inches in women, 40 inches in men) if one or more of the following co-morbid conditions are present:
 - Coronary artery disease;

- Diabetes mellitus type 2;
- Hypertension (Systolic Blood Pressure greater than or equal to 140 mm Hg or Diastolic Blood Pressure greater than or equal to 90 mm Hg on more than one occasion)
- Obesity-hypoventilation syndrome
- Obstructive sleep apnea;
- Cholesterol and fat levels measured (Dyslipidemia):
 - a. HDL cholesterol less than 35 mg/dL ; *or*
 - b. LDL cholesterol greater than or equal to 160 mg/dL; *or*
 - c. Serum triglyceride levels greater than or equal to 400 mg/dL.

➤ For children 2 to 18 years

- Services must be provided by an in-network provider who specializes in childhood obesity;
- Child must present a BMI \geq 85th percentile for age and gender.

Engagement in the Program

In addition to meeting the requirements listed under the section titled “Criteria for Obesity/Overweight weight loss benefits”, you must remain “actively engaged” in a medically supervised weight loss program. Actively engaged is defined as:

- A. Participation in the NVision Health and Wellness program by completing the annual Health Assessment Questionnaire and biometric screenings for participants and adult eligible dependents over 18 years of age. Children ages 2 – 18 years may not be required to complete the annual Health Assessment Questionnaire and biometric screening but may be subject to other requirements specific to the individual.
- B. Participation in regular office visits with your weight loss medical provider. The frequency of the office visits will be determined by your weight loss medical provider who will in turn report this information to PEBP’s third party administrator for monitoring.
- C. Consistently demonstrating a commitment to weight loss by adhering to the weight loss treatment plan developed by your weight loss medical provider including but not limited to routine exercise, proper nutrition and diet and pharmacotherapy if prescribed. Commitment to your weight loss treatment will be measured by PEBP’s third party administrator who will review monthly progress reports submitted by the provider.
- D. Losing weight at a rate determined by the weight loss medical provider.

Monitoring Engagement

PEBP’s third party administrator will assist your weight loss medical provider with completing monthly progress reports. The initial report should include your weight and BMI or waist circumferences, and a description of your treatment plan to include weekly weight loss goals, final weight loss goal, exercise regimen, diet and nutrition instructions. Subsequent monthly reports should provide information regarding your weight loss progress and adherence to the treatment plan. **Submission of these reports will be a requirement for payment under the**

enhanced wellness benefits. If your monthly weight loss reports are not received by PEBP's third party administrator, your benefits under this program will end and your coverage will return to the standard CDHP/PPO benefits where the annual deductible, coinsurance and other plan limitations will apply. The effective date of the return to the standard PPO benefits will be the first day of the month following the non-compliance notification received from PEBP's third party administrator.

How to Enroll in the Obesity and Overweight Care Management Program

- Step 1:** **For adults 18 years and older** - Complete NVision Health and Wellness annual Health Assessment Questionnaire and biometric screenings
For children ages 2 – 18 years - Completion of the NVision annual Health Assessment Questionnaire and biometric screenings is not required.
- Step 2:** Contact PEBP's third party administrator for a list of participating weight loss providers. This information is located on the third party administrator's website at www.healthscopebenefits.com.
- Step 3:** Make an appointment with a participating weight loss provider. You may consider the physical location of the provider when considering which provider may work best with you. PEBP's third party administrator can also help you identify which participating provider may best meet your needs, based on geography or other specialized needs you may have.
- Step 4:** When you make an appointment with your participating weight loss provider, before you go, be sure to take an Obesity and Overweight Care Management Program enrollment form with you. This form is located on the third party administrators' website under forms.
- Step 5:** Have your participating weight loss provider complete the enrollment form and submit (by mail or fax) the completed form to PEBP's third party administrator. Their name, address and fax number are provided on the enrollment form.
- Step 6:** PEBP's third party administrator will review the information submitted by your provider and if the information indicates that you meet the criteria for the weight loss program benefits, PEBP's third party administrator will enroll you in the program. The third party administrator will notify PEBP and PEBP's Pharmacy Benefits Manager of your enrollment. If you do not meet the criteria for weight loss benefits, PEBP's third party administrator will notify you of the denial of benefits.
- Step 7:** Engagement in the program.

NOTE: Once you have met your final weight loss goal as determined by your weight loss provider in a medically supervised weight loss program, benefits under the Obesity and Overweight Care Management program will end. This plan does not provide benefits for ongoing maintenance care. If you choose to receive ongoing maintenance care, you will be responsible for the cost of receiving services.

Obesity and Overweight Care Management

This chart explains the benefits payable by the wellness benefit of the Self-funded Plan while engaged in Care Management.

All benefits are subject to the deductible except where noted.

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	In-Network
<p>Certain obesity medications. To find out if a certain medication is covered under this benefit, please contact PEBP's Prescription Drug Plan Administrator listed in the Plan Contacts section of this document.</p>	<p>Medications related to the treatment of overweight or obesity will be identified by PEBP's Prescription Drug Plan Administrator. Before you begin your medication weight loss treatment, please contact PEBP's Prescription Drug Plan Administrator to make sure the medication that your provider has prescribed is covered under this program.</p> <p>Other Limitations</p> <ul style="list-style-type: none"> • Copayments for obesity related drugs are not applied to the medical and prescription drug annual deductible or out-of-pocket maximum. • This plan does not coordinate prescription drug plan benefits. • Participant or covered dependent must be actively engaged in the Obesity and Overweight Care Management program. • Copayment at 90 day supply retail is subject to three times the listed 30 day retail copayment. • Medications purchased at non-participating pharmacies are not covered under this plan. • This benefit does not include products such as HCG whether prescribed or obtained over the counter. 	<p>In-Network Retail :</p> <ul style="list-style-type: none"> • Tier 1 Generic: \$5 copay • Tier 2 Preferred Brand: \$25 copay • Tier 3 Non Preferred Brand: 100% copay* <p>Mail Order Services</p> <ul style="list-style-type: none"> • Tier 1 Generic: \$15 copay • Tier 2 Preferred Brand: \$75 copay* • Tier 3 Non Preferred Brand: 100% copay* <p>*Tier 3 Non-preferred name brand drugs: Participant is responsible for 100% of the Preferred Contract Rate. Deductible credit is not applied.</p>

Obesity and Overweight Care Management

This chart explains the benefits payable by the wellness benefit of the Self-funded Plan while engaged in Care Management.

All benefits are subject to the deductible except where noted.

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p>Office visits Laboratory test Nutritional counseling services</p>	<p>Office visits must be provided by:</p> <ul style="list-style-type: none"> An in-network provider who specializes in weight loss services according to PEBP's PPO provider network; or An in-network provider who is certified by the American Board of Bariatric Medicine (ABBM); or An in-network provider who is in training to become certified by the American Board of Bariatric Medicine (ABBM); or If no provider as described above is available within 50 miles of a member's residence, services may be provided by any in-network provider. <p>Laboratory test must be provided by an in-network provider.</p> <p>Participant and/or covered dependent must meet criteria stated in the Obesity and Overweight Care Management section of this document.</p> <p>Participant and/or covered dependent must be actively engaged in the Obesity and Overweight Care Management program.</p> <p>Participant and/or covered dependent must remain actively engaged in a medically supervised weight loss program to receive this benefit.</p> <p>Please refer to the Obesity and Overweight Care Management section of this document for more information about this program.</p> <p>The frequency of nutritional counseling services will be determined by PEBP's third party administrator and will be based on medical necessity.</p>	<p>100% of PPO contracted rate under the wellness benefit.</p>	<p>Not covered under wellness benefit. Subject to 50% coinsurance and annual out of network deductible and out of pocket maximum. U & C allowable applies.</p>

Obesity and Overweight Care Management This chart explains the benefits payable by the wellness benefit of the Self-funded Plan while engaged in Care Management. All benefits are subject to the deductible except where noted. See also the Exclusions and Definitions sections of this document for important information.			
Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
Meal replacement therapy	<p>Benefit is for individuals who are diagnosed as morbidly obese only.</p> <ul style="list-style-type: none"> • Meal replacements must be prescribed and dispensed by the weight loss medical provider. • Participant or covered dependent is required to pay for their meal replacements and request reimbursement from the Plan. • Reimbursement will only be approved if the patient is considered actively engaged in each of the three months following the month the expense was incurred. • Does not include Weight Watchers, Lean Cuisine, NutriSystem, Atkins or other similar prepared meals or meal replacements. • Meal replacement costs do not apply to the annual deductible or out-of-pocket maximum. <p>Morbid obesity means that a person is more than 100 pounds over normal weight or has a BMI of 40 or higher. This must be confirmed by your weight loss medical provider.</p> <p>Participants cannot use their Health Savings Account or Health Reimbursement Arrangement to pay for expenses related to meal replacements that are reimbursed by the plan. Even if an expense is not reimbursed by the plan (i.e., the participant fails to remain actively engaged), the IRS may still not allow reimbursement. For more details, see the Weight-Loss Program section in IRS Publication 502 or refer to your tax consultant.</p>	50% of the cost to the participant, up to a maximum benefit of \$50 per month.	Not covered.

<p align="center">Obesity and Overweight Care Management</p> <p align="center">This chart explains the benefits payable by the wellness benefit of the Self-funded Plan while engaged in Care Management.</p> <p align="center">All benefits are subject to the deductible except where noted.</p> <p align="center">See also the Exclusions and Definitions sections of this document for important information.</p>			
Description	Explanations and Limitations	In-Network	Out-of-Network
Gym membership	Gym membership is not included in this benefit.	Not covered	Not covered
Exercise equipment	Exercise equipment is not included in this benefit.	Not covered	Not covered
Bariatric weight loss surgery	Bariatric weight loss surgery is not included in this benefit.	Not covered	Not covered

Wellness/Preventive Services

The safest and most effective way to treat an illness is to prevent it from happening. An important PEBP Self-funded PPO benefit is coverage of wellness/preventive services and lifestyle education in order to aid participants in working with their physicians to maintain good health. PEBP has made several tools available to participants for customizing their care and providing opportunities to achieve goals and success in healthcare.

As the average participant age increases, preventive screening tests such as colonoscopies, hearing tests, skin cancer examinations, and hypertension evaluation should be considered as part of your preventive medicine schedule. Participants should consult with their physicians to determine what their individual screening needs might be. See the charts later in this section for screening recommendations by the Center for Disease Control and the National Preventive Services Task Force.

Note: Participants should consult with the third party administrator listed in the Participant Contact Guide in this document to learn if a particular screening test, wellness evaluation or lifestyle education course is covered.

This benefit is only available when participating PPO providers such as physicians and laboratories are used. Preventive screening benefits are for wellness only. Any test or procedure done that is related to a known or present condition may be considered as a regular medical claim and processed accordingly. It is important to check with PEBP's third party administrator listed in the Participant Contact Guide in this document to inquire if a particular screening test is covered.

Wellness and Preventive Guidelines
Sample Guidelines for Preventive Screenings, as Recommended by the Center for Disease Control (CDC)

Adult Preventive Guidelines (Male and Female)

Exam	How Often	Purpose
Height and Weight	Annually	To measure changes that could relate to a medical issue
Blood Pressure	Annually	To check whether your blood pressure is too high
Fecal Occult Blood	As recommended by the CDC beginning at age 50 years	To check for blood in your stool
Blood Sugar (Glucose)	Annually	To check your blood sugar levels
Cholesterol	Annually	To check the amount of different types of fat in your blood
Sigmoidoscopy	As recommended by the CDC beginning at age 50 years	To check for changes or growths in your intestines
Colonoscopy	Every 10 years if low risk beginning at age 50 years. Individuals with a family history of colon cancer may receive this service before age 50 years and at a frequency determined by their physician	To check for changes or growths and the removal of growths in your intestines
Electrocardiogram	Annually	To check your heart rate or rhythm
Hearing exam	Annually	To check how well you hear
Clinical skin exam	Annually beginning at age 18 years	To look for changes in any moles or growths
Tobacco Use	Annually	Tobacco/smoking cessation
Depression Screen/Stress Management	Annually	To help you identify behavioral health issues
Pneumococcal Vaccine *Schedule based on recommendations by the Center for Disease Control	*Recommended for all children under age 59 months, adults with certain risk factors, children 24 months or older who are at high risk of pneumococcal disease, all adults age 65 years and older. May also be administered through the Prescription Drug Benefit with certain pharmacies. Contact the Pharmacy Benefits Manager listed in the Participant Contact Guide for a list of participating pharmacies. Participating pharmacies typically do not administer this vaccine to children. Please contact your child's physician for additional information.	

Exam	How Often	Purpose
HPV vaccination for females and males	As recommended by CDC and physician	May also be administered through the Prescription Drug Benefit with certain pharmacies. Contact the Pharmacy Benefits Manger listed in the Participant Contact Guide for a list of participating pharmacies
Tetanus, Diphtheria and Pertussis (TDaP)	As recommended by the CDC and/or physician.	May also be administered through the Prescription Drug Benefit with certain pharmacies. Contact the Pharmacy Benefits Manger listed in the Participant Contact Guide for a list of participating pharmacies
Influenza (vaccine or mist) *Schedule based on recommendations by the Center for Disease Control	*Annually for all ages as recommended by the CDC.	May also be administered through the Prescription Drug Benefit with certain pharmacies. Contact the Pharmacy Benefits Manger listed in the Participant Contact Guide for a list of participating pharmacies.
Herpes Zoster (Shingles) Vaccine (Zostavax)	Recommended for individuals over age 60 or as recommended by physician.	May also be administered through the Prescription Drug Benefit with certain pharmacies. Contact the Pharmacy Benefits Manger listed in the Participant Contact Guide for a list of participating pharmacies
Meningococcal Vaccines	For vaccination of meningococcal diseases, as recommended by the CDC.	Please contact your child's physician for additional information.

Adult Preventive Guidelines (Female)

Exam	How Often	Purpose
Self Breast Exam	First day of every month or after your period	To check for changes in the skin, nipple discharge or for any lumps
Clinical Breast Exam	Annually beginning at age 35 years	To check for changes in the skin, nipple discharge or for any lumps
Mammogram	Annually or as recommended by your physician	To check for internal changes to your breast that cannot be felt or seen
Pelvic Exam and Pap Smear	Annually or as recommended by your physician	To check for changes in the vagina, cervix, uterus, ovaries or other female organs
Bone Density exam	As needed beginning at age 50 years or earlier if risk factors for osteoporosis is present	To check the density of your bones

Some screening frequencies are recommended by the CDC, while others are recommended by the US Preventive Services Task Force.

Adult Preventive Guidelines (Male)

Exam	How Often	Purpose
Prostate Specific Antigen (PSA)/Digital Rectal Examination	Annually or as recommended by your physician	A blood test to identify risk level for prostate cancer

For more information regarding preventive care recommendations and immunizations, please visit the websites for the Centers for Disease Control and Preventions or the United States Department of Human Services:

Adults:

- Preventive Services for Adults: <http://www.guideline.gov/browse/by-topic.aspx>
- Immunization schedule: <http://www.cdc.gov/vaccines>

Women's Health:

- <http://www.cdc.gov/women>

Men's Health

- <http://www.cdc.gov/men>

Pediatric Preventive Guidelines

Exam (Birth – 18 months of age)	How Often	Comments
Height and Weight Head circumference	Birth to 18 months	
Immunizations *	<ul style="list-style-type: none"> • Birth – 2 months: Hep B • 2 months: Hep B, TDaP, IPV, PCV, Rota • 4 months: TDaP, Hib, PCV, Rota • 6 months: TDaP, Hib, PCV, Rota • 12 – 18 months: Hep B, TDaP, Hib, IPV, MMR, Var, Pneu Booster 	Recommended immunizations may be administered within age ranges; consult your pediatrician. Varicella recommended for children who have not had chickenpox
Recommended Well Visits	<ul style="list-style-type: none"> • Birth – 15 months: at least 6 visits • 15 – 24 months: 3 visits 	
Exam (2-6 years of age)	How Often	Comments
Height and Weight Blood Pressure Eye Exam	As scheduled by your pediatrician	
Exam (7-12 years of age)	How Often	Comments
Height and Weight Blood pressure	As scheduled by your pediatrician	
Immunizations	<p>11 – 12 years of age: meningococcal vaccines, Hep B if series is not completed, TD if last TDaP was 5+ years prior, MMR if not second dose, Var for those without prior immunization or history of chickenpox</p> <p>HPV 11-12 years of age: (see Comments)</p>	<p>HPV for young females can be early as age 9 years, recommended at ages 11-12 years, and should be done at any time from ages 13-26 years if not done at ages 11-12 years.</p> <p>HPV for young males can be early as age 9 years, recommended at ages 11-12 years, and for males ages 13-21 years, who did not get any or all of the 3 recommended doses when they were younger.</p>

Recommended Well Visits	Annually or as scheduled by your doctor	
Anticipatory Guidance	Diet and exercise, injury prevention (safety belts and bicycle helmets), home safety (firearms, matches, pool safety, drug and chemical storage, smoke detectors) and skin protection from ultraviolet light	
Exam (13 – 18 years)	How Often	Comments
Height and Weight Blood Pressure	Annually or as scheduled by your pediatrician	
Recommended Well Visits	Annually or as scheduled by your pediatrician	
Anticipatory Guidance	Diet and exercise, substance abuse (tobacco, alcohol, and other drugs), sexual practices (pregnancy, STD's), injury prevention (safety belts, safety helmets, firearms, violent behavior), dental health, skin protection for ultraviolet light and suicide risk factors	
Influenza *Schedule based on recommendations by the Center for Disease Control	*Annually for all children and infants over 6 months of age and without serious egg allergies	

Pediatric Preventive Guidelines (cont.)

Immunizations

- Hep B = Hepatitis B
- TDaP = Tetanus, Diphtheria & Pertussis (whooping cough)
- Hib = H. influenza type b
- IPV = Polio
- MMR = Measles, Mumps, Rubella
- Var = Varicella (chickenpox)
- Hep A= Hepatitis A
- PCV = Pneumococcal
- Td = Tetanus, diphtheria booster
- HPV= Human Papillomavirus
- Rota= Rotavirus
- MPSV4= Meningococcal

For more information regarding preventive care recommendations and immunizations, please visit the websites for the Centers for Disease Control and Preventions or the United States Department of Human Services: Children

- Well child check-ups: <http://www.cdc.gov/ncbddd/>
- Immunization schedule: <http://www.cdc.gov/vaccines>

Tobacco/Smoking Cessation

Prescription and over-the-counter tobacco/smoking cessation products are covered under the Prescription Drug program. Over-the-counter tobacco/smoking cessation products must be accompanied by a prescription written by a physician. This table provides you with important suggestions for the Clinical Use of Pharmacotherapies for Tobacco/Smoking Cessation with identified first-line Pharmacotherapies provided by the Surgeon General's Office and approved by the FDA. See physician for second-line therapies and tobacco/smoking-cessation management.

Pharmacotherapy	Dosage	Duration
Bupropion SR	150 mg every morning for 3 days then 150 mg twice daily (Begin treatment 1-2 weeks pre-quit)	7-12 weeks maintenance up to 6 months
Chantix	0.5 mg once daily for 3 days, then twice a day for 4 days, then 1 mg twice a day	3-6 months
Commit Lozenge	1st cig>30 min. after waking- 2mg lozenge (up to 24 pcs/day) 1st cig<30min. after waking- 4 mg lozenge (up to 24 pcs/day)	Up to 12 weeks
Nicotine Gum	1-24 cigs/day-2 mg gum (up to 24 pcs/day) 25+cigs/day-4 mg gum (up to 24 pcs/day)	Up to 12 weeks
Nicotine Inhaler	6-16 cartridges/day	Up to 6 months
Nicotine Nasal Spray	8-40 doses/day	3-6 months
Nicotine Patch	1) 21 mg/24 hours 2) 14 mg/24 hours 3) 7 mg/24 hours	1) 4 weeks 2) then 2 weeks 3) then 2 weeks

The following table provides a list of additional preventive/wellness screenings and therapies recommended by the United States preventive services task force.

NOTES:

- Participants should consult with PEBP's third party administrator (TPA) listed in the Participant Contact Guide in this document to learn if a particular screening test is covered.
- It is the participant's responsibility to contact their physician to discuss recommended screenings and therapies such as aspirin, folic acid and oral fluoride supplements. Neither PEBP nor its third party administrators are capable of making such recommendations.
- Over the counter products such as aspirin should be submitted to the third party administrator with a copy of the written prescription from your physician.
- Unless otherwise noted, preventive/wellness benefits are available only when provided by participating PPO providers such as physicians, radiologists and laboratories.

- Preventive screening benefits are only for wellcare. Any test or procedure done that is related to a known or present condition may be considered as a regular medical claim and processed accordingly.

Wellness must be the primary diagnosis submitted by the physician or other healthcare provider for the claim to be considered wellness/preventive. If your healthcare provider does not submit the claim to the TPA with a wellness diagnosis as the primary reason for the visit or medical service, the claim may be processed under the annual deductible and coinsurance.

Subject	Recommendation
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men aged 65 to 75 who have ever smoked.
Alcohol misuse counseling	The USPSTF recommends screening to reduce alcohol misuse by adults, including pregnant women, in primary care settings.
Anemia screening: pregnant women	The USPSTF recommends routine screening for iron deficiency anemia in asymptomatic pregnant women.
Aspirin to prevent CVD: men	The USPSTF recommends the use of aspirin for men age 45 to 79 years when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
Aspirin to prevent CVD: women	The USPSTF recommends the use of aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 weeks' gestation or at the first prenatal visit, if later.
Blood pressure screening	The USPSTF recommends screening for high blood pressure in adults aged 18 years and older.
BRCA screening, counseling about	The USPSTF recommends that women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.

Subject	Recommendation
Breast cancer preventive medication	The USPSTF recommends that clinicians discuss chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. Clinicians should inform patients of the potential benefits and harms of chemoprevention.
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1-2 years for women aged 40 and older.
Breastfeeding counseling	The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.
Cervical cancer screening	The USPSTF strongly recommends screening for cervical cancer in women who have been sexually active and have a cervix.
Chlamydial infection screening: non-pregnant women	The USPSTF recommends screening for chlamydial infection for all sexually active non-pregnant young women aged 24 and younger and for older non-pregnant women who are at increased risk.
Chlamydial infection screening: pregnant women	The USPSTF recommends screening for chlamydial infection for all pregnant women aged 24 and younger and for older pregnant women who are at increased risk.
Cholesterol abnormalities screening: men 35 and older	The USPSTF strongly recommends screening men aged 35 and older for lipid disorders.
Cholesterol abnormalities screening: men younger than 35	The USPSTF recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.
Cholesterol abnormalities screening: women 45 and older	The USPSTF strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease.
Cholesterol abnormalities screening: women younger than 45	The USPSTF recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.

Subject	Recommendation
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults, beginning at age 50 years and continuing until age 75 years. The risks and benefits of these screening methods vary.
Dental caries chemoprevention: preschool children	The USPSTF recommends that primary care clinicians prescribe oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.
Depression screening: adolescents	The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal).
Depression screening: adults	The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment.
Diabetes screening	The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
Folic acid supplementation	The USPSTF recommends that all women planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid.
Gonorrhea prophylactic medication: newborns	The USPSTF strongly recommends prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.
Gonorrhea screening: women	The USPSTF recommends that clinicians screen all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).

Subject	Recommendation
Healthy diet counseling	The USPSTF recommends dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease. Counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.
Hearing loss screening: newborns	The USPSTF recommends screening for hearing loss in all newborn infants.
Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
HIV screening	The USPSTF strongly recommends that clinicians screen for human immunodeficiency virus (HIV) all adolescents and adults at increased risk for HIV infection.
Hypothyroidism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism in newborns.
Iron supplementation in children	The USPSTF recommends routine iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia.
Obesity screening: adults	The USPSTF recommends that clinicians screen all adult patients for obesity to promote sustained weight loss for obese adults.
Obesity screening: children	The USPSTF recommends that clinicians screen children aged 6 years and older for obesity to promote improvement in weight status.
Osteoporosis screening: women	The USPSTF recommends that women aged 65 and older be screened routinely for osteoporosis. The USPSTF recommends that routine screening begin at age 60 years for women at increased risk for osteoporotic fractures.
PKU screening: newborns	The USPSTF recommends screening for phenylketonuria (PKU) in newborns.

Subject	Recommendation
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
Rh incompatibility screening: 24-28 weeks gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.
STIs counseling	The USPSTF recommends behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
Tobacco use counseling and interventions: non-pregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. (See the Tobacco/ Cessation Section of this document for limitations)
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke. (See the Tobacco/ Cessation Section of this document for limitations)
Syphilis screening: non-pregnant persons	The USPSTF strongly recommends that clinicians screen persons at increased risk for syphilis infection.
Syphilis screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for syphilis infection.
Visual acuity screening in children	The USPSTF recommends screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than age 5 years.

Health Savings Accounts for CDHP Participants

ACTIVE EMPLOYEES

Note: This section of PEBP's Master Plan Document provides summary information only. For more detailed information regarding this important benefit, see Internal Revenue Service (IRS) Publications 502 and 969 or contact PEBP's claims administrator listed in the Participant Contact Guide located in the front of this document.

The PEBP Health Savings Account (HSA) provides a mechanism that allows employees to set aside and spend pre-tax dollars on qualified medical expenses in accordance with applicable Internal Revenue Service (IRS) provisions.

The PEBP Consumer Driven Health Plan (CDHP) is an "HSA-friendly" health plan, which means that it complies with federal requirements regarding deductibles, out-of-pocket maximums, and certain other features. Because the CDHP meets these requirements, active employees in the CDHP are eligible to establish and contribute to an HSA while covered under the CDHP (subject to certain limitations described below). HSAs are not available to retirees or PEBP's HMO participants.

PEBP contributions will be placed in the employee's HSA each plan year. Employees may also fund their HSA through voluntary pre-tax payroll deductions. Funds in the HSA may be used to pay for any qualified medical expense as defined by the IRS (see IRS Publications 502 & 969), including payment of deductibles, coinsurance, dental costs or vision costs incurred by the participant, the participant's spouse or any other dependent claimed on the participant's annual tax return. HSA funds may not be used for a person who does not meet the IRS definition of "dependent," 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. In general, HSA funds may not be used to pay premiums. There are certain exceptions for retirees or former employees enrolled in a plan offered under COBRA provisions.

Distributions from the HSA are tax-free as long as they are for the reimbursement of qualified medical expenses. Use of HSA funds for other than qualified medical expenses can result in taxes and penalties being imposed by the IRS.

(See next page for HSA contribution table)

State Employees			
State Employees	Base Contribution	One-time Supplemental Contribution	Total Base and One-time Supplemental Contribution
Participant Only	\$700	\$697	\$1,397
Per Dependent (Up to 3 Dependents)	\$200	\$215	\$415

Non-State Employees			
Non-State Employees	Base Contribution	One-time Supplemental Contribution	Total Base and One-time Supplemental Contribution
Participant Only	\$700	\$400	\$1,100
Per Dependent (Up to 3 Dependents)	\$200	\$100	\$300

- New hires effective August 1, 2013 and later receive a prorated base contribution (participant and dependents) based on their CDHP coverage effective date.
- One-time supplemental contribution applies only to participants/dependents covered under the CDHP on July 1, 2013.

Calendar Year 2013 HSA Contribution Limits for All	
Individual	Family (two or more HSA eligible family members)
\$3,250	\$6,450

The total contributions (combined employee/employer) cannot exceed the 2013 calendar year limit.

Family maximum is based on an employee's family status as reported to the IRS. To contribute the family maximum, the employee and at least one dependent claimed on the federal tax return must be eligible for the HSA. The Family maximum applies regardless of whether two employees are married and eligible for the HSA. For example, if one employee is covering an HSA eligible dependent and the other employee is covered as self-only, the maximum for the entire family is \$6,450.

Employees age 55 years and older at the end of the tax year may contribute an additional \$1,000 to the HSA.

In order to contribute more than the IRS individual HSA maximum amount up to the family maximum, the employee and at least one other dependent must be covered under a High Deductible Health Plan and not covered under any of the items listed under the Note below.

Any funds remaining in the HSA at the end of the year will roll over to future years (i.e., will not be forfeited). There is no maximum balance. Contributions to the HSA grow tax free, and are portable. When an employee retires or terminates employment, the employee keeps the funds in the HSA. The employee can continue to use the funds in the HSA for health care and other qualified medical expenses after employment ends with the State or other entity covered by PEBP.

Unlike the Flexible Spending Account, employees cannot be reimbursed from funds that have not yet been added to the HSA. Any reimbursement from the HSA will be the lesser of the available HSA balance or the claim amount paid to the provider.

PEBP has selected Healthcare Bank as the single HSA provider to which it will forward PEBP contributions and voluntary HSA pre-tax payroll deductions. PEBP does not (i) endorse Healthcare Bank as an HSA provider; (ii) limit an employee's ability to move funds to other HSA providers, (iii) impose conditions on how HSA funds are spent, (iv) make or influence investment decisions regarding HSA funds, or (v) receive any payment or compensation in connection with an HSA. PEBP HSA contributions and employee voluntary pre-tax payroll deductions will only be deposited to an HSA at Healthcare Bank. Employees may choose to establish an HSA with any HSA trustee or custodian and may transfer funds deposited into a Healthcare Bank HSA account to another HSA account held by another trustee or custodian. However, PEBP will not pay any fees associated with any other HSA account including transfer fees.

The IRS requires any person with an HSA to submit form 8889 with their annual income tax return.

Note: Employees may not establish or contribute to a Health Savings Account if any of the following apply:

- The employee is covered under other medical insurance coverage unless that medical insurance coverage: (1) is also a High Deductible Health Plan as defined by the IRS; (2) covers a specific disease state (such as cancer insurance); or (3) only reimburses expenses after the deductible is met
- The employee is enrolled in Medicare
- The employee is enrolled in Tricare
- The employee is enrolled in Tribal coverage
- The employee can be claimed as a dependent on someone else's tax return unless the employee is Married Filing Jointly
- The employee or the employee's spouse has a Medical Flexible Spending Account (excludes Dependent Care or Limited Use Flexible Spending Accounts)
- The employee's spouse has an HRA that can be used to pay for the medical expenses of the employee
- The employee is on COBRA
- The employee is retiree

Health Reimbursement Arrangement for CDHP Participants

ACTIVE EMPLOYEES AND RETIREES - CDHP HRA

Note: This section of PEBP's Master Plan Document provides summary information only. For more detailed information regarding this important benefit, see Internal Revenue Service (IRS) Publication 502 or contact PEBP's claims administrator listed in the Participant Contact Guide located in the front of this document.

For participants who are on the PEBP CDHP and who are not eligible for an HSA, or who fail to establish an HSA, a CDHP Health Reimbursement Arrangement (HRA) account will be established in the participant's name. CDHP HRAs are not available for PEBP's HMO participants.

Each plan year, PEBP contributions will be available for use through a CDHP HRA account established in the participant's name. Funds in the CDHP HRA account may be used, tax-free, to pay for any qualified medical expense as defined by the IRS (see IRS Publication 502), other than premiums, including payment of deductibles, coinsurance, dental costs or vision costs incurred by the participant, the participant's spouse or any other dependent claimed on the participant's annual tax return. CDHP HRA funds may not be used for a person who does not meet the IRS definition of "dependent," 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.

The entire annual PEBP contribution for Plan Year 2014 will be available for use at the beginning of the plan year on July 1, 2013 (subject to certain limitations). Participants and dependents who become eligible for PEBP coverage after July 1, 2013 will receive a prorated base contribution for the participant and their dependent(s) (up to a maximum of 3 dependents) based upon the coverage effective date and the months remaining in the plan year. Participants cannot contribute to a CDHP HRA. If the annual funds in the CDHP HRA are exhausted, neither PEBP nor the participant will contribute any additional funds.

Any funds remaining in the CDHP HRA at the end of the PEBP Plan Year will roll over (i.e., will not be forfeited) and will be available for use in future plan years. In this manner the CDHP HRA may "grow" and can be used to reduce your out-of-pocket medical costs in future Plan years. However, in future years, PEBP may establish a limit on the balance that can be rolled over from one year to the next.

Unlike a Flexible Spending Account (FSA), participants cannot be reimbursed from funds that are not yet available in the CDHP HRA. Any reimbursement from the CDHP HRA will be the lesser of the available CDHP HRA balance or the claim amount paid to the provider.

CDHP HRA funds are not portable; participants cannot use CDHP HRA funds if they are no longer covered by the CDHP. If a participant terminates their CDHP coverage, the remaining balance in the CDHP HRA account will revert back to PEBP.

For active employees who retire and who are not Medicare retirement age (typically at age 65 years) the employee can maintain the balance in their CDHP HRA account when they retire if they elect to continue coverage under the CDHP plan or elect COBRA coverage as long as there is no break in the CDHP coverage. If a participant elects COBRA coverage, the CDHP HRA account will remain in place until COBRA coverage is terminated. In the case of a retroactive coverage termination, any funds used from the CDHP HRA for expenses that are incurred after the date of coverage termination will be recovered by PEBP through the collection process.

NOTE: When your coverage with PEBP ends and you are an HRA participant you will have one year (12 months) from the date your coverage ends to file a claim for reimbursement from your HRA for eligible claims incurred during your coverage period.

Health Reimbursement Arrangement (HRA) For Eligible State Retirees and Employees Enrolled in the CDHP			
State Retiree/Employee	Base Contribution	One-time Supplemental Contribution	Total Base and One-time Supplemental Contribution
Participant Only	\$700	\$697	\$1,397
Per Dependent (Up to 3 Dependents)	\$200	\$215	\$415

Health Reimbursement Arrangement (HRA) For Eligible Non-State Retirees and Non-State Employees Enrolled in the CDHP			
Non-State Retiree/Employee	Base Contribution	One-time Supplemental Contribution	Total Base and One-time Supplemental Contribution
Participant Only	\$700	\$400	\$1,100
Per Dependent (Up to 3 Dependents)	\$200	\$100	\$300

- One-time supplemental contribution applies only to participants/dependents covered under the CDHP on July 1, 2013.
- New hires with coverage effective August 1, 2013 or later will receive a prorated Base contribution concurrent with their CDHP coverage effective date.

Medical Exclusions

The following is a list of services and supplies or expenses not covered by the Medical CDHP Plan. The Plan Administrator and its designees will have discretionary authority to determine the applicability of these exclusions and terms of the plan, and determines eligibility and entitlement to plan benefits. General Exclusions are listed first followed by specific medically related plan exclusion(s).

General Exclusions (applicable to all medical services and supplies):

Autopsy: Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.

Complications of a non-covered service: Expenses for care, services or treatment required as a result of complications from a treatment or service not covered under this plan, except complications from an abortion.

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

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

Educational Services: Expenses for educational/vocational services, supplies or equipment including (but not limited to) computers, software, printers, books, tutoring, visual aides, auditory aides, and speech aides, programs to assist with auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation or self-esteem, etc. (even if they are required because of an injury, illness or disability of a Covered Individual).

Employer-Provided Services: Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by your or your covered dependents' employer; or for benefits otherwise provided under this plan or any other plan that PEBP contributes to or otherwise sponsors (e.g., HMOs).

Expenses Exceeding Maximum Plan Benefits: Expenses that exceed any plan benefit limitation or plan year maximum benefits as described in the Medical Expense Coverage section of this document.

Expenses Exceeding Usual and Customary Charges and PPO contracted rates: Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Usual and Customary charge or PPO contracted rate (as defined in the Definitions section of this document).

Expenses for Which a Third Party Is Responsible: Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act

of that third party (see the provisions relating to Third Party Liability in the Coordination of Benefits section in this document for an explanation of the circumstances under which the plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies).

Expenses Incurred Before or After Coverage: Expenses for services rendered or supplies provided either before the patient became covered under the medical program or after the date the patient's coverage ends, except under those conditions described in the COBRA section of this document.

Experimental and/or Investigational Services: Unless mandated by law, expenses for any medical services, supplies, drugs or medicines that are determined by the Plan Administrator or its designee to be experimental and/or investigational services as defined in the Definitions section of this document.

Government-Provided Services (Tricare/CHAMPUS, VA, etc.): Expenses for services provided to a covered individual also covered under any government-sponsored plan or program unless the governmental program provides otherwise.

Hospital Employee, Medical Students, Interns or Residents: Expenses for the services of an employee of a hospital, skilled nursing facility or other health care facility, when the facility is obligated to pay that employee.

Illegal Act: Expenses incurred by any covered individual for injuries resulting from commission (or attempted commission by the covered individual) of an illegal act the Plan Administrator determines involved violence or the threat of violence to another person, or in which any weapon or explosive is used by the covered Individual. The Plan Administrator's determination that this exclusion applies shall not be affected by any prosecution, or acquittal of (or failure to prosecute) the covered individual in connection with the acts involved, unless such injury is the result of a physical or mental health condition or domestic violence.

Internet/Virtual Office Visit: Expenses related to an online Internet consultation with a Physician or other health care practitioner (also called a virtual office visit/consultation), physician-patient web service or physician-patient e-mail service (including receipt of advice, treatment plan, prescription drugs or medical supplies obtained) from an online Internet provider.

Medically Unnecessary Services: Services or supplies determined by the Plan Administrator or its designee not to be medically necessary, as defined in the Definitions section of this document.

Modifications of Homes or Vehicles: Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a covered Individual, including, without limitation, any construction or modification (e.g., ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, hand rails, emergency alert system, etc.)

No-Cost Services: Expenses for services rendered or supplies provided without cost, or for which there would be no charge if the person receiving the treatment were not covered under this plan.

No Provider Recommendation: Expenses for services rendered or supplies provided that are not recommended or prescribed by a physician, except for covered services provided by a behavioral health practitioner, midwife or nurse midwife, nurse practitioner, physician assistant, chiropractor, dentist, homeopath, podiatrist or certain wellness/preventive screening services.

Non-emergency hospital admission: Care and treatment billed by a hospital for a non-medical emergency admission on a Friday or Saturday, unless surgery is performed within 24 hours of the admission.

Non-Emergency Travel and Related Expenses: Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a health care provider, covered individual or family member of a covered individual except where otherwise noted under travel expenses for organ/ tissue transplants and bariatric weight loss surgery.

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

Personal Comfort Items: Expenses for patient convenience, including (but not limited to) care of family members while the covered individual is confined to a hospital (or other health care facility, or to bed at home), guest meals, television, VCR/DVD, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.

Private Room in a Hospital or Health Care Facility: The use of a private room in a hospital or other health care facility, unless the facility has only private room accommodations, or unless the use of a private room is certified as medically necessary by the Plan Administrator or its designee.

Stand-By Physicians or Health Care Practitioners: Expenses for any physician or other health care provider who did not directly provide or supervise medical services to the patient, even if the physician or health care practitioner was available on a stand-by basis.

Telephone Calls: Expenses for any and all telephone calls between a physician or other health care provider and any patient, other health care provider, utilization management company, or any representative of the plan for any purpose whatsoever.

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

Charges excluded or limited by Plan design as noted in this document
Alternative/Complementary Health Care Services Exclusions

- Expenses for chelation therapy, except as may be medically necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.

- Expenses for prayer, religious healing or spiritual healing, except services provided by a Christian Science Practitioner.
- Expenses for naturopathic, naprapathic services or treatment/supplies.
- Expenses for homeopathic treatments/supplies that are not FDA approved. Note: Homeopathic office visits are payable under physician services in the Schedule of Medical benefits.

Behavioral Health Care Exclusions

- Expenses for hypnosis and hypnotherapy.
- Expenses for behavioral health care services related to: adoption counseling; court-ordered behavioral health care services; custody counseling; dance/poetry/art therapy, developmental disabilities; dyslexia, gambling addiction, learning disorders; attention deficit disorders (with or without hyperactivity, except when the services are for diagnosis and/or the prescription of medication as prescribed by a physician or other health care practitioner); family planning counseling; marriage/couples/and/or sex counseling; mental retardation; pregnancy counseling; transsexual counseling; vocational disabilities, and organic and non-organic therapies including (but not limited to) crystal healing/EST/primordial therapy/L-Tryptophan/vitamin therapy, religious/spiritual, etc.
- Expenses for tests to determine the presence of or degree of a person's dyslexia or learning disorder.

Corrective Appliances, Durable Medical Equipment and Nondurable Supplies Exclusions

- Expenses for any items that are not corrective appliances, orthotic devices, prosthetic appliances, or durable medical equipment (as each of those terms is defined in the Definitions section of this document), including (but not limited to) personal comfort items like air purifiers, humidifiers, electric heating units, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation, pillows, orthopedic mattresses, water beds, and air conditioners.
- Orthopedic shoes and foot orthotics are not a covered benefit unless the foot orthotic is permanently attached to a brace.
- Expenses for replacement of lost, missing, or stolen, duplicate or personalized corrective appliances, orthotic devices, prosthetic appliances, or durable medical equipment.
- Expenses for corrective appliances and durable medical equipment to the extent they exceed the cost of standard models of such appliances or equipment.
- Expenses for occupational therapy (orthotic) supplies and devices needed to assist a person in performing activities of daily living, including self-help devices such as feeding utensils, reaching tools and devices to assist in dressing and undressing.
- Expenses for nondurable supplies, except as payable under Nondurable Supplies in the Schedule of Medical Benefits.

Cosmetic Services Exclusions

Expenses related to surgery or medical treatment to improve or preserve physical appearance, but not physical function, and complications thereof. Cosmetic surgery or treatment includes, but is not limited to removal of tattoos, breast augmentation, or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee. The medical program does cover medically necessary reconstructive services such as services related to leaking breast implants and services under the Women's Health and Cancer Rights Act. To determine the extent of this coverage, see Reconstructive Services in the

Schedule of Medical Benefits. Plan participants should use the plan's pre-certification procedure to determine if a proposed surgery or service will be considered cosmetic surgery or medically necessary reconstructive services.

Custodial Care Exclusions

Expenses for Custodial Care as defined in the Definitions section of this document, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, sitter/companion service, except when custodial care is provided as part of a covered hospice program.

Services required to be performed by physicians, nurses or other skilled health care providers are not considered to be provided for custodial care services, and are covered if they are determined by the Plan Administrator or its designee to be medically necessary. However, any services that can be learned to be performed or provided by a family member who is not a physician, nurse or other skilled health care provider are not covered, even if they are medically necessary.

Dental Services Exclusions

- Expenses for dental prosthetics or dental services or supplies of any kind, even if they are necessary because of symptoms, congenital anomaly, illness or injury affecting the mouth or another part of the body.
- Expenses for dental services may be covered under the medical plan if they are incurred for the repair or replacement of injury to sound and natural teeth or restoration of the jaw if damaged by an external object in an accident. For the purposes of this coverage by the plan, an accident does not include any injury caused by biting or chewing. See Oral, Craniofacial and TMJ Services in the Schedule of Medical Benefits to determine if those services are covered. Coverage for dental services as the result of an injury to sound and natural teeth will be extended under the medical plan to a maximum of two years following the date of the injury. Restorations past the two year time period will be considered under the dental benefits described in this document.
- Expenses for oral surgery to remove teeth (including wisdom teeth), gingivectomies, treatment of dental abscesses, root canal (endodontic) therapy, except those oral surgery services listed as payable under the Oral and Craniofacial section of the Schedule of Medical Benefits.

Drugs, Medicines and Nutrition Exclusions

- Pharmaceuticals requiring a prescription that have not been approved for use by the U.S. Food and Drug Administration (FDA); have not been prescribed for a medically necessary indication as defined in the Definitions section of this document; or are Experimental and/or Investigational (as defined in the Definitions section of this document).
- Non-prescription (non-legend or over-the-counter) drugs or medicines, except insulin and Prilosec.
- Foods and nutritional supplements including (but not limited to) home meals, formulas, foods, diets, vitamins, herbs and minerals (whether they can be purchased over-the-counter or require a prescription), except: when provided during hospitalization; prenatal vitamins or minerals requiring a prescription; and Medical Foods (as defined in the Definitions section of this document) unless noted as payable in the Schedule of Medical Benefits.
- Medical Foods (as defined in the Definitions section of this document), except for the benefit described as covered under Medical Foods in the Schedule of Medical Benefits section or

elsewhere in this document under the section titled "Obesity and Overweight Care Management Program".

- Naturopathic, naprapathic or homeopathic treatments/substances.
- Weight control or anorexiant (phentermine, Xenical), except those anorexiant used for treatment of children with attention deficit hyperactivity disorder (ADHD) or individuals with narcolepsy or where noted in this document under the section titled "Obesity and Overweight Care Management Program".
- Compounded prescriptions in which there is not at least one ingredient that is a legend drug requiring a prescription, as defined by federal or state law.
- Take-home drugs or medicines provided by a hospital, emergency room, ambulatory surgical facility/center, or other health care facility
- Vaccinations, immunizations, inoculations or preventive injections, except those provided under the Wellness Benefit for children and/or adults; and those required for treatment of an injury or exposure to disease or infection (such as anti-rabies, tetanus, anti-venom, or immunoglobulin).
- Outpatient prescription drugs are payable only via the prescription drug program listed under Drugs in the Schedule of Medical Benefits.
- Non-prescription devices and drugs purchased from retail or mail-order pharmacies are not payable under the prescription drug program. See the Wellness section for information regarding tobacco/smoking cessation products.

Drugs, medicines or devices for:

- drugs to enhance athletic performance such as anabolic steroids;
- non-prescription contraceptives, e.g. condoms, spermicides, sponges;
- treatment of fertility and/or infertility;
- dental products such as topical fluoride preparations and products for periodontal disease;
- hair removal or hair growth products (*i.e.*, Propecia, Rogaine, Minoxidil, Vaniqa);
- vitamin A derivatives (retinoids) for *dermatologic* use; however Retin A is payable to age 24 years.

NOTE: This plan does not coordinate pharmacy benefits.

Durable Medical Equipment Exclusions

See the Exclusions related to Corrective Appliances and Durable Medical Equipment.

Fertility and Infertility Services Exclusions

Expenses for the treatment of infertility, along with services to induce pregnancy (and complications thereof), including (but not limited to): services, prescription drugs, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor egg/semen, cryostorage of egg or sperm, adoption, ovarian transplant, infertility donor expenses and reversal of sterilization procedures.

Foot/Hand Care Exclusions

- Expenses for treatment of weak, strained, flat, unstable or unbalanced feet; metatarsalgia (pain in metatarsal bones of the feet); or bunions. Surgery to correct bunions or hammer toes is payable (when pre-certified).
- Expenses for routine foot care (including but not limited to: trimming of toenails, removal of corns and callouses, preventive care with assessment of pulses, skin condition and sensation)

or hand care, (including manicure and skin conditioning), unless the Plan Administrator or its designee determines such care to be medically necessary. Routine foot care from a podiatrist for treatment of foot problems such as corns, calluses and toenails is payable for individuals with a metabolic disorder such as diabetes, or a neurological or peripheral-vascular insufficiency affecting the feet.

Genetic Testing and Counseling Exclusions

- Genetic Testing: Expenses for genetic tests, except where otherwise noted in this document, including obtaining a specimen and laboratory analysis, to detect or evaluate chromosomal abnormalities, or genetically transmitted characteristics including:
- Pre-parental genetic testing intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents; and
- Prenatal genetic testing intended to determine if a fetus has chromosomal abnormalities that indicate the presence of a genetic disease or disorder, except that payment is made for fluid or tissue samples obtained through amniocentesis, chorionic villus sampling (CVS), fetoscopy and alphafetoprotein (AFP) analysis in pregnant women.
- Plan participants should contact the Plan's Utilization Management vendor or Third Party Claims Administrator to determine if proposed genetic testing is covered or excluded. See also the exclusions related to Prophylactic Surgery or Treatment later in this section.
- Genetic Counseling: Expenses for genetic counseling, except as related to payable genetic testing as listed under Genetic Testing in the Schedule of Medical Benefits.
- Genetic Counseling: Expenses for genetic counseling, except as related to payable genetic testing as listed under Genetic Testing in the preventive/wellness section of this document.

Hair Exclusions

- Expenses for or related to hair removal, hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Vaniqa; or for hair replacement devices, including (but not limited to) wigs, toupees and/or hairpieces or hair analysis. Patients undergoing chemotherapy may be able to receive benefits for some hair replacement devices, as listed above.

Hearing Care Exclusions

- Special education and associated costs in conjunction with sign language education for a patient or family members.

Home Health Care Exclusions

- Expenses for any home health care services other than part-time, intermittent skilled nursing services and supplies.
- Expenses under a home health care program for services that are provided by someone who ordinarily lives in the patient's home or is a parent, spouse, sibling by birth or marriage, or child of the patient; or when the patient is not under the continuing care of a physician.
- Expenses for a homemaker, custodial care, childcare, adult care or personal care attendant, except as provided under the plan's hospice coverage.

Maternity/Family Planning Exclusions

- Contraception: Expenses related to prescription or non-prescription male contraceptive drugs and devices such as condoms.
- Termination of Pregnancy: Expenses for elective termination of pregnancy (abortion) unless the attending physician certifies the health of the woman would be endangered if the fetus were carried to term.
- Childbirth courses.
- Expenses related to the maternity care and delivery expenses associated with a pregnant dependent child, except for expenses related to complications of pregnancy.
- Expenses related to the maternity care and delivery expenses associated with a surrogate mother's pregnancy.
- Expenses related to cryostorage of umbilical cord blood or other tissue or organs.
- For Nondurable supplies

Prophylactic Surgery or Treatment Exclusions

Unless otherwise noted in this document, expenses for medical or surgical services or procedures, including prescription drugs and the use of Prophylactic Surgery (as defined in the Definitions section of this document), when the services, procedures, prescription of drugs, or prophylactic surgery is prescribed or performed for the purpose of:

- avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results, in certain circumstances; or
- treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder.

Plan participants should use the plan's utilization management company to assist in the determination of a proposed surgery to determine if it is or is not covered under this Plan.

NOTE: Some prophylactic surgeries may be covered under this Plan if certain criteria are met. Please refer to the section in this document titled "Reconstructive Services and Breast Reconstruction after Mastectomy". For additional information, please contact PEBP's utilization management vendor or PEBP's third party claims administrator.

Rehabilitation Therapy Exclusions (Inpatient or Outpatient)

- Expenses for educational, job training, vocational rehabilitation, and/or special education for sign language.
- Expenses for massage therapy, Rolfing and related services.
- Expenses incurred at an inpatient rehabilitation facility for any inpatient rehabilitation therapy services provided to an individual who is unconscious, comatose, or in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including (but not limited to) coma stimulation programs and services.
- Expenses for Maintenance Rehabilitation, as defined under Rehabilitation in the Definitions section of this document.
- Expenses for speech therapy for functional purposes including (but not limited to) stuttering, stammering and conditions of psychoneurotic origin; or for childhood developmental speech delays and disorders.

- Expenses for treatment of delays in childhood speech development, unless as a direct result of an injury, surgery or the result of a covered treatment.

Sex Change Exclusions

- Sex Change Counseling, Therapy and Surgery: Expenses for medical, surgical or prescription drug treatment related to transsexual (sex change) procedures, the preparation for such procedures, or any complications resulting from such procedures.

Smoking Cessation or Tobacco Withdrawal Exclusions

- Expenses for non-prescription (over the counter) tobacco/smoking cessation products such as nicotine gum or patches, unless prescribed by a physician under the Wellness Program. Note: prescription smoking/tobacco cessation products are payable under the Prescription Drug benefit as described in the Schedule of Medical Benefits and Wellness section of this document.

Transplant (Organ and Tissue) Exclusions

- Expenses for human organ and/or tissue transplants that are experimental and/or investigational, including (but not limited to) donor screening, acquisition and selection, organ or tissue removal, transportation, transplants, post-operative services and drugs or medicines, and all complications thereof, except those Transplant Services as described under Transplantation in the Schedule of Medical Benefits.
- Expenses related to non-human (Engrafted) organ and/or tissue transplants or implants, except heart valves.
- Expenses incurred by the person who donates the organ or tissue, unless the person who receives the donated organ/tissue is the person covered by this plan.

Vision Care Exclusions

- Any vision care services in excess of the Vision care benefit maximums. Vision therapy (orthoptics) unless prior approved by PEBP or PEBP's third party claims administrator, elective corrective eye surgeries (such as lasik surgery), materials and supplies.

Weight Management and Physical Fitness Exclusions

- Medical or surgical treatment for weight-related disorders including (but not limited to) surgical interventions, dietary programs and prescription drugs, except those services payable under the Wellness (Prevention) section of the Schedule of Medical benefits. Surgery for weight reduction is payable only if pre-certified by the Plan Administrator or its designee. Surgery for weight reduction must be performed at a Bariatric Center of Excellence. Please refer to the Utilization Management section of this document for more information.
- If you don't follow the required Pre-certification Review process for weight reduction surgery, benefits payable for the services you failed to pre-certify will be reduced by 50% of the allowable charges. Expenses related to the penalty will not be counted to meet your plan year deductible or out-of-pocket maximum.
- Benefits are payable for medically supervised weight loss treatment programs under the Wellness Benefit. Please refer to the Wellness section of this document for more information. The benefit does not include programs such as Weight Watchers, Jenny Craig, NutriSystems, Slim Fast or the rental or purchase of any form of exercise equipment.
- Expenses for medical or surgical treatment of severe underweight, including (but not limited to) high calorie and/or high protein food supplements or other food or nutritional

supplements, except in conjunction with Medically Necessary treatment of anorexia, bulimia or acute starvation. Severe underweight means a weight more than 25 percent under normal body weight for the patient's age, sex, height and body frame based on weight tables generally used by Physicians to determine normal body weight.

- Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment.
- One obesity related surgery per lifetime while covered under the PEBP CDHP or any previous PEBP PPO Plan.

Prescription Drug Benefits

Eligible Benefits

Benefits for prescription drugs are provided through the Prescription Drug Plan. Coverage is provided only for those pharmaceuticals (drugs and medicines) approved by the U. S. Food and Drug Administration (FDA) as requiring a prescription and FDA approved for the condition, dose, route, duration and frequency, if prescribed by a physician or other health care practitioner. Coverage is also provided for:

- Prenatal & pediatric prescription vitamins;
- Prescription contraceptives limited to birth control pills, injectables like Depo-Provera and Lunelle and diaphragms;
- Insulin, and insulin injecting devices; (excluding Insulin pumps and supplies);
- Diabetic supplies;
- Influenza and Pneumonia vaccines;
- HPV vaccine;
- Herpes Zoster vaccine;
- TDAP (whooping cough) vaccine.

Some over the counter (OTC) drugs such as Prevacid and Zatidor when presented with a prescription from your physician.

Some over the counter (OTC) contraception products are covered when presented with a prescription from your physician. These types of products include the female condom, sponges and spermicides. Refer to the Female Contraception section of the Explanation of Medical Benefits for more information or call the Pharmacy Benefit Manager, whose contact information is in the Participant Contact Guide.

The plan provides a mandatory generic program meaning that if a brand name drug is dispensed in place of a generic, regardless of whether or not the participant or the physician requests it, you will pay 100% of the discounted rate. Deductible credit and out of pocket credit is not applied for the difference between the cost of the generic prescription and the brand name prescription.

Prescription Drug Deductible

Each plan year, you are responsible for paying all of your eligible medical and prescription drug expenses until satisfying the plan year deductible before the plan begins to pay benefits.

Deductibles are applied to the eligible medical and prescription drug expenses in the order in which claims are received by the Plan. Deductibles under this Plan are accumulated on a Plan year basis. Only eligible medical and prescription drug expenses can be used to satisfy the Plan's deductibles. All prescription drugs, including generics and some over the counter (OTC) drugs are subject to the plan year deductible. Some OTC drugs and some prescription drugs are eligible to be covered under the Plan's preventative/ wellness benefit. Some of these drugs can include (this list is not all inclusive):

- Aspirin
- Folic Acid
- Iron Supplementation

For more information on the Plan's deductible, refer to the CDHP Plan Overview section of this document.

PEBP's Prescription Drug Administrator has provided a search engine on their website that allows participants to search for a drug by name and determine their estimated out of pocket cost. See the Vendor Contact Guide section of this document or go to the PEBP website at www.pebp.state.nv.us.

Prescription Retail Drugs

To obtain a 30 day supply of medications, present your ID card to any in-network retail pharmacy. You can find the location of in-network retail pharmacies by contacting the Prescription Drug Administrator in the Participant Contact Guide section of this document.

Specialty Drugs

Certain drugs fall into a category called specialty drugs. Specialty drugs are available **only** through the Specialty Pharmacy (see the Participant Contact Guide) and prescriptions are limited to a 30-day supply. Members are encouraged to register with the Specialty Pharmacy before filling their first prescription for a specialty drug. A list of specialty drugs may be obtained by calling the Prescription Drug Plan Administrator.

90 Day Supply Options

You may be eligible for a 90 day supply of maintenance prescription medications vs. the 30 day supply typically dispensed by retail pharmacies. Maintenance medications include non-emergency, extended use prescription drugs such as those used for high blood pressure, lowering cholesterol, controlling diabetes or birth control. You can choose to receive a 90-day supply through either Mail Order or the *90-Day at Retail* program. In order to fill a 90 day supply medication make certain your physician writes the prescription for 90 days.

To determine whether your medication is less expensive at Retail or Mail Order, you may contact the Prescription Drug Administrator or log on to their website. See the Vendor Contact Guide section of this document.

90-Day at Retail Program

Through the *90-Day at Retail* program, you can receive a 90-day supply of your maintenance prescription medications at select retail pharmacies. To take advantage of this benefit, ask your physician to write a new prescription for a 90-day supply of any maintenance medication you are currently taking (plus refills of up to one year, if appropriate).

The 90-Day at Retail program is available through select retail pharmacies nationwide. To determine if your pharmacy will fill a 90-day supply of your maintenance medication, contact the Prescription Drug Administrator.

Mail Order Drug Service

You may use the mail order service to have prescriptions mailed directly to your home. Not all medicines are available via mail order. Check with the Prescription Drug Plan Administrator for further information on the availability of your particular prescription medication.

To use the mail order service, have your doctor write the prescription for a 90-day supply and indicate the number of appropriate refills. Mail your prescription and the mail order form to the mail order service. Mail order forms may be obtained from the Prescription Drug Plan Administrator listed on the Participant Contact Guide. Allow up to 14 days to receive your order.

Diabetes Supplies Mail Order Benefit

This is a preferred mail order service for diabetic supplies. For participants who enroll in PEBP's Diabetes Care Management Program you may receive up to a 90-day supply of diabetic supplies not subject to annual deductible or co-insurance requirements. Diabetic supplies include blood glucose monitors, test strips, insulin, syringes, alcohol pads, and lancets.

To enroll, contact the Diabetic Mail Order Program, listed in the Participant Contact Guide.

Prior Authorization Requirements and Other Utilization Management Procedures

Prior Authorization (pre-certification) may be required from the Prescription Drug Plan for certain drugs. Prescription drugs that might need prior authorization should be reviewed prior to purchase to ensure that you do not incur additional expenses. Participants should contact the Prescription Drug Plan Administrator, or have their physicians do so, if there are questions about a certain medication or its coverage.

The Prior Authorization process is designed to assist participants in the management of prescriptions that: are relatively expensive, have significant potential for misuse/abuse, and/or require close monitoring because of potentially serious side effects. Approval is required before such a prescription drug can be covered. Prior Authorizations typically have to be renewed annually; however, your physician will be notified of the length your Prior Authorization was approved for. Prior Authorization is usually contingent upon certain criteria, which could include, but not limited to:

- documentation of specific diagnosis,
- documentation of dosing regimen,
- documented results of commonly recognized testing to determine medical necessity,
- failure of or intolerance to first line agents, or
- other relevant clinical characteristics that make the drug medically necessary.

If you are required to obtain a Prior Authorization for your medication, it must be renewed annually by your physician and addressed to the Prescription Drug Plan Administrator. Contact the Prescription Drug Plan Administrator listed in the Participant Contact Guide for details of drugs such as:

All Specialty Drug medications including but not limited to:

- Self-injectables, such as those for Multiple Sclerosis or Rheumatoid Arthritis
- Factor medications for treatment of Hemophilia
- Rheumatoid Arthritis medications
- Enoxaparin

Some prescription drugs have certain limitations which also require Prior Authorization, such as Vitamin A skin preparations, e.g. Retin A, for persons over age 24 years. It is always best to check with the Prescription drug administrator to determine if your prescriptions require Prior Authorization or are subject to other limitations of the plan.

Quantity Limits

Some drugs may have quantity limits per month, for example:

- Sexual dysfunction drugs such as Viagra, Cialis or Muse (max 6 pills or injections/month);

- Oral migraine medication such as Maxalt or Zomig (max 18 tabs/month), or injectables such as Imitrex (max 18 injections/month);
- Epi-Pen and Glucagon (max 1 per year, however, you may be able to receive more than one of these medications at a time with Prior Authorization and a prescription from your doctor)

Contact the Prescription Drug Administrator to determine if your prescription has quantity limits under the Plan.

Extended Absence Benefit

If you are going to be away from your home for an extended period of time, either in the country or outside of the country, you may obtain an additional supply of your prescription drugs from your local retail or mail order pharmacy. This limited benefit must be requested in advance by the participant to the Prescription Drug Plan Administrator listed in the Participant Contact Guide. You may be required to obtain a new written prescription from your physician and any necessary Prior Authorizations.

Out-of-Network Pharmacy

If you fill a prescription at an out-of network pharmacy location, you will need to pay for the drug at the time of purchase and later send your drug receipt attached to a Direct Member Reimbursement (DMR) to the Prescription Drug Plan Administrator. DMR forms may be obtained from the Prescription Drug Plan. Eligible prescriptions will be processed according to the amount that would have been allowed had you used an in network retail pharmacy, minus the appropriate annual deductible.

Out-of-Country Medication Purchases

If you reside in the United States and you purchase prescription drugs from or in a foreign country your purchase is not eligible for reimbursement.

If you reside in the United States and are traveling in a foreign country and require prescription drugs as the result of a medical or dental emergency while traveling out of the United States, you may be eligible for reimbursement for the purchase of the prescription drugs. If you reside outside of the United States, permanently or on a part-time basis, and require prescription drugs, you may be eligible for reimbursement for the purchase of the prescription drugs. Eligible prescription drug purchases made outside of the United States may be submitted to the Prescription Drug Plan Administrator for consideration. Prescription drug purchases made outside of the United States are subject to plan provisions, limitations and exclusions, clinical review and determination of medical necessity. The review will also include regulations determined by the FDA.

If your purchase is eligible for reimbursement you must use the Direct Member Reimbursement (DMR) form available from the Prescription Drug Plan Administrator. In addition to the DMR form you are required to provide:

- A legitimate copy of the written prescription completed by your physician
- Proof of payment from you to the provider of service (typically your credit card invoice)
- Prescription and receipt must be translated to English
- Reimbursement request must be converted to United States dollars.

Any foreign purchases of prescription medications will be subject to Plan limitations such as:

- deductibles
- coinsurance
- dispensing maximums
- annual benefit maximums
- medical necessity
- Usual and Customary (U&C) or Prescription drug administrator's contracted allowable
- FDA approval
- Plan prior authorization requirements

Contact the Prescription Drug Plan Administrator before traveling or moving to another country to discuss any criteria that may apply to a prescription drug reimbursement request.

Other Limitations

This plan does not coordinate prescription drug plan benefits. See exclusions related to medications in the exclusions section of this document.

Schedule of Prescription Benefits

The following schedule provides information regarding prescription benefits offered by the self-funded plan.

Schedule of Prescription Drug Benefits – Plan Year 2014
This chart explains the benefits payable by the Self-funded Plan.
All benefits are subject to the deductible except where noted.

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	Participant Responsibility
<p><u>Prescription Drug Plan</u> Coverage is provided only for medications approved by the U. S. Food and Drug Administration (FDA) as requiring a prescription and FDA approved for the condition, dose, route, duration and frequency, if prescribed by a physician or other health care practitioner.</p> <p>Coverage is also provided for:</p> <ul style="list-style-type: none"> • Prenatal & pediatric prescription vitamins; • Contraceptives limited to birth control pills and some injectables like Depo-Provera and Lunelle and diaphragms; • Birth control pills covered under the female reproductive benefit are limited to generic only unless a prior authorization request to the Pharmacy Benefits Manager determines a generic contraceptive is not medically appropriate in which case a brand name oral contraceptive would be covered. • Insulin, and insulin injecting devices; • Diabetic supplies. 	<p>The plan provides a mandatory generic program meaning that if a brand name drug is dispensed in place of a generic, regardless of whether or not the participant or the physician requests it, you will pay 100% of the discounted rate. Deductible and out of pocket credit is not applied.</p> <p>Retail Drugs: To obtain a 30-day or 90-day supply of medication, present your ID card to any in-network retail pharmacy. Contact the Prescription Drug Plan Administrator for locations of in-network retail pharmacies.</p> <p>90-Day Supply of Retail Drug: You may use a participating retail pharmacy to obtain up to a 90-day supply of non-emergency, extended-use "maintenance" prescription drugs, such as for high blood pressure or diabetes. Check the Prescription Drug Plan Administrator's website for further information including a list of participating pharmacies.</p> <p>Specialty Medications: Certain medications fall into a category called 'specialty medications'. Specialty medications are available only through the Specialty Pharmacy (see the Participant Contact Guide) and prescriptions are limited to a 30-day supply. A list of specialty drugs may be obtained by calling the Prescription Drug Plan Administrator or logging on to their website.</p> <p>Mail Order Drug Service: You may use the mail order service (see the Participant Contact Guide) to receive up to a 90-day supply of non-emergency, extended-use "maintenance" prescription drugs, such as for high blood pressure or diabetes. Note: not all medicines are available via mail order. Check with the Prescription Drug Administrator for further information, or log onto their website.</p> <p>For a list of drugs classified as Tier 2 Brand and Tier 3 Non-Preferred Brand, contact the Prescription Drug Administrator, or log onto their website for more information.</p>	<p>In-Network Retail :</p> <ul style="list-style-type: none"> • 25% co-insurance after plan year deductible <p>Mail Order Services:</p> <ul style="list-style-type: none"> • 25% co-insurance after plan year deductible <p>Specialty Medications – 30-day supplies are available through specialty mail order provider, or through your local retail Walgreens.</p> <p>*Non-preferred name brand and non-preferred generic drugs Participant is responsible for 100% of the Preferred Contract Rate. Deductible credit and out of pocket credit is not applied.</p>

Schedule of Prescription Drug Benefits – Plan Year 2014
This chart explains the benefits payable by the Self-funded Plan.
All benefits are subject to the deductible except where noted.

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	Participant Responsibility
<p>Prescription Drug Plan (continued)</p> <p>Prior Authorization is required from the Prescription Drug Plan Administrator for some medications. See the Prescription Drug Plan Administrator’s website for details.</p> <p>Some medications may have quantity limits per month like:</p> <ul style="list-style-type: none"> • Sexual dysfunction drugs such as Viagra, Cialis or Muse (max 6 pills or injections/month); • Oral migraine medication such as Maxalt or Zomig (max 18 tabs/month), or injectables such as Imitrex (max 18 injections/month); • Epi-Pen and Glucagon (max 1 per year.) 	<p>Diabetes Supplies Mail Order Benefit: This is a preferred mail order service for diabetic supplies for participants. To enroll in this benefit, contact the diabetes mail order benefit program whose name and phone number is listed on the Participant Contact Guide. Once enrolled, you are able to receive up to a 90-day supply of the following items subject to deductible and coinsurance, unless you are enrolled in the Diabetes Care Management Program: blood glucose monitors, test strips, insulin syringes, alcohol pads, and lancets. Participants who are enrolled in the Diabetes Care Management Program can receive these supplies by paying a copayment that is not subject to deductible and coinsurance. See the Diabetes Care Management section of this document for more information.</p> <p>Tobacco/Smoking Cessation Products: The Plan waives the deductible for prescription and over-the-counter smoking cessation products. See the Wellness section for more information.</p> <p>Vaccine Coverage: The Plan waives the deductible for certain vaccine services, see the Eligible Benefits section for more information.</p> <p>Out-of-network pharmacy, Out-of-country pharmacy, or extended absence benefits: See the Prescription Drug Administrator section of this document for detailed information.</p> <p>Other Limitations:</p> <ul style="list-style-type: none"> • The Medical and Prescription Drug Annual Deductible is based on your selected coverage tier. Refer to the CDHP Plan Overview section of this document. 	<p>Specialty Medications – 30 day supplies are available through specialty mail order provider, or through your local retail Walgreens.</p> <p>In-Network Retail :</p> <ul style="list-style-type: none"> • 25% co-insurance after plan year deductible <p>Mail Order Services:</p> <ul style="list-style-type: none"> • 25% co-insurance after plan year deductible <p>*Non-preferred name brand and non-preferred generic drugs Participant is responsible for 100% of the Preferred Contract Rate. Deductible credit and out of pocket credit is not applied.</p>

Self-Funded Dental Benefits

Eligible Dental Expenses

You are covered for expenses you incur for most, but not all, dental services and supplies provided by a Dental Care Provider as defined in the Definitions section of this document that are determined by PEBP or its designee to be “medically necessary,” but only to the extent that:

- PEBP or its designee determines that the services are the most cost effective ones that meet acceptable standards of dental practice and would produce a satisfactory result; and
- the charges for them are “Usual and Customary (U&C)”(see the Definitions section under “Usual and Customary)”

Non-Eligible Dental Expenses

The plan will not reimburse you for any expenses that are not eligible dental expenses. That means you must pay the full cost for all expenses that are not covered by the Plan, as well as any charges for eligible dental expenses that exceed the amount determined by the Plan to be usual and customary.

Out-of-Country Dental Purchases:

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

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

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

- Proof of payment from you to the provider of service (typically your credit card invoice)
- Itemized bill to include complete description of the services rendered and admitting diagnosis(es)
- Itemized bill must be translated to English
- Reimbursement request must be converted to United States dollars.
- Any foreign purchases of dental care and services will be subject to Plan limitations such as:
 - deductibles
 - coinsurance
 - frequency maximums
 - annual benefit maximums
 - medical necessity
 - FDA approval
 - Usual and Customary (U & C)

If the provider will accept payment directly from PEBP you must also provide the following:

- Assignment of Benefits signed by you or an individual with the authority to sign on your behalf such as a legal guardian or Power of Attorney (POA).

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

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

Deductibles

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

There are two types of deductibles: individual and family. The individual deductible is the maximum amount one covered person has to pay each plan year before plan benefits are available for Basic or Major services. The Plan's individual deductible is \$100. The family deductible is the maximum amount that a family of three or more has to pay each plan year. The Plan's family deductible is \$300. Both in- and out-of-network services are combined to meet your plan year deductible.

Coinsurance

There is no coinsurance amount for preventive services, unless services are rendered by a non-PPO dental provider. For Basic or Major services, once you've met your plan year deductible, the Plan pays its percentage of the eligible usual and customary dental expenses, and you are responsible for paying the rest (the applicable percentage paid by the Plan is shown in the Schedule of Dental Benefits). The part you pay is called the coinsurance. Note that you pay less money if you use the services of a dental provider who is part of the Preferred Provider Organization (PPO), also called in-network.

Plan Year Maximum Dental Benefits

The plan year maximum dental benefits payable for any individual covered under this plan is \$1,000. The maximum plan year dental benefit is for both in network and out-of-network services. Under no circumstances will the combination of in network and out-of-network benefit payments exceed the plan year maximum benefit \$1,000. This maximum does not include your deductible or any amounts over usual and customary. Benefits paid for preventive dental services do not apply to the annual maximum dental benefit.

Payment of Dental Benefits

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

Fixed partial dentures, bridgework, crowns, inlays and onlays: All services related to installation of fixed partial dentures, bridgework, crowns, inlays and onlays are considered to have been incurred on the date the tooth (or teeth) is (or are) prepared for the installation.

Removable partial or complete dentures: All services related to the preparation of removable partial or complete dentures are considered to have been incurred on the date the impression for the dentures is taken.

Root Canal Treatment (Endodontics): All services related to root canal treatment are considered incurred on the date the tooth is opened for the treatment.

Extension of Dental Coverage

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

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

Alternative Procedures

Often there are several ways to treat a particular dental problem that will produce a satisfactory result. The plan will pay benefits based on the procedure that meets acceptable standards of dental practice that PEBP or its designee determines to be most cost-effective. You may choose a more costly procedure; however, if you do, you will be responsible for paying the difference between the charges for the more costly procedure and the benefits paid by the Plan. All treatment decisions rest with you and your dentist. The pretreatment estimate procedure described below will help you know what benefits the Plan will pay. You will then be able to determine the difference (if any) that you may have to pay yourself.

Pretreatment Estimates

Whenever you expect that your dental expenses for a course of treatment will be more than \$300, you should use the pretreatment estimate procedure. This procedure lets you know how much you will have to pay before you begin treatment.

To obtain a pretreatment estimate, you and your dentist should complete the regular dental claim form (available from and to be sent to the Claims Administrator, whose name and address are listed on the Participant Contact Guide in this document), indicating the type of work to be performed, along with supporting x-rays and the estimated cost (valid for a 60-day period).

Once it is received, the Claims Administrator will review the form and then send your dentist a statement within the next 60 days showing what the Plan may pay. Your dentist may call the Claims Administrator (whose number is listed on the Participant Contact Guide in this document) for a prompt determination of the benefits payable for a particular dental procedure.

Prescription Drugs Needed for Dental Purposes

Necessary prescription drugs needed for a dental purpose, such as antibiotics or pain medications, should be obtained using the prescription drug benefit of the medical plan. (Note: some medications for a dental purpose are not payable, such as fluoride or periodontal mouthwash. See the Medical Exclusions section under Drugs for more information).

Schedule of Dental Benefits

Charts outlining descriptions of the plan's dental benefits are provided on the following pages.

Schedule of Dental Benefits – Plan Year 2014

This chart explains the benefits payable by the Self-funded Dental PPO Plan.

All benefits are subject to the deductible except where noted.

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Preventive Services</u></p> <ul style="list-style-type: none"> • Oral examination • Prophylaxis (routine cleaning of the teeth without the presence of periodontal disease) • Bitewing x-rays • Topical application of sodium or stannous fluoride • Space maintainers • Application of sealants 	<p>Preventive services are not subject to the individual plan year maximum dental benefit.</p> <p>Oral examinations are limited to four times per plan year.</p> <p>Prophylaxis, scaling, cleaning and polishing limited to four times per plan year. Even if your dentist recommends more than four routine prophylaxes, the Plan will only consider four for benefit purposes. You will be responsible for charges in excess of four cleanings in a single plan year.</p> <p>Bitewing x-rays limited to twice per plan year.</p> <p>Fluoride treatment for individuals age 18 years and under is payable twice per plan year.</p> <p>Application of sealants for children under age 18 years.</p> <p>Initial installation of a space maintainer (to replace a primary tooth until a permanent tooth comes in) is payable for individuals under age 16 years. Plan allows fixed, unilateral (band or stainless steel crown type), fixed cast type (Distal shoe), or removable bilateral type.</p> <p>Benefits for preventive dental services do not apply to the annual maximum dental benefit.</p>	<p>No deductible.</p> <p>100% of the discounted PPO allowed fee schedule.</p>	<p>No deductible.</p> <p>The Plan pays 80% of the in network provider fee schedule for the Las Vegas service area.</p> <p>For services outside of Nevada, the Plan will reimburse at the U & C rates.</p>

Schedule of Dental Benefits – Plan Year 2014

This chart explains the benefits payable by the Self-funded Dental PPO Plan.

All benefits are subject to the deductible except where noted.

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p>Basic Services</p> <ul style="list-style-type: none"> • Office visits during regular office hours for treatment and observation of injuries to teeth and supporting structures (other than for routine operative procedures) • Professional visits • After hours for emergency dental care • Consultation by a specialist for case presentation when a general dentist has performed diagnostic procedures • Emergency treatment • Film fees, including examination and diagnosis, except for injuries • Periapical, entire dental film series (14 films), including bitewings as necessary every 36 months or panoramic survey covered once every 36 months 	<p>Plan year deductible applies. Basic services are subject to the individual plan year maximum dental benefit.</p> <p>Full-mouth periodontal maintenance cleanings, payable four times per plan year. Even if your dentist recommends more than four periodontal maintenance cleanings, the Plan will only consider four for benefit purposes. You will be responsible for charges in excess of four cleanings in a single plan year.</p> <p>Laboratory services, including cultures necessary for diagnosis and/or treatment of a specific dental condition.</p> <p>For multiple restorations, one tooth surface will be considered a single restoration.</p> <p>No coverage for root canal therapy when the pulp chamber was opened before coverage under this dental plan began.</p> <p>Initial installation of a removable, fixed or cemented inhibiting appliance to correct thumb sucking is payable for individuals under age 16 years.</p> <p>Alternate procedures, such as CT scans, used for dental procedures, are not payable. See the “Alternate Procedures” section under dental benefits.</p>	<p>After the deductible is met, the Plan pays 75% of the discounted PPO-allowed fee schedule.</p>	<p>After the deductible is met, Plan pays 50% of the in network provider fee schedule for the Las Vegas service area.</p> <p>For services outside of Nevada, the Plan will reimburse at the U & C rates.</p>

Schedule of Dental Benefits – Plan Year 2014

This chart explains the benefits payable by the Self-funded Dental PPO Plan.

All benefits are subject to the deductible except where noted.

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p>Basic Services (continued)</p> <ul style="list-style-type: none"> • Biopsy, examination of oral tissue, study models, microscopic exam • Oral surgery, limited to alveoplasty or alveolectomy, removal of cysts or tumors, torus and impacted wisdom teeth, including local anesthesia and postoperative care • Amalgam restorations for primary and permanent teeth, synthetic, silicate, plastic and composite fillings, retention pin when used as part of restoration other than a gold restoration • Appliance for thumb sucking (Individuals under 16 years of age) or nightguard for bruxism (grinding teeth) 		<p>After the deductible is met, the Plan pays 75% of the discounted PPO-allowed fee schedule.</p>	<p>After the deductible is met, Plan pays 50% of the in network provider fee schedule for the Las Vegas service area.</p> <p>For services outside of Nevada, the Plan will reimburse at the U & C rates.</p>

Schedule of Dental Benefits – Plan Year 2014

This chart explains the benefits payable by the Self-funded Dental PPO Plan.

All benefits are subject to the deductible except where noted.

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p><u>Major Services</u></p> <ul style="list-style-type: none"> • Gold restorations (inlays and onlays) only when teeth cannot be restored with a filling material • Repair or re-cementing of inlays, crowns, bridges and dentures • Initial installation of fixed or removable bridges, dentures and full or partial dentures (except for special characterization of dentures) including abutment crowns • Bridgework, dentures, and replacement of bridgework and dentures which are 5 years old or more and cannot be repaired. Covered expenses for temporary and permanent services cannot exceed the usual and customary fees for permanent services • Dental implants (endosseous, ridge extension, and ridge augmentation only) • Post and core on non-vital teeth only • Denture relining and/or adjustment more than six months after installation 	<p>Plan year deductible applies.</p> <p>Major services are subject to the individual plan year maximum dental benefit.</p> <p>No coverage for a crown, bridge or gold restoration when the tooth was prepared before coverage under this dental plan began.</p> <p>Facings on crowns or pontics posterior to the second bicuspid are considered cosmetic and not covered.</p> <p>If payment is requested for temporary appliances, the cost of the temporary appliance will be deducted from the benefits payable for the permanent appliance, meaning the Plan will not pay for both a temporary and a permanent appliance. Under no circumstances will the benefit paid for a temporary appliance and permanent appliance exceed the PPO allowed amount or Usual and Customary allowance.</p>	<p>After the deductible is met, Plan pays 50% of the discounted PPO-allowed fee schedule.</p>	<p>After the deductible is met, Plan pays 50% of the in network provider fee schedule for the Las Vegas service area.</p> <p>For services outside of Nevada, the Plan will reimburse at the U & C rates.</p>

Schedule of Dental Benefits – Plan Year 2014

This chart explains the benefits payable by the Self-funded Dental PPO Plan.

All benefits are subject to the deductible except where noted.

See also the Exclusions and Definitions sections of this document for important information.

Benefit Description	Explanations and Limitations	In-Network	Out-of-Network
<p>Major Services (continued)</p> <ul style="list-style-type: none"> • Prosthodontics (artificial appliance of the mouth). No coverage of fees to install or modify an appliance for which an impression was made before coverage under this dental plan began • Crown (acrylic, porcelain or gold with gold or non-precious metal), including crown build up only when teeth cannot be restored with a filling material • Teeth added to a partial denture to replace extracted natural teeth, including clasps if needed 	<p>Plan year deductible applies.</p> <p>Major services are subject to the individual plan year maximum dental benefit.</p> <p>No coverage for a crown, bridge or gold restoration when the tooth was prepared before coverage under this dental plan began.</p> <p>Facings on crowns or pontics posterior to the second bicuspid are considered cosmetic and not covered.</p>	<p>After the deductible is met, Plan pays 50% of the discounted PPO-allowed fee schedule.</p>	<p>After the deductible is met, Plan pays 50% of the in network provider fee schedule for the Las Vegas service area.</p> <p>For services outside of Nevada, the Plan will reimburse at the U & C rates.</p>

Dental Network

In-Network Services

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

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

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

At least once each year, a Directory of Dental Providers will be made available to you. There is no cost to you for the provider directory. If you lose or misplace your directory, you can obtain another at no cost, by calling the dental PPO network shown in the Participant Contact Guide in this document.

Out-of-Network Services

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

If a participant travels to an area serviced by the Plan's PPO network, the participant should use an in-network provider in order to receive benefits at the in-network benefit level. If a participant uses an out-of-network provider within this service area, benefits will be considered as out-of-network. In-network provider contracted rates for the Diversified Dental Las Vegas service area will apply to all out of network dental claims in Nevada. The participant may be responsible for any amount billed by the out-of-network provider that exceeds the in-network provider

contracted rate. The \$1,000 dental benefit for each covered individual includes both in-network and out-of-network dental services.

Plan participants may be required to submit proof of claim before any such reimbursement will be made. Non-network dental care providers may bill the plan participant for any balance that may be due in addition to the amount payable by the plan, also called balance billing. You can avoid balance billing by using in-network providers.

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

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

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

Exclusions: Dental PPO Plan

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Experimental and/or Investigational Services - Expenses for any dental services, supplies, drugs or medicines that are determined by the Claims Administrator or its designee to be Experimental and/or Investigational (as defined in the Definitions section of this document).

Frequent Intervals Services – Services provided at more frequent intervals than covered by the dental plan as described in the Schedule of Dental Benefits.

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

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

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

Illegal Act - Expenses incurred by any covered individual for injuries resulting from commission, or attempted commission by the covered individual, of an illegal act that PEPP determines involves violence or the threat of violence to another person or in which a firearm is used by the covered individual. PEPP's discretionary determination that this exclusion applies

shall not be affected by any subsequent official action or determination with respect to prosecution of the covered individual (including, without limitation, acquittal or failure to prosecute) in connection with the acts involved.

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

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

Myofunctional - Therapy Expenses for myofunctional therapy.

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

Occupational Illness, Injury or Conditions Subject to Workers' Compensation - All expenses incurred by you or any of your covered dependents arising out of or in the course of employment (including self-employment) if the Injury, Illness or Condition is subject to coverage, in whole or in part, under any Workers' Compensation or occupational disease or similar law. This applies even if you or your covered dependent were not covered by Workers' Compensation insurance, or if the covered Individual's rights under Workers' Compensation or occupational disease or similar law have been waived or qualified.

Orthodontia - Expenses for any dental services relating to orthodontia evaluation and treatment. Installation or replacement of appliances, restorations or procedures for altering vertical dimension.

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

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

Reconstructive dental surgery - When that service is:

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

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

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

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

CDHP and Self-Funded Dental PPO Claims Administration

How Medical and Dental Benefits are Paid

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

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

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

How to File a Medical or Dental Claim

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

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

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

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

To assure that medical, pharmacy or dental expenses you incur are eligible under this Plan, the Plan has the right to request additional information from any hospital, facility, physician, laboratory, radiologist, dentist, pharmacy or any other eligible medical or dental provider. For example, the Plan has the right to deny deductible credit or payment to a provider if the provider's bill does not include or is missing one or more of the following components. This is not an all-inclusive list.

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

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

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

Where to Send the Claim Form

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

CDHP Claim Appeal Process

Written Notice of Denial of Claim (Adverse Benefit Determination)

The plan or its designee, typically the Claims Administrator, will notify you in writing of an adverse benefit determination for a Claim of Benefits. It will explain the reasons why, with reference to the plan provisions on which the adverse benefit determination was based. You will be told what steps you may take to submit an appeal of the adverse benefit determination. When applicable, you will be told what additional information is required from you and why it is needed. Your request for appeal must be made in writing to the office where the claim was originally submitted (the Claims Administrator) within 180 days after you receive a notice of denial. A participant or their designee cannot circumvent the claims and appeals procedures by initiating a cause of action against the PEBP (or State of Nevada) in a court proceeding.

Discretionary Authority of Plan Administrator and Designee

In carrying out their respective responsibilities under the Plan, the Plan Administrator and its designees have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority would be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious. Services that are covered, as well as specific plan exclusions are described in this document.

Internal Appeals

Written Notice of Denial of Claim

The Plan will notify you in writing if payment of your claim is denied in whole or in part. It will explain the reasons why, with reference to the Plan provisions on which the denial was based. When applicable, you will be told what additional information is required from you and why it is needed. You will be told what steps you may take to submit your claim for appeal. Your request for appeal must be made in writing to the office where the claim was originally submitted (the Claims Administrator) within 180 days after you receive a notice of denial. A participant or their designee cannot circumvent the claims and appeals procedures by initiating a cause of action against the PEBP (or State of Nevada) in a court proceeding.

The appeal process works as follows:

Level 1 Appeal (medical, dental and vision)

If your claim is denied, or if you disagree with the amount paid on a claim, you may request a review from the Claims Administrator within 180 days of the date you received the Explanation of Benefits (EOB) 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 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 EOB 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. The Claims Administrator will review your claim (by a person at a higher

level of management than the one who originally denied the claim). If any additional information is needed to process your request for appeal, it will be requested promptly.

The decision on your appeal will be given to you in writing. Ordinarily, a decision on your appeal will be reached within 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 provisions of the Plan upon 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 (medical, dental and vision)

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.

If, after a Level 1 appeal is completed, you are still dissatisfied with the denial of your 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 Administrator's section of the Participant Contact Guide 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. 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 claims administrator by the participant.

The Executive Officer or his designee will use all resources available, including but not limited to, members of the staff of the Board, third party administrator, prescription drug administrator, Internet, and the PEBP Master Plan Document to determine if the claim was adjudicated correctly.

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.

Appealing a UM Determination

You may request an appeal of any adverse determination made during the pre-certification, concurrent review, retrospective review, case management or second opinion review process described in this section. To appeal the denial of a claim or bill, see the Claims Information section of this document.

The appeal process for determinations made by the UM company may be initiated by the plan participant, treating provider, parent, legal guardian, or person authorized to make health care decisions by a power of attorney. There are two levels of appeal review:

- Expedited Appeal, and
- Standard Appeal

- Qualifications of Reviewer
- A physician (other than the physician who rendered the original decision) is utilized to complete the appeal. This physician is Board Certified in the area under review and is in active practice.

The name, address and phone number of the UM company is in the Participant Contact Guide section of this document and on the PEBP website (pebp.state.nv.us).

Expedited Appeal Process - You may obtain an expedited medical review of a denied pre-certification (pre-service) or concurrent review request if the physician certifies that the time required to process the appeal could cause significant negative change in your medical condition. Requests for Expedited Appeal may be made by telephone or any other reasonable means that will ensure the timely receipt of the information required to complete the appeal process to the UM company. If your physician requests a consultation with the reviewing physician, this will occur within 1 business day. The UM company will make a determination on an Expedited Appeal within 72 hours of receipt of the information needed to complete the appeal. The results of the determination of an Expedited Appeal will be provided immediately to the managing physician via a phone call and in writing to the patient, managing physician, facility and Claims Administrator. Upon receipt of a request, the UM company will provide the recipients of an adverse determination letter with the clinical rationale for the non-certification decision. If non-certification is upheld, you may pursue an External Appeal as described in this document.

Standard Appeal Process - If you have a denied pre-certification request (or a denial/non-certification at any other level of UM review such as concurrent review, retrospective review, second opinion or case management issue) and you do not qualify for an Expedited Appeal, you may request a Standard Appeal Review. Requests for Standard Appeal Review may be made by writing to the UM company.

Appeals must be made within 180 days of the date of the denial/non-certification. Actual medical records are encouraged to be provided to assist the reviewer. Review will be completed by a physician within 30 business days of the request for the Standard Appeal. The results of the determination of a Standard Appeal will be provided in writing to the patient, managing physician, facility and Claims Administrator.

A participant or their designee can choose to bypass this appeal process and request a review by an external review board. To request a review by the external review board, please refer to the section of this document called Claim Appeal Process.

EXTERNAL APPEALS (Medical claims only)

An External Appeal may be requested by a Participant and/or the Participant's treating physician after you have exhausted the internal review process. This means that you may have a right to have PEBP's decision reviewed by independent health care professionals if PEBP's decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care setting or treatment you requested.

A Participant must file a request for an external review with the Office for Consumer Health Assistance (OCHA) if the request is filed within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. A standard external review request form can be found on the PEBP website at www.pebp.state.nv.us.

The request must be submitted to:

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

For standard external review, a decision will be made within 45 days of receiving the request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an expedited external appeal of PEBP's denial. If PEBP's denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you also may be entitled to file a request for external review of our denial. Please refer to the section in this document titled "Experimental and Investigational External Review".

Pre-Service Urgent Care Claim Appeal (Expedited External Review)

If you need a quick decision, you may request that your external appeal be handled on an expedited basis.

Expedited external review is available only if the patient's treating health care provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An expedited external review must be completed at most within 72 hours of receipt. As with the standard External Review, an Expedited External Review must be submitted to the Office for Consumer Health Assistance at:

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

For instructions on how to submit a request for an expedited external review, please refer to the form located on the PEBP website www.pebp.state.nv.us titled "Certification of Treating Health Care Provider for Expedited Consideration of a Patient's External Review".

Experimental and Investigational External Review

If you have had a service such as drug therapy, durable medical device, procedure or other therapy denied because PEBP or its designee (third party administrator, prescription drug administrator or utilization management company) determined that the proposed therapy is experimental and/or investigational, you may request an External Review. To proceed with the experimental and investigational external review, you must obtain a certification from the treating physician indicating that the treatment would be significantly less effective if not promptly initiated.

A "Physician Certification of Experimental/Investigational /Denials" is located under "Forms" on the PEBP website at www.pebp.state.nv.us. After this form is completed by the treating physician, it should be attached to the Request for External Review" form and submitted to the Office for Consumer Health Assistance at:

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

Facility of Payment

If the Plan Administrator or its designee determines that you cannot submit a claim or prove that you or your covered dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated, in a coma, or deceased, the Plan may, at its discretion, pay plan benefits directly to the health care provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of plan benefits will completely discharge the Plan's obligations to the extent of that payment.

Neither the Plan, Plan Administrator, Claims Administrator, nor any other designee of the Plan Administrator, will be required to ensure that the benefits paid on behalf of a participant are applied to the charges and services submitted, other than standard claims processing which provides a remittance listing of benefits paid as covered by the Plan.

Coordination of Benefits (COB)

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

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

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

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

When and How Coordination of Benefits (COB) Applies

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

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

If the PEBP plan is secondary coverage, the participant will be required to meet their PEBP plan year medical and dental deductibles.

For the purposes of this Coordination of Benefits section, the word "plan" refers to any group medical or dental policy, contract or plan, whether insured or self-insured, that provides benefits payable for medical or dental services incurred by the covered individual, or that provides medical or dental services to the covered individual. A "group plan" provides its benefits or

services to employees, retirees or members of a group who are eligible for and have elected coverage.

"Allowable expense" means a health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering the person, except as described below, or where a statute requires a different definition. This means that an expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense. Examples of what is not an allowable expense:

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

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

Which Plan Pays First: Order of Benefit Determination Rules

The Overriding Rules

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

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

Rule 1 Non-Dependent/Dependent

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

- secondary to the plan covering the person as a dependent;
- primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee);

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

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

Rule 2: Dependent Child Covered Under More Than One Plan

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

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

If the specific terms of a court decree state that one parent is responsible for the child’s health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child’s health care services or expenses, but that parent’s current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any plan year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child’s health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

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

Rule 3: Active/Laid-Off or Retired Employee

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

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

Rule 4: Continuation Coverage

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

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

Rule 5: Longer/Shorter Length of Coverage

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

Administration of COB

To administer COB, the Plan reserves the right to:

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

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

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

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

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

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

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

This Plan does not coordinate pharmacy benefits.

Coordination with Medicare

Coordination with Medicare is not applicable for participants and their dependents who have transitioned to the Medicare Exchange. See retirees who are eligible for Medicare in the Eligibility section of this document.

Entitlement to Medicare Coverage: When you or your dependent reach Medicare eligible age, you must enroll in the Medicare plan for which you are eligible. Generally, anyone age 65 years or older is entitled to Medicare Part A and Part B coverage. Anyone under age 65 years who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.

When the Plan Participant is Not Eligible for Premium Free Medicare Part A: This plan will pay as primary for services that would have been covered by Part A when you are not eligible for Premium Free Medicare Part A. However, you must enroll in Medicare Part B and PEBP will be the secondary payer for Medicare Part B services This Plan will always be secondary to Medicare Part B, whether or not you have enrolled. This Plan will assume that Medicare has paid 80% of Medicare Part B eligible expenses. This plan will only consider the remaining 20% of Medicare Part B expenses.

Coverage Under Medicare and This Plan When You Have End-Stage Renal

Disease: If, while you are actively employed, you or any of your covered dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins, or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage or the first month after the

individual receives a kidney transplant, Medicare pays first and this Plan pays second. If you are under age 65 years and are receiving Medicare ESRD benefits you will not be required to transition to PEBP's Medicare Exchange program. When you reach age 65 years you will be transitioned to the Medicare Exchange in accordance with PEBP's eligibility requirements as stated in the Eligibility section of this document.

How Much This Plan Pays When It Is Secondary to Medicare

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

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

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

Coordination with Other Government Programs

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

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

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

Workers' Compensation

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

Third Party Liability

Subrogation and Third Party Recovery

Subrogation applies to situations where the Covered Person is injured and another party is responsible for payment of health care expenses (s)he incurs because of the injury. The other party may be an individual, insurance company or some other public or private entity. Automobile accident injuries or personal injury on another's property are examples of cases frequently subject to subrogation.

The Subrogation provision allows for the right of recovery for certain payments. Any payments made for the Covered Person's injuries under the Plan may be recovered from the other party. Any payments made to the Covered Person for such injury may be recovered from the Covered Person from any judgment or settlement of his or her claims against the other party or parties.

By accepting Coverage under the Plan, the Covered Person automatically assigns to the Plan any rights the Covered Person may have to recover all or part of any payments made by the Plan from any other party, including an insurer or another group health program. Therefore, the Plan Administrator may act as the Covered Person's substitute in the event any payment made by this Plan for health care benefits, including any payment for a covered pre-existing condition, is or becomes the responsibility of another party. Such payments shall be referred to as Reimbursable Payments. This assignment allows the Plan to pursue any claim that the Covered Person may have, whether or not the Covered Person chooses to pursue that claim.

The Covered Person must cooperate fully and provide all information needed under the Plan to recover payments, execute any papers necessary for such recovery, and do whatever else is necessary to secure such rights to the Plan. The other party may be sued in order to recover the payments made for the Covered Person under the Plan.

Right of Reimbursement and Recovery

Specifically, by accepting Coverage under the Plan the Covered Person agrees that if the Covered Person receives any recovery in the form of a judgment, settlement, payment or compensation (regardless of fault, negligence or wrongdoing) from (1) a tortfeasor, (2) a liability insurer for a tortfeasor, or (3) any other source, including but not limited to any form of insured or underinsured motorist coverage, any medical payments, no-fault or school insurance coverages, workers' compensation coverage, premises liability coverage, any medical malpractice recovery, or any other form of insurance coverage ("Recovery"), the Covered Person must repay the Plan in full for any medical, dental, vision, or disability benefits which have been paid or which will in the future be payable under the Plan for expenses already incurred or which are reasonably foreseeable at the time of such Recovery.

The Plan has an equitable lien against the Recovery rights of the Covered Person and has the right to be paid from any such Recovery any and all monies or properties: (1) paid; (2) payable to; or (3) for the benefit of, a Covered Person to the extent of benefits paid by the Plan ("Subrogated Amount"), whether or not the Covered Person has been "made whole" for the injuries received. This right applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the Covered Person constitute a full or partial recovery, and applies to funds paid for non-health care charges or attorney fees, or other costs and expenses. This right for first priority in contravention of the "make whole" doctrine

shall not be affected or limited in any way by the manner in which the Covered Person or any person or entity responsible for paying any Recovery attempts to designate or characterize the Recovery, regardless of whether the recovery itemizes or identifies an amount awarded for Plan benefits or medical expenses, or is specifically linked to certain kinds of damages or payments. Payment of the Subrogated Amount to the Plan shall be without reduction, set-off or abatement for attorney's fees or costs incurred by the Covered Person in the collection of damages. The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such monies or properties. At the discretion of the Claims Administrator, the Plan may reduce any future Eligible Expenses otherwise available to the Covered Person under the Plan by an amount up to the total amount of Subrogated Amount that is subject to the equitable lien. All rights of recovery will be limited to the amount of payments made under this Plan.

The equitable lien shall also attach to the first right of Recovery to any money or property that is obtained by anybody, including but not limited to the Covered Person, the Covered Person's attorney, and/or a trust for the direct or indirect benefit of the Insured or for his/her "special needs," as a result of an exercise of the Covered Person's rights of Recovery.

The Plan may, in its sole discretion, require the Covered Person, as a pre-condition to receiving benefit payments, to sign a subrogation agreement and to agree in writing to assist the Plan to secure the Plan's right to payment of the Subrogation Amount from the third party. In the event that the Plan does not receive payment of the Subrogated Amount, the Plan may, in its sole discretion, bring legal action against the Covered Person or reduce or set-off the unpaid Subrogated Amount against any future benefit payments to the Covered Person. If the Plan takes legal action to enforce its subrogation rights, the Plan shall be entitled to recover its attorneys' fees and costs from the Covered Person.

The following provisions apply to the Plan's right of subrogation, reimbursement, and creation of an equitable lien:

1. **"Pay and Pursue."** The Plan Administrator has elected the "pay and pursue" option in connection with the subrogation, reimbursement and equitable lien rights for claims involving Eligible Expenses. Pursuant to the election of "pay and pursue," benefit payments will be made **prior** to applying the subrogation, reimbursement and equitable lien rights under the Plan.
2. **Scope of Subrogation, Reimbursement and Equitable Lien Rights.** The subrogation, reimbursement and equitable lien rights apply to any benefits paid by the Plan on behalf of the Covered Person as a result of the Injuries sustained, including, but not limited to:
 - a. Any no-fault insurance;
 - b. Medical benefits coverage under any automobile liability plan. This includes the Covered Person's Plan or any third party's policy under which the Covered Person is entitled to benefits;
 - c. Under-insured and uninsured motorist coverage;
 - d. Any automobile medical payments and personal injury protection benefits;
 - e. Any third party's liability insurance
 - f. Any premises/guest medical payments coverage;
 - g. Any medical malpractice recovery;
 - h. Workers' compensation benefits. The right of subrogation, reimbursement and equitable lien attach to any right to payment for workers' compensation, whether by judgment or

settlement, where the Plan has paid expenses otherwise eligible as Covered Services prior to a determination that the Covered Services arose out of and in the course of employment. Payment by Workers' Compensation insurers or the employer will be deemed to mean that such a determination has been made.

- i. Any other governmental agency reimbursement (i.e., state medical malpractice compensation funds).
4. **Excess Payments.** If the Plan erroneously makes total payments that exceed the maximum amount to which the Covered Person is entitled at any time under the Plan, the Plan shall have the right to recover the excess amount from any persons to, or for, or with respect to whom such excess payments were made.
5. **Reduction of Future Benefits.** The Plan provides that recovery of excess amounts may include a reduction of future benefit payments available to the Covered Person under the Plan of any amount up to the aggregate amount of Reimbursable Payments that have not been reimbursed by the Plan.
6. **"Make Whole" and "Common Fund" Rules Do Not Apply.** The provisions of the Plan concerning subrogation, reimbursement, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines and/or state laws commonly referred to as the "make whole" rule and the "common fund" rule.
7. **No Deductions for Costs or Attorneys' Fees.** The reimbursement required under the Plan shall not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation unless separately agreed to, in writing, by the Plan Administrator at the exercise of its sole discretion.

***PEBP is entitled to first priority payment out of any recovery by a participant, or from any third party, as restitution or as any other relief typically available in equity.*

COBRA: Continuation of Medical Coverage

This notice is a summary of rights and obligations under the Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation Coverage law. Since this is only a summary, actual rights will be governed by the provisions of the COBRA law itself. It is important that you and your spouse take the time to read this notice carefully and be familiar with its contents.

Entitlement to COBRA Continuation Coverage

In compliance with a federal law commonly called COBRA, this plan offers its employees, retirees and their covered dependents (called "qualified beneficiaries" by the law) the opportunity to elect a temporary continuation ("COBRA Continuation Coverage") of the group health coverage sponsored by PEBP, including medical coverage (the "Plan"), when that coverage would otherwise end because of certain events (called "qualifying events" by the law). The participant must be covered by the group health coverage sponsored by PEBP the day before the Qualifying Event in order to continue coverage under COBRA. Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

A Qualified beneficiary is entitled to elect COBRA Continuation Coverage when a qualifying event occurs, and as a result of that qualifying event, that person's health care coverage ends, either as of the date of the qualifying event or as of some later date.

Qualified Beneficiary

Under the law, a qualified beneficiary is any employee, retiree, spouse or dependent child of an employee or retiree who was covered by the Plan when a qualifying event occurred, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a dependent child by birth, adoption or placement for adoption with the covered employee or retiree during a period of COBRA Continuation Coverage is also a qualified beneficiary. A person who becomes the new spouse of an employee or retiree during a period of COBRA Continuation Coverage is not a qualified beneficiary. A dependent that had previous coverage under the primary insured participant can be added to COBRA coverage if a qualifying event occurs, however they can only have the COBRA coverage as long as the primary participant maintains COBRA coverage.

Qualifying Event

Qualifying events are those shown in the following chart. Qualified beneficiaries are entitled to COBRA Continuation Coverage when qualifying events (which are specified in the law) occur, and, as a result of the qualifying event, coverage of that qualified beneficiary ends. A qualifying event triggers the opportunity to elect COBRA when the covered individual loses health care coverage under this Plan. If a covered individual has a qualifying event but does not lose their health care coverage under this Plan (*e. g.*, employee continues working even though entitled to Medicare), then COBRA is not yet offered.

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 section 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 on 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	Dependent Child(ren)
Employee terminated (for other than gross misconduct).	18 months	18 months	18 months
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 the Plan Must Be Notified of a Qualifying Event

In order to elect COBRA Continuation Coverage after a divorce, or after a child ceases to be a “dependent child” under the Plan, you and/or a family member must inform PEBP in writing of that event no later than 60 days after that event occurs. That notice should be sent to PEBP at the address listed on the Participant Contact Guide in this document. If such a notice is not received by PEBP within the 60-day period, the qualified beneficiary will not be entitled to choose COBRA Continuation Coverage.

Notice When You Become Entitled to COBRA Continuation Coverage

When your health care coverage ends because your employment terminates, your hours are reduced so that you are no longer entitled to coverage under the plan, you die, become entitled to Medicare, or when PEBP is notified that a dependent child lost dependent status, or you divorced, PEBP will give you and/or your covered dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. Under the law, you and/or your covered dependents will then have only 60 days from the date of receipt of that notice, or 60 days from the date the coverage ends, whichever is later, to enable you and/or them to apply for COBRA Continuation Coverage.

If you and/ or any of your covered dependents do not choose COBRA continuation coverage within 60 days after receiving notice, or 60 days from the date coverage ends, whichever is later, you and/ or they will have no group health care coverage from this Plan until after the date of coverage ends.

The COBRA Continuation Coverage That Will Be Provided

If you choose COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay the COBRA premium (See the section on Paying for COBRA Continuation Coverage that appears later in this section for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts). If there is a change in the health coverage provided by the Plan to similarly situated active employees/retirees and their families, that same change will apply to your COBRA Continuation Coverage.

When a Second Qualifying Event Occurs During an 18-Month COBRA Continuation Period

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, or become divorced, become entitled to Medicare, or if a covered child ceases to be a dependent child under the Plan, the maximum COBRA Continuation period for the affected spouse and/or child is extended to 36 months from the date of your termination of employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier, as described below).

This extended period of COBRA Continuation Coverage is not available to anyone who became your spouse after the termination of employment or reduction in hours. However, this extended period of COBRA Continuation Coverage is available to any child(ren) born to, adopted by or placed for adoption with you (the covered employee/retiree) during the 18-month period of COBRA Continuation Coverage.

However, if you become entitled to COBRA Continuation Coverage because of termination of employment or a reduction in hours worked that occurred less than 18 months after the date you become entitled to Medicare; and if your spouse and/or any dependent child has a second qualifying event as described in the first paragraph of this section; then your spouse and/or dependent child(ren) would be entitled to a 36-month period of COBRA Continuation Coverage, beginning on the date you became entitled to Medicare.

In no case is an employee whose employment terminated (or who had a reduction in hours) entitled to COBRA Continuation Coverage for more than a total of 18 months (unless the employee is entitled to an additional period of up to 11 months of COBRA Continuation Coverage on account of disability as described in the following section). As a result, if an employee experiences a reduction in hours followed by termination of employment, the termination of employment is not treated as a second qualifying event and COBRA may not be extended beyond 18 months from the initial qualifying event.

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months (except for retirees who become entitled to COBRA Continuation Coverage because of a Chapter 11 bankruptcy reorganization proceeding on the part of PEBP).

Extended COBRA Continuation Coverage

If, at any time during or before the first 60 days of an 18-month period of COBRA Continuation Coverage, the Social Security Administration makes a formal determination that you or a covered spouse or dependent child have a total and permanent disability so as to be entitled to

Social Security Disability Income benefits, the person with the disability and any covered family members who so choose, may be entitled to keep the COBRA Continuation Coverage for up to 29 months (instead of 18 months), or until the person with the disability becomes entitled to Medicare or ceases to have a disability (whichever is sooner).

This extension is available only if:

- the Social Security Administration determines that the individual's disability began no later than 60 days after the termination of employment or reduction in hours; and
- you or another family member notifies PEBP of the Social Security Administration determination within 60 days after that determination was received by you or another covered family member; and
- that notice is received by PEBP before the end of the 18-month COBRA Continuation period.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

By law, any person who elects COBRA Continuation Coverage will have to pay the full cost of the COBRA Continuation Coverage. PEBP is permitted to charge the full cost of coverage for similarly situated employees/retirees and families (including both PEBP's and employee's/retiree's share), plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the plan may add an additional 50% applicable to the COBRA family unit (but only if the person with a disability is covered) during the 11-month additional COBRA period.

Each person will be told the exact dollar charge for the COBRA Continuation Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

Grace Periods: The initial payment for the COBRA Continuation Coverage is due within 45 days after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After that, payments are due on the first day of each month, but there will be a 30-day grace period to make those payments. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be cancelled as of the due date. Payment is considered made when it is postmarked.

Confirmation of Coverage Before Election or Payment of the Cost of COBRA Continuation Coverage

If a health care provider requests confirmation of coverage and you, your spouse or dependent child(ren) have elected COBRA Continuation Coverage and the amount required for COBRA Continuation Coverage has not been paid while the grace period is still in effect, or you, your spouse or dependent child(ren) are within the COBRA election period but have not yet elected COBRA, COBRA Continuation Coverage will be confirmed, but with notice to the Health Care Provider that the cost of the COBRA Continuation Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the COBRA Continuation Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

Addition of Newly Acquired Dependents

If, while you (the employee or retiree) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that spouse or child for coverage for the balance of the period of COBRA Continuation Coverage if you do so within 31 days after the marriage, birth, adoption, or placement for adoption. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

Loss of Other Group Health Plan Coverage

If, while you (the employee or retiree) are enrolled for COBRA Continuation Coverage your spouse or dependent loses coverage under another group health plan, you may enroll the spouse or dependent for coverage for the balance of the period of COBRA Continuation Coverage. The spouse or dependent must have been eligible but not enrolled in coverage under the terms of the pre-COBRA plan and, when enrollment was previously offered under that pre-COBRA healthcare plan and declined, the spouse or dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the spouse or dependent within 31 days after the termination of the other coverage. Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

When COBRA Continuation Coverage May Be Cut Short

Once COBRA Continuation Coverage has been elected, it may be cut short on the occurrence of any of the following events:

- The date on which PEBP no longer provides group health coverage to any of its employees/retirees;
- The first day of the time period for which the amount due for the COBRA Continuation Coverage is not paid on time;
- The date, after the date of the COBRA election, on which the covered person first becomes entitled to Medicare; or
- The date, after the date of the COBRA election, on which the covered person first becomes covered under another group health plan, and that plan does not contain any legally applicable exclusion or limitation with respect to a pre-existing condition that the covered person may have.
- The date the plan has determined that the covered person must be terminated from the plan for cause.

Termination and Refund Policy

Payment for coverage is due on the first of each month. Nonpayment of premiums will result in coverage termination. Acceptance and deposit of a payment does not guarantee coverage. If the participant fails to meet enrollment and eligibility requirements, coverage may be terminated and the payment refunded to the participant.

Any account which is 45 days past due will be terminated retroactive to the last day of the month when payment was received. In order to maintain COBRA coverage, payments must be current,

including the proper payment through the end of the election period. For example, if someone elects at 60 days and pays on the 45th day following that, (i.e., payment is received on the 105th day), they owe for 3 months of coverage on that 105th day (60+45). Furthermore, they will need to pay within 15 days for the fourth month of coverage in order to continue coverage past the fourth month.

If COBRA coverage is terminated, there is no reinstatement. Participants are responsible, and will be billed, for any claims incurred by the participant or their dependents that access the plan during a period when they are ineligible for coverage. Participants who fail to pay their premiums or ineligible claims may be turned over to a private collection agency for collection of past due amounts. Collection costs may also be assessed to the participant.

Note: PEBP reserves the right to retroactively cancel COBRA coverage and seek reimbursement of all benefits paid after Medicare entitlement if the qualified participant fails to notify PEBP within 60 days of the Medicare entitlement.

If you have any questions about your COBRA rights, please contact PEBP at the address listed on the Participant Contact Guide in this document. Also, remember that to avoid loss of any of your rights to obtain COBRA Continuation Coverage, you must notify PEBP:

- within 31 days if you have changed marital status; or have a new dependent child; or
- within 60 days of the date you or a covered dependent spouse or child has been determined to have a total and permanent disability by the Social Security Administration; or
- within 60 days if a covered child ceases to be a “dependent child” as that term is defined by the plan; or
- promptly if you or your spouse have changed your address.

FMLA and COBRA

Taking a leave under the Family & Medical Leave Act (FMLA) is not a COBRA qualifying event. A qualifying event can occur after the FMLA period expires, if the person does not return to work and thus loses coverage under their group health plan. Then the COBRA period is measured from the date of the qualifying event—in most cases, the last day of the FMLA leave. Note that if the employee notifies the employer that they are not returning to employment prior to the expiration of the maximum FMLA 12-week period, a loss of coverage could occur earlier. *Federal Notice Regarding Overseas Competition and Job Loss*

If you are ever faced with the situation of losing your job or having a reduction in hours as a result of competition from foreign trade or production being moved overseas, you may be eligible for Trade-Adjustment Assistance (TAA) or Alternate Trade Adjustment Assistance (ATAA) benefits. You may apply for TAA or ATAA benefits through the Department of Labor on or after November 4, 2002.

PEBP must make a second 60-day COBRA election period available to you if you are eligible for TAA/ATAA benefits. You qualify for this second chance to elect COBRA continuation of benefits if you have been certified to receive TAA/ATAA benefits on or after November 4, 2002, and within six months of losing group health plan coverage, and you did not elect COBRA coverage when it was offered during the first election period following termination.

The special second COBRA election period begins on the first day of the month in which you are certified to be eligible for TAA/ATAA benefits, provided the election is made within six months

after the initial loss of coverage. Please refer to the United States Department of Labor for more information on TAA/ATAA benefits.

When your COBRA coverage ends, PEBP will provide you and/or your covered dependents with a Certificate of Coverage that indicates the period of time you and/or they were covered under the plan. If, within 62 days after your coverage under this plan ends, you and/or your covered dependents become eligible for coverage under another group health plan, or if you buy a health insurance policy for yourself and/or your covered dependents, you may need this certificate to reduce any exclusion for pre-existing conditions that may apply to you and/or your covered dependents in that group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under this plan, and certain additional information that is required by law.

The certificate will be sent to you (or to any of your covered dependents) by first class mail shortly after your (or their) coverage under this plan ends. This certificate will be in addition to a certificate that will be sent to you after your pre-COBRA group health coverage ended. In addition, a certificate will be provided to you and/or any covered dependent upon a request for such a certificate if that request is received by PEBP within two years after the later of the date your coverage under this plan ended or the date COBRA Continuation Coverage ended, if the request is addressed to PEBP at the address listed on the Participant Contact Guide in this document.

Life Insurance

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

Eligibility for Life Insurance

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

- Class 1: Full-time employees of the State of Nevada (or any non-State agency approved by the PEBP board), professional full-time employees of the Nevada System of Higher Education (under annual contract), and members of the Nevada Senate or Assembly are all eligible for this benefit. A full-time employee is one who works at least 80 hours per month, before reduction due to mandatory furloughs. Your employer pays the full cost of Basic Life Insurance.
- Class 2: Retirees of the State of Nevada receiving PERS, TIAA or CREF or judge retirement benefits and legislators qualifying under Chapter 242 of the Sessions Law of the sixty-third Session of the Nevada State Legislature (or NRS 287.045) are eligible for this benefit. Retirees pay a contribution toward the cost of Basic Life Insurance.

Coverage

Life insurance benefits are as follows:

	Class 1 (Employee) Benefit Amount	Class 2 (Retiree) Benefit Amount
Life Insurance amount	\$10,000	\$5,000

Long-Term Disability (LTD) Insurance

If you are a person with a disability for an extended period due to an illness or injury and are under the regular care of a physician, long-term disability (LTD) benefits help you financially while your ability to work is limited. The LTD benefits are insured through an insurance company whose name and address are listed on the Participant Contact Guide. Questions about your LTD benefits should be directed to the insurance company whose name and contact information is located in the Participant Contact Guide section of this document.

Premium Payment

Your employer pays the full cost of your LTD insurance.

How the LTD Benefit Works

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

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

Note: This insurance does not replace or affect the requirements for coverage by any Workers' Compensation insurance.

General Provisions and Notices

Name of the Plan

Public Employees' Benefits Program (PEBP)

Plan Administrator

Public Employees' Benefits Program (PEBP)

901 South Stewart Street, Suite 1001

Carson City, NV 89701

Phone: (775) 684-7000 or (800) 326-5496

Tax Identification Number (TIN)

88-0378065

Type of Plan

Group Health Plan including medical expense benefits.

Type of Administration

PEBP is liable for all expenses associated with the benefits of the CDHP medical and dental plans outlined in this document. An independent Claims Administrator administers the benefits for the CDHP and the Self-funded PPO Dental Plan. Refer to the Participant Contact Guide in this document for the name and address of the Claims Administrator.

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

Agent for Service of Legal Process

For disputes arising under the plan, service of legal process may be made on the Plan Administrator, and must comply with the Nevada Revised Statute 41.031, in care of:

Public Employees' Benefits Program (PEBP)

901 South Stewart Street, Suite 1001

Carson City, NV 89701

Phone: (775) 684-7000 or (800) 326-5496

Plan Year

The Plan's CDHP and Self-Funded Dental PPO Plan benefits are administered on a Plan Year typically beginning July 1 and ending June 30. PEBP has the authority to revise the benefits and premium 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.

Fiscal records are kept on a 12-month period basis beginning on July 1 and ending on June 30.

Plan Amendments or Termination of Plan

PEBP reserves the right to amend or terminate these plans, or any parts of them at any time.

Amendments may occur on the approval of its Board, or on such other date as may be specified in the document amending the plan. These plans or any coverage under them may be terminated by its Board, and new coverages may be added by its Board.

Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the plans, the Plan Administrator and its designees have discretionary authority to interpret the terms of the plans and to determine eligibility and entitlement to plan benefits in accordance with the terms of the plans. Any interpretation or determination under such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious. Such interpretations or determinations regarding benefits should be guided by evidence based practice of medicine and medical necessity.

No Liability for Practice of Medicine

The Plan Administrator and its designees are **not** engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the Plan Administrator nor any of its designees will have any liability whatsoever for any loss or injury caused to you by any health care provider by reason of negligence, by failure to provide care or treatment, or otherwise.

Right of Plan to Require a Physical Examination

The Plan reserves the right to have the person who is has a total disability, or who has submitted a claim for benefits and is undergoing treatment under the care of a physician, to be examined by a physician selected by the Plan Administrator or its designee at any time during the period that benefits are extended under this provision. The cost of such an examination will be paid by the Plan.

When You Must Repay Plan Benefits

If it is found that plan benefits paid by the Plan are too much because:

- some or all of the medical expenses were not paid or payable by you or your covered dependent; **or**
- you or your covered dependent received money to pay some or all of those expenses from a source other than the Plan; **or**
- you or your covered dependent achieve any recovery whatsoever, through a legal action or settlement in connection with any sickness or injury alleged to have been caused by a third party, regardless of whether or not some or all of the amount recovered was specifically for the expenses for which plan benefits were paid; **or**
- the Plan erroneously paid benefits to which you were not entitled under the terms and provisions of the Plan.

The Plan will be entitled to a refund from you (or your health care provider) of the difference between the amount actually paid by the Plan for those expenses, and the amount that should have been paid by the Plan for those expenses, based on the actual facts (see also the Subrogation section of the Coordination of Benefits section).

Privacy, Confidentiality and Release of Records or Information

Any information collected by PEBP and its contracted vendors will be treated as confidential information and will not be disclosed to anyone without your written consent, except as follows:

- Information will be disclosed to those who require that information to administer the plans or to process claims.
- Information with respect to duplicate coverage will be disclosed to the plan or insurer that provides duplicate coverage.

- Information needed to determine if health care services or supplies are medically necessary (or if the charges for them are usual and customary) will be disclosed to the individual or entity consulted to assist the Plan Administrator or its designee in making those determinations.
- Information will be disclosed as required by law or regulation or in response to a duly issued subpoena.
- Information will be disclosed according to the HIPAA Federal Regulations, as outlined in the Privacy Notice in a previous section in this document, and with the following policy guidelines:

PEBP will not use or disclose Personal Health Information (PHI) other than as permitted or as required by law.

PEBP will ensure that any agents or subcontractors to whom PHI is supplied by PEBP, agree to the same restrictions and conditions that apply to PEBP, most commonly through the use of a HIPAA-compliant Business Associate Agreement and/or a Confidentiality Agreement.

PEBP will not use or disclose PHI for employment-related actions.

PEBP will report to the Privacy Officer or Security Officer any use or disclosure of the information that is inconsistent with the permitted uses or disclosures.

PEBP will make PHI available to plan participants, consider their amendments and, upon request, provide them with an accounting of PHI disclosures.

PEBP will make its internal practices and records relating to the use and disclosure of PHI available to DHHS upon request.

Information You or Your Dependents Must Furnish to the Plan

In addition to information you must furnish in support of any claim for plan benefits under this Plan, you or your covered dependents must furnish information you or they may have that may affect eligibility for coverage under the Plan. If you fail to do so, you or your covered dependents may lose the right to obtain COBRA Continuation Coverage or to continue coverage of a dependent child with a disability.

Submit such information in writing to PEBP at the address shown in the Participant Contact Guide in this document. The information needed and timeframes for submitting such information are outlined below:

Type of Information Needed	Date Such Information is to be Submitted to the Plan
Change of name or address, or the existence of other medical coverage for any covered person	As soon as possible, but not later than 30 days after the change or other coverage
Marriage, divorce, addition of a new dependent, death of any covered person	Within 60 days. For COBRA participants see the COBRA section
Employee receives a determination of disability from the Social Security Administration (SSA)	Within 60 days of the date of SSA determination
Covered dependent (spouse or child) becoming a person	Within 60 days of the date the person

with a disability or no longer having a disability	becomes a person with a disability or loses their status of having a disability
Covered child ceases to be a dependent as defined by this plan (e.g., over the limiting age of the plan, loses student status, etc.)	Within 60 days of the date the child is no longer considered a dependent
Medicare enrollment or disenrollment	Within 60 days

Important Privacy Notice – Disclosure and Access to Medical Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

By law, PEBP is required to protect the privacy of your personal medical information. PEBP is also required to give you this notice to tell you how PEBP may use and give out ("disclose") your personal medical information held by PEBP.

PEBP is declared a hybrid entity, the Plan is an affiliated covered entity and this Notification of Privacy Practice serves as notification for all health care components, your health information may be shared between health plans for continuum of care.

PEBP must use and give out your personal medical information to provide information to you or someone who has the legal right to act for you (your personal representative), to a state or federal entity charged with making sure your privacy is protected, and where required by law.

PEBP has the right to use and give out your personal medical information to pay for your health care and to operate the programs offered by PEBP. PEBP considers this to be part of an organized health care arrangement. Examples include the following:

- PEBP uses your personal medical information for enrollment records, pay or deny your claims, to collect any premiums due, and to share your benefit payment with your other insurer(s) if applicable.
- PEBP may use your personal medical information to make sure you and other PEBP participants get quality health care, to provide customer service to you, to resolve any complaints you have, or to contact you about extra benefits or even research studies that may benefit you.
- PEBP may use or give out your personal medical information for the following purposes under limited circumstances;
 - to federal or other state agencies that have the legal right to receive PEBP data (such as audits to make sure PEBP is making proper payments),
 - for public health activities (such as reporting disease outbreaks),
 - for government health care oversight activities (such as fraud or abuse investigations),
 - for judicial and administrative proceedings (such as in response to a court order),
 - for law enforcement purposes (such as providing limited information to locate a missing person),
 - for research studies, including surveys, that meet all privacy law requirements (such as research related to the prevention of disease or disability),
 - to avoid a serious and imminent threat to health or safety,
 - to contact you about new or changed benefits under PEBP, and
 - to create a collection of information that can no longer be traced back to you.

By law, PEBP must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that isn't set out in this notice. You may take back ("revoke") your written permission at any time, except if PEBP has already acted based on your permission.

By law, you have the right to:

- see and get a copy of your personal medical information held by PEBP.
- have your personal medical information amended if you believe that it is wrong or if information is missing, and PEBP agrees. If PEBP disagrees, you may have a statement of your disagreement added to your personal medical information.
- get a listing of those getting your personal medical information from PEBP. The listing won't cover your personal medical information that was given to you or your personal representative, that was given out to pay for your health care or for PEBP operations, or that was given out for law enforcement purposes.
- ask PEBP to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- ask PEBP to limit how your personal medical information is used and given out to pay your claims and run the programs offered by PEBP. Please note that PEBP may not be able to agree to your request.
- get a separate paper copy of this notice.

You will find a copy of this notice on the PEBP website and in the Plan documents. Please call PEBP with any further questions regarding the privacy notice. (775) 684-7000 or (800) 326-5496.

If you feel your privacy rights have been violated, you may file a complaint with PEBP or with the federal government through the Office of Civil Rights. You will not be penalized for filing a complaint.

PEBP Privacy Officer
901 S. Stewart St., Ste. 1001
Carson City NV 89701
(775) 684-7000 Phone
(800) 326-5496
(775) 684-7028 Fax

Office of Civil Rights
Dept. of Health & Human Services
907 7th St., Ste. 4-100
San Francisco CA 94103
(800) 368-1019 Phone
(415) 437-8329 Fax
TDD (800) 537-7697

<http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html>

By law, PEBP is required to follow the terms in this privacy notice. PEBP has the right to change the way your personal medical information is used and given out. If PEBP makes any changes to the way your personal medical information is used and given out, you will get a new notice within 60 days of the change.

This Notice of Privacy Practices for PEBP is effective July 1, 2013, and replaces all other privacy notices that have been in effect since April 14, 2003.

Important Notice - PEBP Security Practices

By law, PEBP is required to:

- put in place administrative, physical, and technical safety measures to reasonably protect your personal medical information that is stored electronically;
- make sure there are security measures in place to protect and separate your personal medical information that is stored electronically from other agencies, employees, or employers who do not need access to it;
- make sure that any agents or vendors who help PEBP with its operations also have in place security measures to protect PEBP personal medical information; and
- report to the PEBP security officer any security problems or incidences resulting from unauthorized access, use or interference of systems operations in a system containing PEBP personal medical information, known by PEBP or any agent or vendor.

Other Notices Provided by PEBP

National Defense Authorization Act (NDAA)

On January 28, 2008, President Bush signed into law H.R. 4986, the National Defense Authorization Act (NDAA). Section 585 of the NDAA amends the Family and Medical Leave Act of 1993 (FMLA) to permit a "spouse/ domestic partner, son, daughter, parent, or next of kin" to take up to 26 workweeks of leave to care for a "member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness."

The NDAA also permits an employee to take FMLA leave for "any qualifying exigency (as the Secretary [of Labor] shall, by regulation, determine) arising out of the fact that the spouse/ domestic partner, or a 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."

You can read more about the National Defense Authorization Act by going to the US Department of Labor website at: www.dol.gov.

Heroes Earning Assistance and Relief Tax Act (HEART Act)

The Heroes Earnings Assistance and Relief Tax Act of 2008 (HEART Act) requires employers to provide certain retirement and welfare benefits for returning military personnel and their beneficiaries. For more information on the HEART Act (Heroes Earning Assistance and Relief Tax), PEBP directs you to the IRS website at: www.irs.gov.

Uniformed Services Employment and Reemployment Rights Act

The Uniformed Services Employment and Reemployment Rights Act of 1994 ([USERRA, 38 U.S.C. § 4301 – 4335](#)) is a federal law intended to ensure that persons who serve or have served in the Armed Forces, Reserves, National Guard or other "uniformed services:" (1) are not disadvantaged in their civilian careers because of their service; (2) are promptly reemployed in their civilian jobs upon their return from duty; and (3) are not discriminated against in employment based on past, present, or future military service. For more information about USERRA, please refer to the following website: <http://www.dol.gov/elaws/userra.htm>.

The Americans with Disability Amendments Act

Effective January 1, 2009, changes the language regarding any condition that substantially limits a major life activity will be considered a disability, even if the individual can offset or compensate for the disability with the mitigating measures such as hearing aids or artificial limbs. These provisions of the bill were designed to essentially overturn several Supreme Court decisions that found that individuals who could compensate for their disabilities were not afforded under the protection of the ADA. You can read more about the ADA and the Amendments Act by visiting the US Equal Employment Opportunity Commission at: www.eeoc.gov/ada.

Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 is effective for PEBP on July 1, 2010. This legislation requires that full parity be established between mental health/ substance abuse benefits and other surgical and medical benefits offered under the Plan. You can find more information at: www.govtrack.us/congress and searching for The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Genetic Information Nondiscrimination Act of 2008
The Genetic Information Nondiscrimination Act of 2008 (GINA) was enacted May 21, 2008. Title I (regarding genetic nondiscrimination in group health plans) is effective for plan years beginning after May 21, 2009. Title II (regarding genetic nondiscrimination in employment) becomes effective November 21, 2009. GINA amends ERISA, the Code and Public Health Service Act to prevent group health plans and health insurance companies from basing enrollment decisions, premium costs, or participant contributions on genetic information. Group health plans and group insurers will be prohibited from requiring that individuals undergo genetic testing. Employers are preventing conditioning of hiring or firing decisions on the basis of genetic information. Lastly, GINA will extend medical privacy and confidentiality rules to the disclosure of genetic information. Currently, PEBP and the State of Nevada do not use genetic information in regards to either employment or the determination of benefits. Genetic testing is a plan exclusion. You can read more about GINA by visiting www.genome.gov/10002328.

NAC and NRS Regarding the PEBP Plan and Your Coverage.

The information provided below is a summary of the applicable NRS and NAC. For detailed information, please refer to the Nevada Legislature website at <http://leg.state.nv.us/Law1.cfm>.

NAC 287.095 - Employees on a biennial working schedule and former members of the school district board of trustees are eligible to participate in PEBP.

NAC 287.135 - The five year service credit requirement in the definition of "retired officer or employee", the participation requirements for those retired officers who are eligible to participate in the PEBP because they are receiving a distribution from a public employer's long-term disability plan. The five year full time participation requirement for those eligible to participate in the PEBP because they are receiving a distribution of benefits from a retirement program offered by the Nevada System of Higher Education.

NAC 287.317 - Members of the professional staff of the Nevada System of Higher Education must submit an election form within 30 days after their hire date; otherwise, they will be placed in PEBP's base plan (default plan). The base plan is defined as the self-funded Consumer Driven Health Plan (CDHP).

NAC 287.320 - Retirees enrolled in the PEBP as of November 30, 2008 are still eligible to continue participation in the PEBP subsequent to November 30, 2008 even if their local employer opts out of the Plan.

NAC 287.357 - All opt-out plans are considered covered entities by PEBP and are subject to HIPAA's privacy regulations.

NAC 287.440 - Except as otherwise provided in this section, retired officers and employees shall pay their premiums or contributions directly to the Program. Retired officers and employees who receive a retirement benefit from the Public Employees' Retirement System shall pay their premiums or contributions to the Program through an automatic deduction from that benefit unless the retirement benefit is less than the premium or contribution

NAC 287.450 - An employee on leave without pay, to the extent he or she is receiving a paycheck, has an option to have the cost of his or her premiums deducted from that paycheck.

NAC 287.530- If the participant and his or her spouse or domestic partner who are retired officers or employees who retired before July 1, 2004, and elect to participate in the Program, one may elect to be the dependent of the other. A spouse or a domestic partner who elected to be the dependent pursuant to this subsection may elect to become a primary insured during open enrollment. If the retired officer or employee designated as the primary insured dies, the spouse or domestic partner who elected to be the dependent becomes the primary insured.

- A person who retires on or after July 1, 2004, and who is eligible to participate in the Program as a primary insured may not elect to be a dependent of his or her spouse or domestic partner who is a primary insured in the Program.
- A surviving spouse or domestic partner who:
 - (a) Retired before July 1, 2004;
 - (b) Is enrolled in the Program as a surviving dependent; and
 - (c) Is eligible to participate in the Program as a primary insured, may elect to change his or her status to retiree status during open enrollment. A person who chooses such an election pursuant to this subsection must meet the requirements of NAC 287.485 to be eligible for a subsidy.
- A person who is a surviving dependent of a deceased officer or employee of a participating public agency, or a deceased retired officer or employee, and who, at the time of his or her death, was a participant under the Program, may maintain the coverage or insurance from the Program if:
 - (a) The surviving dependent receives retirement benefits from which premiums or contributions can be deducted or such dependent pays the premium or contribution directly to the Program; and
 - (b) Within 60 days after the date of death of the participant, the surviving dependent:
 - Notifies the last public employer of the deceased participant that the surviving dependent intends to enroll in or continue coverage by reenrolling in the Program; and
 - Enrolls or reenrolls, as appropriate, in the Program.

- Continued coverage provided to a surviving dependent who reenrolls in the Program in accordance with this section may not be changed until the next period of open enrollment.
- If the surviving spouse or domestic partner has a dependent who is not covered under the Program at the time of death of the officer or employee of a participating public agency, or retired officer or employee, or acquires a dependent by marriage, adoption or birth, the dependent is not eligible for coverage or insurance.
- A retired officer or employee who wishes to enroll or reenroll in the Program more than 60 days after his or her official date of retirement or total disability must comply with the requirements of NRS 287.0475.

NAC 287.540- Coverage of participating employee of State who reenrolls upon retirement or total disability. If at the time of retirement or total disability was:

- Employed by a participating state agency; and
- A participant in the Program; and
 - Within 60 days after the official date of retirement or total disability must notify the participating state agency that employed the participant at the time of retirement or total disability of his intent to continue coverage in the Program. If the participant reenrolls in the Program, the participant will have uninterrupted benefits and is not subject to any waiting period. Upon reenrollment, the participant may change their choice of coverage, e.g. CDHP to HMO or vice versa.

NAC 287.542- Coverage of an employee of a participating local governmental agency who retires on or before September 1, 2008, and reenrolls upon retirement or total disability.

A person who is a retired officer or employee on or before September 1, 2008 and is a retired officer or employee on or before September 1, 2008 and at the time of retirement or total disability was:

- Employed by a participating local governmental agency; and was a participant in the Program; and within 60 days after the official date of retirement or total disability:
 - Notifies the participating local governmental agency that employed him or her at the time of retirement or total disability of his or her intent to continue coverage in the Program; and
 - Reenrolls in the Program, will have uninterrupted benefits and is not subject to any waiting period.
 - Upon reenrollment, the participant may change their choice of coverage, e.g. CDHP to HMO or vice versa.
- Coverage continues until the person chooses to terminate or decline the coverage. If the person chooses to terminate or decline the coverage after November 30, 2008, the person may subsequently only reinstate in the Program pursuant to NRS 287.023 and 287.0475.

NAC 287.544- Coverage of an employee of a nonparticipating local governmental agency who retires on or before September 1, 2008, and enrolls upon retirement or total disability.

A person who is a retired officer or employee on or before September 1, 2008 and at the time of retirement or total disability was:

- Employed by a participating local governmental agency; and was not a participant in the Program; and within 60 days after the official date of retirement or total disability:
 - Notifies the participating local governmental agency that employed him or her at the time of retirement or total disability of his or her intent to enroll in the Program; and
 - Enrolls in the Program, is subject to a 60-day waiting period.
- Coverage continues until the person chooses to terminate or decline the coverage. If the person chooses to terminate or decline the coverage after November 30, 2008, the person may subsequently only reinstate in the Program pursuant to NRS 287.023 and 287.0475.

NAC 287.546- Coverage of participating employee of local governmental agency who retires after September 1, 2008, and reenrolls upon retirement or total disability.

- A person who becomes a retired officer or employee after September 1, 2008 and at the time of retirement or total disability, was:
 - Employed by a participating local governmental agency; and a participant in the Program; and within 60 days after the official date of retirement or total disability:
 - Notifies the participating local governmental agency that employed him or her at the time of retirement or total disability of his or her intent to continue coverage in the Program; and
 - Reenrolls in the Program, will have uninterrupted benefits and is not subject to any waiting period.
 - Continued coverage provided to a person described in in this section may be changed by the person at the time of reenrollment, e.g. CDHP to HMO or vice versa.
- Coverage of a person pursuant to this section terminates on the date on which the participating local governmental agency that employed the person at the time of retirement or total disability terminates its participation in the Program. If the participating local governmental agency subsequently reestablishes its participation in the Program pursuant to NAC 287.310, the person may subsequently reinstate in the Program pursuant to NRS 287.023 and 287.0475.

NAC 287.548- Coverage of nonparticipating employee of local governmental agency who retires after September 1, 2008.

- A person who becomes a retired officer or employee after September 1, 2008; and at the time of retirement or total disability:
 - Was employed by a participating local governmental agency; and
 - Was not a participant in the Program, may only enroll or reenroll in the Program pursuant to the provisions of NRS 287.0475.
- Coverage provided to a person pursuant to this section terminates on the date on which the participating local governmental agency that employed the person at the time of retirement or total disability terminates its participation in the Program. If the participating local governmental agency subsequently reestablishes its participation in the Program pursuant to NAC 287.310, the person may subsequently reinstate in the Program pursuant to NRS 287.023 and 287.0475.

NAC 287.680 - An appeal request for a Level 2 Review 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 claims administrator by the participant.

NRS 287.023- Option of retired officer or employee or dependent to cancel or continue group insurance, plan of benefits, medical and hospital service, or coverage under Public Employees' Benefits Program; notice of selection of option; payment of costs for coverage.

NRS 287.0406 – Program is defined as the Public Employees' Benefits Program established pursuant to subsection 1 of [NRS 287.043](#)

NRS 287.043- Defines the PEBP Board's powers and duties related to the benefit structure, rate setting and administration of certain parts of the Public Employees' Benefits Program.

NRS 287.0435- Creation; investment; disbursements; administration by State Treasurer; checking account for payment of claims, specifically disbursements from the Program Fund must be made as any other claims against the State are paid and may only be made for the benefit of the participants in the Program.

NRS 287.0436- Creation and purpose of the State Retirees' Health and Welfare Benefits Fund:

- The State Retirees' Health and Welfare Benefits Fund is created as an irrevocable trust fund.
- The purpose of the Retirees' Fund is to account for the financial assets designated to offset the portion of the current and future costs of health and welfare benefits paid pursuant to subsection 2 of [NRS 287.046](#).

NRS 287.046- Defines how the Department of Administration will establish assessments to pay portion of premiums or contributions for participating retirees with state service; amounts assessed to be deposited in Retirees' Fund; adjustments to portion paid to Program by Retirees' Fund.

NRS 287.047- Retention by certain retired state officers and employees and dependents' of membership in coverage under Program. If the retention is consistent with the terms of any agreement between the State and the insurance company which issued the policies pursuant to the Program or with the plan of self-insurance of the Program.

NRS 287.0475 - A retiring officer or employee of a local governmental agency who had not been a participant in the PEBP at the time of his or her retirement is no longer eligible to participate as a retiree, nor is he or she eligible to be reinstated at a later date.

NRS 689B.033- Coverage for newly born and adopted children and children placed for adoption. This plan provides coverage for any medical, surgical, hospital or dental expenses for children with respect to:

- A newly born child of the plan participant from the moment of birth;
- A child adopted by the plan participant from the date the adoption becomes effective
- A child placed with the plan participant for the purpose of adoption from the moment of placement as certified by the public or private agency making the placement. The

coverage of the child will cease if the adoption proceedings are terminated as certified by the public or private agency making the placement.

- This plan does not exclude premature births.

This Plan requires that the plan participant notify PEBP of:

- The birth of a newly born child;
- The effective date of adoption of a child; or
- The date of placement of a child for adoption.

Payments of the required premium, if any, must be furnished to PEBP within 31 days after the date of birth, adoption or placement for adoption in order to have the coverage continue beyond the 31-day period.

Please refer to the Eligibility section of this document for more information about newly born and adopted children.

NRS 695G.164- if you are seeing a provider that is in network and that provider leaves the network, and you are actively undergoing a medically necessary course of treatment and you and your provider agree that a disruption to your current care may not be in your best interest or if continuity of care is not possible immediately with another in network provider, PEBP will pay that provider at the same level they were being paid while contracted with PEBP's PPO network, if the provider agrees. If the provider agrees to these terms, coverage may continue until:

- the 120th day after the date the contract is terminated; or
- if the medical condition is pregnancy, the 45th day after:
 - The date of delivery; or
 - If the pregnancy does not end in delivery, the date of the end of the pregnancy.

NRS 698B.287 - PEBP will not deny a claim, cancel a policy, or refuse to issue a policy solely due to a claim resulting from an injury sustained while intoxicated or under the influence of a controlled substance. PEBP may enforce any provisions to deny a claim, cancel a policy, or refuse to issue a policy in which a contributing cause of injury in a claim was the attempt or commission of a felony.

Plan Definitions

The following are definitions of specific terms and words used in this document, or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

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

Active Rehabilitation refers to therapy in which a patient, who has the ability to learn and remember, actively participates in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding or eating, use of the toilet, ambulating, and taking drugs or medicines that can be self-administered.

Acupuncture: A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow. When benefits for the services of an acupuncturist are payable by this plan, the acupuncturist must be properly licensed by the state in which he or she is practicing and must be performing services within the scope of that license, or, where licensing is not required, be certified by the National Certification Commission for Acupuncturists (NCCA).

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

Allogenic refers to transplants of organs, tissues or cells from one person to another person. Heart transplants are always allogenic.

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

Ambulance: A vehicle, helicopter, airplane or boat that is licensed or certified for emergency patient transportation by the jurisdiction in which it operates.

Ambulatory Surgical Facility/Center: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

- It is licensed as an ambulatory surgical facility/center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all of the following requirements:
- It is operated under the supervision of a licensed physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one hospital in the area.
- It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthesiologist who is administering the anesthetic, and that the anesthesiologist or anesthesiologist remain present throughout the surgical procedure.
- It provides at least one operating room and at least one post-anesthesia recovery room.
- It is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services.
- It has trained personnel and necessary equipment to handle emergency situations.
- It has immediate access to a blood bank or blood supplies.
- It provides the full-time services of one or more registered graduate nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room.
- It maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local

anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays), an operative report and a discharge summary.

An ambulatory surgical facility/center that is part of a hospital, as defined in this section, will be considered an ambulatory surgical facility/center for the purposes of this Plan.

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

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

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

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

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

Autism Spectrum Disorder: A group of disorders characterized by impairment of development in multiple areas, including the acquisition of reciprocal social interaction, verbal and nonverbal communication skills, and imaginative activity, and by stereotyped interests and behaviors. It includes but is not limited to autistic disorder, Rett syndrome, childhood disintegrative disorder, and Asperger syndrome.

Autologous: Refers to transplants of organs, tissues or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.

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

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

Behavioral Health Disorder: Behavioral health disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Behavioral health disorders covered under this plan may include, but are not limited to: depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods, and is provided by behavioral health practitioners as defined in this section. Certain behavioral health disorders, conditions and diseases are specifically excluded from coverage as noted in the Medical Plan Exclusions section of this document. See also the definitions of Chemical Dependency and Substance Abuse.

Behavioral Health Practitioners: A psychiatrist, psychologist, or a mental health or substance abuse counselor or social worker who has a Master's degree and who is legally licensed and/or legally authorized to practice or provide service, care or treatment of Behavioral Health Disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

Behavioral Health Treatment: Behavioral health treatment includes all inpatient services, including room and board, given by a behavioral health treatment facility or area of a hospital that provides behavioral or mental health or substance abuse treatment for a mental disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). If there are multiple diagnoses, only the treatment for the illness that is identified under the DSM code is considered a behavioral health treatment for the purposes of this Plan.

Behavioral Health Treatment Facility: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of providing a program for diagnosis, evaluation and effective treatment of behavioral health disorders and which fully meets one of the following two tests:

- It is licensed as a behavioral health treatment facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all of the following requirements: has at least one physician on staff or on call and provides skilled nursing care by licensed nurses under the direction of a full-time Registered Nurse (RN) and prepares and maintains a written plan of treatment for each patient based on the medical, psychological and social needs of the patient.

A behavioral health treatment center that qualifies as a hospital is covered by this plan as a hospital and not a behavioral health treatment center. A residential treatment facility, transitional facility, group home, halfway house or temporary shelter is not a behavioral health treatment facility under this plan.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the Usual and Customary Charge, after calculation of all deductibles, coinsurance and copayments, and after determination of the Plan's exclusions, limitations and maximums.

Birth (or Birthing) Center: A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all of the following requirements:
- It is operated and equipped in accordance with any applicable state law for the purpose of providing prenatal care, delivery, immediate post partum care, and care of a child born at the center.
- It is equipped to perform routine diagnostic and laboratory examinations, including (but not limited) to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.
- It has available to handle foreseeable emergencies, trained personnel and necessary equipment, including (but not limited to) oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
- It provides at least two beds or two birthing rooms.
- It is operated under the full-time supervision of a licensed physician, Registered Nurse (RN) or Certified Nurse Midwife.
- It has a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications.
- It has trained personnel and necessary equipment to handle emergency situations.
- It has immediate access to a blood bank or blood supplies.

- It has the capacity to administer local anesthetic and to perform minor surgery.
- It maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a post partum summary.
- It is expected to discharge or transfer patients within 48 hours following delivery.

A birth (or birthing) center that is part of a hospital, as defined in this section, will be considered to be a birth (or birthing) center for the purposes of this plan.

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

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

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

Cardiac Rehabilitation: Cardiac rehabilitation refers to a formal program of controlled exercise training and cardiac education under the supervision of qualified medical personnel capable of treating cardiac emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to a functional level of activity and exercise without cardiovascular complications in order to limit further cardiac damage and reduce the risk of death. Patients are to continue at home the exercise and educational techniques they learn in this program. Cardiac rehabilitation services are payable for patients who have had a heart attack (myocardial infarction) or open-heart surgery.

Case Management: A process administered by the utilization management company in which its medical professionals work with the patient, family, care-givers, health care providers, Claims Administrator and PEBP to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential health care providers.

Certified Surgical Assistant: A person who does not hold a valid healthcare license as an RN, Nurse Practitioner (NP), Physician Assistant (PA), Podiatrist, Dentist, MD or DO, who assists the primary surgeon with a surgical procedure in the operating room and who bills, commonly as an assistant surgeon. Such individuals are payable by this Plan, including designation as a Certified Surgical Assistant (CSA), Certified Surgical Technologist (CST), Surgical Technologist (ST), Certified Technical Assistant (CTA), or Certified Operating Room Technician (CORT).

Chemical Dependency: This is another term for substance abuse. (See also the definitions of Behavioral Health Disorders and Substance Abuse).

Child(ren): See the definition of Dependent Child(ren).

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC) and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column (vertebrae); and who acts within the scope of his or her license.

Christian Science Practitioner: Christian Science is a system of religious teaching based on an interpretation of scripture, founded in 1866 by Mary Baker Eddy. It emphasizes full healing of disease by mental and spiritual means. Certain members of the Christian Science church are designated as Christian Science Practitioners who counsel and assist church members in mental and spiritual means to overcome illness based on Christian Science teachings.

Claim for Benefits: Means a request for a Plan benefit or benefits made by a participant in accordance with the Plan's Appeals Procedures, including any Pre-Service Claims (requests for Precertification) and Post-Service Claims (requests for benefit payment).

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.

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

Complications of Pregnancy: Means any condition that requires hospital confinement for medical treatment, and if the pregnancy is not terminated, is caused by an injury or sickness not directly related to the pregnancy or by acute nephritis, nephrosis, cardiac decompensation, missed abortion or similar medically diagnosed conditions; or if the pregnancy is terminated, results in non-elective cesarean section, ectopic pregnancy or spontaneous termination.

Compound Drugs: Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Concierge medicine: Is a relationship between a patient and a primary care physician or dentist in which the patient usually pays an annual or monthly fee or retainer in order to receive easier access to a primary care provider or dentist. Concierge medicine usually means that the patient will experience quicker scheduling of appointments, limited or no waiting times, longer and more thorough examinations and coordination of all medical or dental care. Other terms in use include boutique medicine, retainer-based medicine, and innovative medical practice design. The practice is also referred to as membership medicine, concierge health care, cash only practice, direct care, direct primary care, and direct practice medicine. Most concierge medicine practices do not bill insurance.

Concurrent Review: A Managed Care program designed to assure that hospitalization and health care facility admissions and length of stay, surgery and other health care services are medically necessary by having the utilization management (UM) company conduct ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or health care facility.

Convalescent Care Facility: See the definition of Skilled Nursing Facility.

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).

Copayment, Copay: The fixed dollar amount you are responsible for paying when you incur an eligible medical expense for certain services, generally those provided by network health care practitioners, hospitals (or emergency rooms of hospitals), or health care facilities. This can be in addition to coinsurance amounts due on the same incurred charges. Copayments are limited to certain benefits under this program.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (orthotic), or replace a missing body part (prosthetic). To determine the category of any particular item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes (but is not limited to) removal of tattoos, breast augmentation, or other medical, dental or surgical treatment

intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

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

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); or
- An eligible participant, their eligible spouse, and their eligible child(ren).

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

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

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

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

Creditable Coverage means prior continuous health coverage and includes prior coverage under:

- another group health plan;
- group or individual health insurance coverage issued by a state regulated insurer or an HMO;
- COBRA;
- Medicaid;
- Medicare;
- State Children's Health Insurance Program (SCHIP);
- the Active Military Health Program;
- Tricare;
- American Indian Health Care Programs;
- a state health benefits risk pool;
- the Federal Employees Health Plan;
- the Peace Corp Health Program; or
- a public health plan, including plans established or maintained by a state, the United States government, a foreign country, or any political subdivision of a state, the United States government; or,
- a foreign country that provides health coverage to individuals who are enrolled in the plan (for example, coverage through the United States Veterans Administration and coverage from a state or federal penitentiary).

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

Custodial Care: Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of custodial care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are custodial care regardless of where the care is given or who

recommends, provides, or directs the care. Custodial care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Custodial care may be payable by this Plan under certain circumstances, such as when custodial care is provided during a covered hospitalization or during a covered period of hospice care.

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

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

Dental: As used in this document, dental refers to any services performed by (or under the supervision of) a dentist, or supplies (including dental prosthetics). Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat: teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection. Dental services and supplies are covered under the dental expense coverage plan, and are not covered under the medical expense coverage of the plan unless the medical plan specifically indicates otherwise in the Schedule of Medical Benefits.

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

Dental Subspecialty Areas:

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

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

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

Denture: A device replacing missing teeth.

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),
- individual under age 26 years for whom you have permanent legal guardianship under a court order signed by a judge.

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

- reaches his or her 26th birthday,
- enters military or similar service anywhere.

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: The participant's domestic partner, as determined by the laws of the State of Nevada. The Plan will require the participant to provide a copy of the Domestic Partner 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 after termination of the domestic partnership.

Durable Medical Equipment: Equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and is not disposable or non-durable and is appropriate for the patient's home. Durable medical equipment includes (but is not limited to) apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. See also the definitions of Corrective Appliances, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device)

Elective Hospital Admission, Service or Procedure: Any non-emergency hospital admission, service or procedure that can be scheduled or performed at the patient's or physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

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. (See the Eligibility section for further information).

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

usual and customary, as defined in this Definitions section; and coverage for the services or supplies is not excluded, as provided in the Dental Exclusions section of this document and the plan year maximum dental benefits for those services or supplies has not been reached.

Eligible Medical Expenses: Expenses for medical services or supplies, but only to the extent that they are medically necessary (as defined in this Definitions section); and the charges for them are Usual and Customary (as defined in this Definitions section); and coverage for the services or supplies is not excluded (as provided in the Exclusions section); and the Plan Year Maximum Benefits for those services or supplies has not been reached.

Emergency: See Medical Emergency.

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness, or within 24 hours of an accidental injury causing a life-threatening situation.

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.

Enroll, Enrollment: The process of completing enrollment, either by use of the online e-PEBP 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. See the Eligibility section for details regarding the mechanics of enrollment.

Enrollment Date: Generally means the date coverage begins under this plan.

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

Experimental and/or Investigational: Unless mandated by law, the Plan Administrator or its designee has the discretion and authority to determine if a service or supply is, or should be, classified as experimental and/or investigational. A service or supply will be deemed to be experimental and/or investigational if, in the opinion of the Plan Administrator or its designee, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for pre-certification under the plan's utilization management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

- The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the health care provider that performs the service or prescribes the supply;
- The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
- In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States, and written by experts in the field, that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational; **or** indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.

- With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered experimental and/or investigational if it is:
 - approved by the FDA as an “investigational new drug for treatment use”; or
 - classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a “life threatening disease,” as that term is defined in FDA regulations; or
 - approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.
- The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; **or** Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

In determining if a service or supply is or should be classified as Experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided or considered for pre-certification under the plan’s utilization management program:

- Medical records of the covered person;
- The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
- Protocols of the health care provider that renders the prescribed service or prescribes or dispenses the supply;
- Authoritative peer-reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person’s diagnosis, including (but not limited to) “United States Pharmacopoeia Dispensing Information”; and “American Hospital Formulary Service”;
- The published opinions of: the American Medical Association (AMA), such as “The AMA Drug Evaluations” and “The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, etc.; or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the American Dental Association (ADA), with respect to dental services or supplies;
- Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply;
- The latest edition of “The Medicare Coverage Issues Manual.”
- Nevada Statutes mandate the following criteria be met in cases of Cancer and Chronic Fatigue Syndrome:
 1. A policy of health insurance must provide coverage for medical treatment in a clinical study or trial if:
 - a. treatment is for either Phase I, II, III, IV cancer or Phase II, III, IV Chronic Fatigue Syndrome;
 - b. study is approved by:
 - i. Agency of National Institute of Health;
 - ii. A cooperative group (see bill for exact definition);

- iii. FDA for new investigational drug
 - iv. US Dept. of Veteran Affairs;
 - v. US Dept. of Defense;
 - c. health care provider and facility have authority to provide the care for Phase I cancer;
 - d. health care provider and facility have experience to provide the care for Phase II, III, IV cancer or Chronic Fatigue Syndrome;
 - e. no other treatment considered a more appropriate alternative;
 - f. reasonable expectation based on clinical data that treatment will be at least as effective as other treatments;
 - g. study is conducted in Nevada;
 - h. participant signs a statement of consent that he has been informed of:
 - i. the procedure to be undertaken;
 - ii. alternative methods of treatment;
 - iii. associated risks of treatment.
2. Coverage for medical treatment is limited to:
- a. a drug or device approved for sale by the FDA;
 - b. reasonable necessary required services provided in treatment or as a result of complications to the extent that they would have otherwise been covered for Phase II, III, IV cancer or Chronic Fatigue Syndrome;
 - c. the cost of any routine health care services that otherwise would have been covered for an insured for Phase I cancer;
 - d. initial consultation; and
 - e. clinically appropriate monitoring.
3. Treatment not required to be covered if provided free by sponsor.
4. Coverage does not include:
- a. portions customarily paid by other government or industry entities;
 - b. a drug or device paid for by manufacturer or distributor;
 - c. excluded health care services;
 - d. services customarily provided free in study;
 - e. extraneous expenses related to study;
 - f. expenses for persons accompanying participant in study;
 - g. any item or service provided for data collection not directly related to study;
 - h. expenses for research management of study.

Note: To determine how to obtain a pre-certification of any procedure that might be deemed to be experimental and/or investigational, see the Pre-certification Review section of the Utilization Management section.

Explanation of Benefits (EOB): When a claim is processed by the Claims Administrator you will be sent a form called an Explanation of Benefits, or EOB. The EOB describes how the claim was processed, such as allowed amounts, amounts applied to your deductible, if your out of pocket maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, etc.

Extended Care Facility: See the definition of Skilled Nursing Facility.

Expedited Appeal: Means if a participant appeals a decision regarding a denied request for precertification (Pre-Service Claim) for an Urgent Care Claim, the participant or participant's Authorized Representative can request an Expedited Appeal, either orally or in writing. Decisions regarding an Expedited Appeal are generally made within seventy-two (72) hours from the Plan's receipt of the request.

External Review: Means an independent review of an Adverse Benefit Determination conducted by an External Review Organization.

External Review Organization: Means an organization that 1) Conducts an External Review of a final Adverse Benefit Determination; and 2) Is certified in accordance with regulations adopted by the Nevada Commissioner of Insurance.

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

Federal Legend Drugs: Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."

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

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

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

Formulary: A list of generic and brand name drug products available for use by plan participants.

Generic Drug: A prescription drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This plan will consider as a generic drug any FDA approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic. (See also the Prescription Drug section of the Schedule of Medical Benefits and the Prescription Drug subsection of the Medical Exclusion section).

Genetic Counseling: Counseling services provided before or in the absence of genetic testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of genetic testing; and provided after genetic testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman.

Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from genetic testing, or that may be inferred from a person's family medical history.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations. Tests that assist the health care practitioner in determining the appropriate course of action or treatment for a medical condition.

Health Care Practitioner: A physician, behavioral health practitioner, chiropractor, dentist, nurse, Nurse Practitioner, Physician Assistant, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist, Master's prepared audiologist, optometrist, optician for Vision Plan benefits, oriental medicine doctor for acupuncture or Christian Science Practitioner, who is legally licensed and/or legally authorized to practice or provide certain health care

services under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license and/or scope of practice.

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

Health Reimbursement Arrangement: A health reimbursement account or arrangement (HRA) is an employer-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 Savings Account: An account that allows individuals 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 under HIPAA for certain employees and dependents who experience a loss of other coverage and when there is an adoption, placement for adoption, birth, or marriage.

Home Health Care: Intermittent skilled nursing care services provided by a licensed home health care agency (as those terms are defined in this section).

Home Health Care Agency: An agency or organization that provides a program of home health care and meets one of the following three tests:

- It is approved by Medicare; or
- It is licensed as a home health care agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets all of the following requirements:
 - It has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a physician or Registered Nurse (RN) to the home.
 - It has a full-time administrator.
 - It is run according to rules established by a group of professional health care providers including physicians and Registered Nurses (RNs).
 - It maintains written clinical records of services provided to all patients.
 - Its staff includes at least one Registered Nurse (RN) or it has nursing care by a Registered Nurse (RN) available.
 - Its employees are bonded.
 - It maintains malpractice insurance coverage.

Homeopathy: A school of medicine based on the theory that when large doses of drugs or substances produce symptoms of an illness in healthy people, administration of very small doses of those drugs or substances will cure the same symptoms. Homeopathy principles are designed to enhance the body's natural protective mechanisms based on a theory that "like cures like" or "treatment by similar." (See also the Exclusions section of this document regarding homeopathic treatment and services.) When the services of homeopaths are payable by this plan (e.g., an office visit), the homeopath must be properly licensed to practice homeopathy in the state in

which he or she is practicing and must be performing services within the scope of that license or, where licensing is not required, have successfully graduated with a diploma of Doctor of Medicine in Homeopathy from an institution which is approved by the American Institute of Homeopathy and completed at least 90 hours of formal post-graduate courses or training in a program approved by the American Institute of Homeopathy.

Hospice: An agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of 6 months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (home hospice services) or in a home-like setting (Inpatient hospice), with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family. The agency must meet one of the following tests:

- It is approved by Medicare; or is licensed as a hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- If licensing is not required, it meets all of the following requirements:
 - It provides 24 hour-a-day, 7 day-a-week service.
 - It is under the direct supervision of a duly qualified physician.
 - It has a full-time administrator.
 - It has a nurse coordinator who is a Registered Nurse (RN) with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
 - The main purpose of the agency is to provide hospice services.
 - It maintains written records of services provided to the patient.
 - It maintains malpractice insurance coverage.
 - A hospice that is part of a hospital will be considered a hospice for the purposes of this plan.

Hospital: A public or private facility or institution, other than one owned by the U.S. Government, licensed and operating according to law, that:

- is approved by Medicare as a hospital; and
- provides care and treatment by physicians and Nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises.

A hospital may include facilities for behavioral health treatment that are licensed and operated according to law. Any portion of a hospital used as an ambulatory surgical facility, birth (or birthing) center, hospice, skilled nursing facility, sub-acute care facility, or other residential treatment facility or place for rest, custodial care, or the aged shall not be regarded as a hospital for any purpose related to this plan.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a physician and as compared to the person's previous condition.

Pregnancy of a covered employee or covered spouse will be considered to be an illness only for the purpose of coverage under this plan. However, infertility is not an Illness for the purpose of coverage under this Plan.

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

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.

Inherited Metabolic Disorder: A genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates or fats, as diagnosed by a physician

using standard blood, urine, spinal fluid, tissue or enzyme analysis. Inherited metabolic disorders are also referred to as inborn errors of metabolism and include Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance without a diagnosis of Galactosemia is not an inherited metabolic disorder under this plan. See also Medical Foods.

Injury: Any damage to a body part resulting from trauma from an external source.

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

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

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

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

Inpatient Services: Services provided in a hospital or other health care facility during the period when charges are made for room and board.

Intensive Care Unit: See Special Care Unit.

Investigational: See the definition of Experimental and/or Investigational.

Legal Guardian: A person recognized by a U. S. court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Maintenance Rehabilitation refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of active rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level. Maintenance rehabilitation is not covered by the Plan.

Managed Care: Procedures designed to help control health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result.

Medical Emergency: means the sudden onset of a medical condition with symptoms severe enough to cause a prudent person to believe that lack of immediate medical attention could result in serious jeopardy to his/her health, jeopardy to the health of an unborn child, impairment of a bodily function or dysfunction of any bodily organ or part.

Medical Foods: See the definition of Special Food Product.

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

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

- is determined by the Plan Administrator or its designee to meet all of the following requirements:
 - It is consistent with the symptoms or diagnosis and treatment of the Illness or Injury; and
 - It is not provided solely for the convenience of the patient, physician, dentist, hospital, health care provider, or health care facility; and
 - It is an “appropriate” service or supply given the patient’s circumstances and condition; and
 - It is a “cost-efficient” supply or level of service that can be safely provided to the patient; and
 - It is safe and effective for the illness or injury for which it is used.
- A medical or dental service or supply will be considered to be “appropriate” if:
 - It is a diagnostic procedure that is called for by the health status of the patient, and is: as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient’s overall health condition.
 - It is care or treatment that is: as likely to produce a significant positive outcome as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient’s overall health condition.

A medical or dental service or supply will be considered to be “cost-efficient” if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply. The fact that your physician or dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be medically necessary for the medical or dental coverage provided by the Plan. A hospitalization or confinement to a health care facility will not be considered to be medically necessary if the patient’s illness or injury could safely and appropriately be diagnosed or treated while not confined. A medical or dental service or supply that can safely and appropriately be furnished in a physician’s or dentist’s office or other less costly facility will not be considered to be medically necessary if it is furnished in a hospital or health care facility or other more costly facility.

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

Medically Necessary for External Review: Means healthcare services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease or any symptoms thereof that are necessary and provided in accordance with generally accepted standards of medical practice, is clinically appropriate with regard to type, frequency, extent, location and duration, is not primarily provided for the convenience of the patient, physician or other provider of healthcare, is required to improve a specific health condition of a member or to preserve his existing state of health and the most clinically appropriate level of healthcare that may be safely provided to the member.

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.

Medi-span: A national drug pricing information database for drug pricing analysis and comparison.

Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorder.

Midwife, Nurse Midwife: A person legally licensed as a midwife or certified as a certified nurse midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administer intravenous fluids and certain medications, provide emergency measures while awaiting aid, perform newborn evaluation, sign birth certificates, and bill and be paid in his or her own name, and who acts within the scope of his or her license. A midwife may not independently manage moderate or high-risk mothers, admit to a hospital, or prescribe all types of medications. See also the definition of Nurse.

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.

Naturopathy: A therapeutic system based on principles of treating diseases with natural forces such as water, heat, diet, sunshine, stress reduction, physical manipulation, massage or herbal tea. Note: Naturopathy providers and treatment/services or substances are not a payable benefit under this plan.

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including (but not limited to) bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic appliance (or Device) and Prosthetic appliance (or Device). Only those nondurable supplies identified in the Schedule of Medical Benefits are covered by this Plan. All others are not.

Non-network: See Out of Network.

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

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife or licensed midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

Nurse Anesthetist: A person legally licensed as a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse Anesthetist (RNA) or Nurse Anesthetist (NA), and authorized to administer anesthesia in collaboration with a physician, and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license.

Nurse Practitioner: A person legally licensed as a Nurse Practitioner (NP), or Registered Nurse Practitioner (RNP) who acts within the scope of his or her license and who in collaboration with a physician, examines patients, establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate health care practitioners under the laws of the state or jurisdiction where the services are rendered.

Occupational Therapist: A person legally licensed as a professional occupational therapist who acts within the scope of their license and acts under the direction of a physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills in order to regain independence.

Office Visit: A direct personal contact between a physician or other health care practitioner and a patient in the health care practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association and with documentation that meets the requirement of such CPT coding. Neither a telephone discussion with a physician or other health care practitioner nor a visit to a health care practitioner's office solely for such services as blood drawing, leaving a specimen, or receiving a routine injection is considered to be an office visit for the purposes of this Plan.

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

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.

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

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

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

Orthotic (Appliance or Device): A type of corrective appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including (but not limited to) crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the medical plan, this definition does not include dental orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic appliance (or Device).

Other Prescription Drugs: Drugs that require a prescription under state law but not under federal law.

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

Out-of-Pocket Maximum: The maximum amount of coinsurance each covered person or family is responsible for paying during a plan year before the coinsurance required by the plan ceases to apply. When the out-of-pocket maximum is reached, the plan will pay 100% of eligible covered

expenses for the remainder of the plan year. See the section on Out of Pocket Maximum in the Medical Expense Coverage section for details about what expenses do not count toward the out-of-pocket maximum.

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

Overage Child with a Disability or Disabled Dependent Child over the age of 26 years:

Overage 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,
- 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,
- Is dependent chiefly on the participant or the participant's spouse for support and maintenance,
- Has maintained continuous medical coverage with no break in service, and
- Is claimed as a tax dependent under the Internal Revenue Code Section 152.

This Plan will require proof of disability at reasonable intervals during the two years following the date the dependent reaches the age of 26 years. After the initial two-year period, the Plan Administrator may require proof of disability 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. An individual covered under a permanent legal guardianship at the time the minor individual was 18 or 19, as applicable, pursuant to NRS 159.191 is included in this definition.

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

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

Passive Rehabilitation refers to therapy in which a patient does not actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive rehabilitation may be covered by the plan, but only during a course of Hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until such time as the patient is able to achieve active rehabilitation. Continued hospitalization for the sole purpose of providing passive rehabilitation will not be considered to be medically necessary for the purposes of this Plan.

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

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

Physical Therapy: Rehabilitation directed at restoring function following disease, injury, surgery or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform activities of daily living such as walking and getting in and out of bed.

Physician: A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license.

Physician Assistant (PA): A person legally licensed as a Physician Assistant, who acts within the scope of his or her license and acts under the supervision of a physician to examine patients, establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising physician; under the laws of the state or jurisdiction where the services are rendered.

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 or dependent child(ren) or a surviving spouse 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.

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

Plan Year Maximum Benefits are the maximum amount of benefits payable each plan year for certain medical expenses incurred by any covered plan participant (or family of the plan participant) under this Plan and any previous medical expense plan provided by PEBP.

Podiatrist: A person legally licensed as a Doctor of Podiatric Medicine (DPM) who acts within the scope of his or her license and who is authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered.

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

Post-Service Claim: Means any Claim for Benefits under a Health Benefit Plan regarding payment of benefits that is not considered a Pre-Service Claim or an Urgent Care Claim.

Pre-Admission Testing: Laboratory tests and x-rays and other medically necessary tests performed on an outpatient basis 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury.

Pre-certification: Pre-certification is a review procedure performed by the utilization management company before services are rendered, to assure that health care services meet or exceed accepted standards of care and that the service, admission and/or length of stay in a health care facility is appropriate and medically necessary.

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

Pre-Service Claim: Means any Claim for Benefits under a Health Benefit Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

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

Prescription Drugs: For the purposes of this plan, Prescription Drugs include:

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

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

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

Prophylactic Surgery: A surgical procedure performed for the purpose of (1) avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on genetic information or genetic testing, or (2) treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder, even at its earliest stages. An example of prophylactic surgery is a mastectomy performed on a woman who has been diagnosed as having a genetic predisposition to breast cancer and/or has a history of breast cancer among her family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease, even if there is medical evidence of a chromosomal abnormality or genetically transmitted characteristic indicating a significant risk of breast cancer coupled with a history of breast cancer among family members of the woman.

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

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

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

Prosthetic Appliance (or Device): A type of corrective appliance or device designed to replace all or part of a missing body part, including (but not limited to) artificial limbs, heart pacemakers, or corrective lenses needed after cataract surgery. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic appliance (or Device).

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.

Reconstructive Surgery: A medically necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy.

Rehabilitation Therapy: Physical, occupational, or speech therapy that is prescribed by a physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, and that is performed by a licensed therapist acting within the scope of his or her license. See the Schedule of Medical Benefits and the Exclusions section of this document to determine the extent to which rehabilitation therapies are covered. See also the definition of Physical Therapy, Occupational Therapy, Speech Therapy and Cardiac Rehabilitation.

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

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.

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

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

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

Retrospective Review: Review of health care services after they have been provided to determine if those services were medically necessary and/or if the charges for them are Usual and Customary Charges.

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

Scale: The removal of calculus (tartar) and stains from the teeth with special instruments.

Second Opinion: A consultation and/or examination, preferably by a board certified physician not affiliated with the primary attending physician, to evaluate the medical necessity and advisability of undergoing surgery or receiving a medical service.

Service Area: The geographic area serviced by the in-network health care providers who have agreements with the plan's PPO. See the section on Medical Networks for additional information.

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 health plan meets the definition of significantly inferior coverage.

Skilled Nursing Care: Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of skilled nursing care services include, but are not limited to the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility (SNF): A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, sick people or people with disabilities, and that meets all of the following requirements:

- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a skilled nursing facility or is recognized by Medicare as a skilled nursing facility; and
- It is regularly engaged in providing room and board and continuously provides 24 hour-a-day skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed physician; and
- It provides services under the supervision of physicians; and
- It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with one licensed Registered Nurse on duty at all times; and
- It maintains a daily medical record of each patient who is under the care of a licensed physician; and
- It is not (other than incidentally) a home for maternity care, rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill, or suffering from tuberculosis; and
- It is not a hotel or motel.

A skilled nursing facility that is part of a Hospital, as defined in this document, will be considered a skilled nursing facility for the purposes of this Plan.

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

Special Food Product: A food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a physician for the dietary treatment of an inherited metabolic disease (as that term is defined in this section). The term does not include a food that is naturally low in protein or foods or formulas for persons who do not have inherited metabolic diseases/disorders as that term is defined in this document.

Specialty Care Unit: A section, ward, or wing within a hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by Registered Nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication to restore normal speech or to correct dysphagic or swallowing defects and disorders lost due to illness, injury or surgical procedure. Speech therapy for functional

purposes, including (but not limited to) a speech impediment, stuttering, lisping, tongue thrusting, stammering, conditions of psychoneurotic origin or childhood developmental speech delays/disorders are excluded from coverage.

Spinal Manipulation/Chiropractic care: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column. Spinal manipulation is commonly performed by chiropractors, but it can be performed by physicians.

Spouse: The employee's lawful spouse as determined by the laws of the State of Nevada. The plan 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.

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

Sub-acute Care Facility: A public or private facility, either free-standing, hospital-based or based in a skilled nursing facility, licensed and operated according to law and authorized to provide sub-acute care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement, to the patient's home or to a suitable skilled nursing facility, and that meets all of the following requirements:

- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a sub-acute care facility or is recognized by Medicare as a sub-acute care facility; and
- It maintains on its premises all facilities necessary for medical care and treatment; and
- It provides services under the supervision of physicians; and
- It provides nursing services by or under the supervision of a licensed Registered Nurse; and
- It is not (other than incidentally) a place for rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
- It is not a hotel or motel.

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

Substance Abuse: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of Behavioral Health Disorders and Chemical Dependency.

Surgery: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Claims Administrator will determine which multiple surgical procedures will be considered as primary, secondary, bilateral, add-on, or separate (incidental) procedures for the purpose of determining benefits under this plan. Multiple surgical procedure allowances are specified below:

Multiple Surgical Procedure Allowances:

- Primary procedure, bilateral primary procedure, or add-on to primary procedure: usual and customary charge or negotiated fee;
- Secondary procedure in same operative area: limited to 50% of usual and customary charge or negotiated fee;
- Bilateral secondary procedure in same operative area: limited to 50% of usual and customary charge or negotiated fee;
- Add-on to secondary procedure in same operative area: limited to 100% of usual and customary charge or negotiated fee;
- Separate (incidental) procedure in same operative area as any of the above: not covered;
- Separate operative area: limited to 50% of usual and customary charge or negotiated fee.

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

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

Therapist: A person trained in and skilled in giving therapy in a specific field of health care such as occupational, physical, radiation, respiratory and speech therapy. See the definition of Occupational, Physical and Speech Therapy.

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

Transplant, Transplantation: The transfer of organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, stem cells or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient. (See the Schedule of Medical Benefits and the Exclusions section for additional information regarding Transplants. See also the Utilization Management section of this document for information about pre-certification requirements for transplantation services).

Xenographic: refers to transplants of organs, tissues or cells from one species to another (for example, the transplant of an organ from a baboon to a human). Xenographic transplants are not covered by this plan, except heart valves.

Urgent Care: Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate, even though health and life are not in jeopardy. Examples of medical conditions that may be appropriate for urgent care include (but are not limited to) fever, sprains, bone or joint injuries, continuing diarrhea or vomiting, or bladder infections.

Urgent Care Claim: Means a Claim for Benefits that is treated in an expedited manner because the application of the time periods for making determinations that are not Urgent Care Claims could seriously jeopardize the participant's life, health or the ability to regain maximum function by waiting for a routine appeal decision. An Urgent Care Claim also means a Claim for Benefits

that, in the opinion of a physician with knowledge of the participant's medical conditions, would subject the participant to severe pain that cannot be adequately managed without the care or the treatment that is the subject of the claim. If an original request for precertification of an Urgent Care service was denied, the participant could request an Expedited Appeal for the Urgent Care Claim.

Urgent Care Facility: A public or private hospital-based or free-standing facility, that includes x-ray and laboratory equipment and a life support system, licensed or legally operating as an urgent care facility, primarily providing minor emergency and episodic medical care with one or more physicians, nurses, and x-ray technicians in attendance at all times when the facility is open. .

Usual and Customary Charge (U&C): The charge for medically necessary services or supplies will be determined by the Plan Administrator or its designee to be the lowest of:

- For medical benefits, no more than the 70th percentile of Fair Health, a national schedule of prevailing health care charges, updated twice per year; or for dental benefits no more than the 70th percentile of the Fair Health updated twice per year; or
- With respect to a PPO or participating health care or dental provider, the fee set forth in the agreement between the PPO or participating health care or dental care provider and the PPO or the Plan; or
- The health care or dental care provider's actual charge; or
- The usual charge by the health care or dental care provider for the same or similar service or supply.

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

NOTE: The Claim Administrator has the discretionary authority to determine the Usual and Customary Charge based upon standards set forth by the Plan Administrator.

Utilization Management (UM): A Managed care process to determine the medical necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include (but is not limited to): pre-certification and/or preauthorization; concurrent and/or continued stay review; discharge planning; retrospective review; case management; hospital or other health care provider bill audits; and health care provider fee negotiation. Utilization management services (sometimes referred to as UM services, UM , Utilization Review services, UR services, Utilization Management, Concurrent Review or Retro Review services) are provided by licensed health

care professionals employed by the utilization management company operating under a contract with the Plan.

Utilization Management Company: The independent utilization management organization, staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer the plan's utilization management services.

Visit: See the definition of Office Visit.

Well Baby Care; Well Child Care: Health care services provided to a healthy newborn or child that are determined by the Plan to be medically necessary, even though they are not provided as a result of illness, injury or congenital defect. The Plan's coverage of Well Baby Care is described under Wellness/Preventive Care in the Schedule of Medical Benefits.

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.