

Introduction to Employee Benefits

Plan Year 2013

STATE OF NEVADA

Public Employees' Benefits Program

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Plan Year 2013

- *Medical*
- *Dental*
- *Prescription Drug*
- *Vision*
- *Basic Life Insurance*
- *Long-term Disability Insurance*
- *Premium Rates*
- *Voluntary Products*

Plan Year 2013

July 1, 2012 - June 30, 2013

State of Nevada
Public Employees' Benefits Program

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This document is for informational purposes only. Any discrepancies between the information contained herein and the *Plan Year 2013 Master Plan Document/HMO Evidence of Coverage Certificates* shall be superseded by the plans' official documents.

Welcome

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP) PEBP provides a comprehensive benefit package to eligible employees offering medical, prescription drug, dental, vision, \$10,000 basic life, and long-term disability insurance. In addition to these core benefits, employees enrolled in a PEBP medical plan are eligible to purchase additional voluntary products such as long-term care insurance, voluntary life insurance, short-term disability, and auto/homeowners' insurance. State employees are also eligible to enroll in Medical, Limited Purpose and Dependent Care Flexible Spending Accounts.

When to Enroll

As a new employee, you 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 with your agency, or no later than the date coverage is scheduled to become effective.

Default Enrollment

Failure to enroll will result in your enrollment being 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. Except as provided in the PEBP Master Plan Document and NAC 287.3125, coverage may not be amended until the next open enrollment period.

Complete your enrollment by doing one of the following:

Enroll online

Go to www.pebp.state.nv.us and select the *E-PEBP Online Enrollment Tool*. After creating your User ID and Password, follow the instructions to complete your enrollment.

Employee Benefit Enrollment and Change Form (E-BECF)

If you do not have access to the Internet, please contact PEBP to request the Employee Benefit Enrollment and Change Form at 775-684-7000 or 800-326-5496.

Public Employees' Benefits Program

901 South Stewart Street, Suite 1001
Carson City, NV 89701

Forms must be original. No copies or facsimiles accepted.

Included with this packet:

Standard Insurance Beneficiary Designation Form

Mail the Standard Insurance Beneficiary Designation Form to:

State of Nevada Life Insurance Team
Mestmaker Insurance Services
P.O. Box 2302
Bakersfield, CA 93303-2302

About Your Enrollment

As a new benefits eligible employee, PEBP requires you to make your enrollment election before your benefits become effective. Note: If you are declining benefits, you must also notify your agency's human resource representative.

Important! If your enrollment election is not received by the date your benefits are scheduled to start, your coverage will be defaulted to the *Participant Only* tier in the *Consumer Driven Health Plan* coverage with a *Health Reimbursement Arrangement*.

The information contained herein is intended to provide you with a summary of the main features of your benefit package. For a detailed description of your benefits, please visit the PEBP website at www.pebp.state.nv.us. We have made every effort to ensure the accuracy of the information contained in this document; however, in the event of a discrepancy, the provisions of the 2013 Master Plan Document will govern. Should you have any questions regarding your benefits and/or eligibility, please contact the PEBP office at 775-684-7000 or 800-326-5496.

Start of Coverage

New Hire

Full-time (or seasonal) employees are eligible for benefits on the first day of the month following *three consecutive* months of full-time employment. Full-time employment is defined as working a minimum of *80 hours per month*. Note: For eligibility purposes, furlough time is considered hours worked when determining full-time employment.

Reinstated Employee

Reinstated employees are individuals who previously satisfied their benefit waiting period and subsequently reinstated to any state agency or the same non-state agency within 12 months of their termination date. Coverage will be reinstated on the first day of the month *concurrent with or following* their reinstatement date. For example, benefits for an employee who terminates employment (state or participating non-state agency) on January 13, 2012 and is rehired on May 15, 2012, would be eligible for coverage effective June 1, 2012. Reinstated employees may elect any plan option and coverage tier that is offered to new hires.

Rehire Employee

A rehire is an employee who returns to work more than 12 months after the employee's previous termination date. The effective date of coverage for a rehire occurs on the first of the month following *three consecutive* months of full-time employment. Full-time employment is defined as working a minimum of *80 hours per month*.

Note: Retirees who return to active work status with the *State of Nevada* or a *participating non-state 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."

Dependent Eligibility

PEBP provides coverage for eligible dependents such as spouses/domestic partners and dependent child(ren) to age 26. To enroll a dependent, PEBP will require copies of supporting documents to establish eligibility on behalf of a dependent. Turn to Summary of Supporting Eligibility Documents on page 4.

Changes to Eligibility

The *participant or dependent* must notify PEBP, in writing, within sixty days after the date he or she no longer meets the eligible requirements to be enrolled for PEBP coverage.

Note: The dependent(s) of two PEBP participants cannot be covered under more than one PEBP plan at the same time.

Child to age 26 Children may be covered from birth through the last day of the month in which the child reaches age 26 (regardless of the child's marital status).

Children are defined as a participant's biological children, stepchildren, legally adopted children, children for whom the participant has assumed a legal obligation for total or partial support in *anticipation* of adoption of the child and children of a participant's registered domestic partner.

A child under legal permanent guardianship may be covered on the first of the month concurrent with or following the date of the guardianship award through the last day of the month in which the guardianship terminates. If the legal permanent guardianship does not specify a termination date the child may be covered through the last month in which the child reaches age 26 or beyond age 26 if the child meets the definition of a disabled child as indicated below.

Disabled child Children of any age with disabilities, mental illness or intellectual, or other developmental disabilities who are incapable of self-support, provided such condition occurs before age 26. The participant must provide evidence of the disability and evidence that the condition occurred before age 26. The participant must notify PEBP in writing, no later than sixty days after the date a child age 26 or older no longer qualifies as a disabled child.

Spouse/domestic partner Spouses or domestic partners are eligible for coverage as a dependent of an employee if he or she is not eligible for employer-based group healthcare coverage through their current employer (whether or not they actually enrolled in that other coverage) or eligible for other employer-based group healthcare coverage that is determined to be significantly inferior coverage. For example, a plan that offers limited benefits (mini-med) plan or a catastrophic plan with a \$5,000 or greater individual deductible and the plan is not coupled with a Health Savings Account or Health Reimbursement Arrangement.

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 to age 26	√		√					
Adopted Child	√		√		√			
Permanent Legal Guardianship of a child	√		√				√	
Stepchild	√	√	√					
Domestic Partner's child	√		√			√		
Domestic Partner's adopted child	√		√		√	√		
Disabled child	√		√					√
Disabled stepchild	√	√	√					√
Domestic Partner's disabled child	√		√			√		√
Spouse*	√	√						
Domestic Partner*	√					√		

*If you are adding a spouse/domestic partner who is eligible for group health care coverage through their own employer, you must provide the other plan's Summary Plan Document indicating that the other plan offers significantly inferior coverage e.g., limited benefits (mini-med) plan or a catastrophic plan with a \$5,000 or greater individual deductible and the plan is not coupled with a Health Savings Account or Health Reimbursement Arrangement.

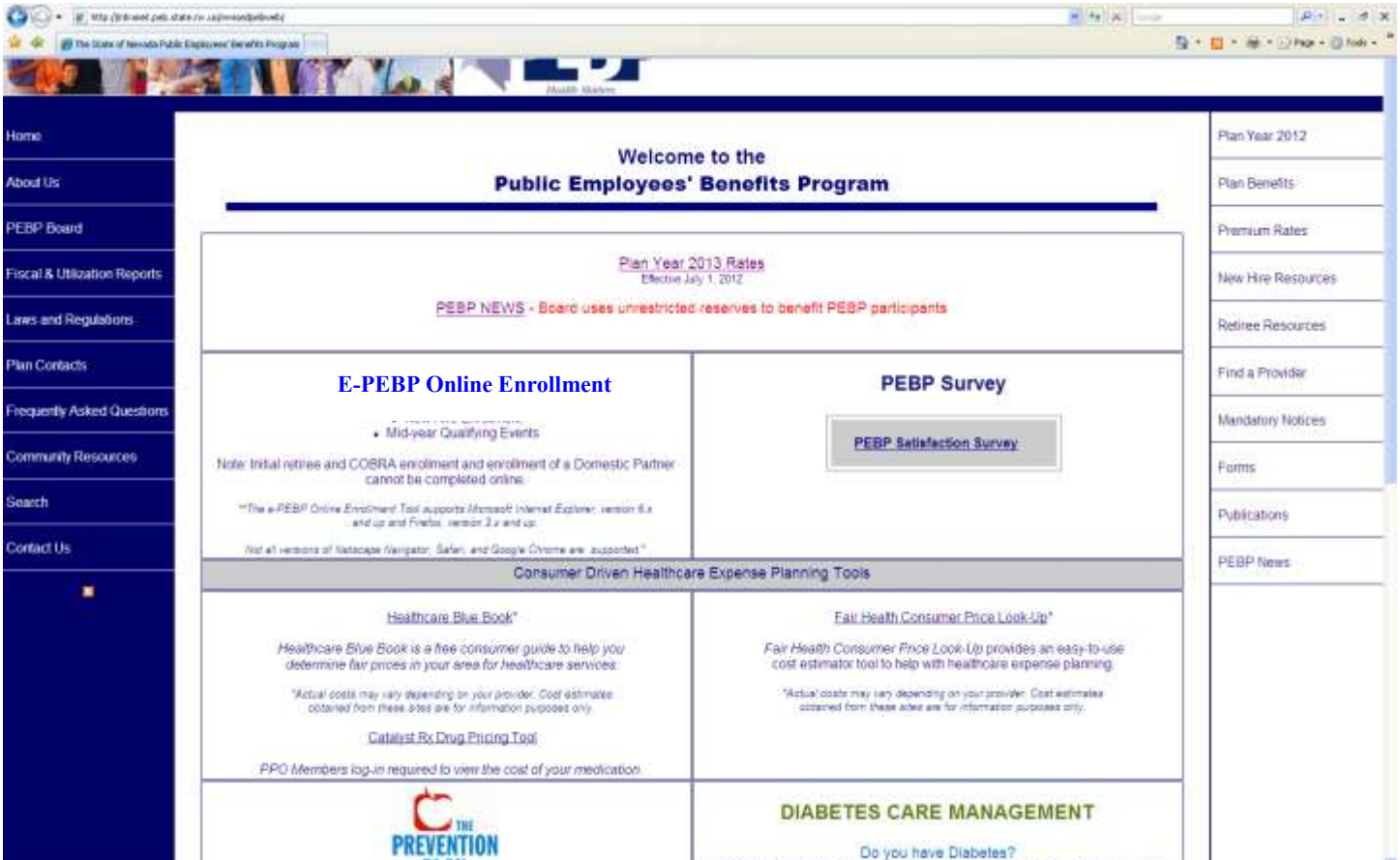
The list above is not exhaustive, PEBP reserves the right to request additional documentation as required to establish dependent eligibility.

Summary of Employee Benefit Options

	State Employee	Non-State Employee	Active Legislator
Medical Plan Options			
Consumer Driven Health Plan (CDHP) with HSA or HRA	√	√	√
Health Plan of Nevada (Southern Nevada HMO) - Clark, Esmeralda and Nye Counties	√	√	√
Hometown Health Plan (Northern Nevada HMO)	√	√	√
Dental Benefits			
Dental Plan	√	√	√
Voluntary Insurance Options			
Long-term Care Insurance	√	√	√
Short-term Disability Insurance	√	√	√
Home and Auto Insurance	√	√	√
Health Care Flexible Spending	√		√
Dependent Care Flexible Spending	√		√
Voluntary Life Insurance	√	√	√

New Hire Resources

www.pebp.state.nv.us



What You Will Find at www.pebp.state.nv.us

Board Meeting Calendar, Agenda, Transcripts, and Audio Recordings	Wellness Programs for the Consumer Driven Health Plan (CDHP) and the HMO plans
Laws and Regulations	New Hire Resources (online enrollment, HRA, Basic Life Insurance, Voluntary Benefits, and contact information for all PEBP vendors.)
Plan Contacts	CDHP Master Plan Document, Evidence of Coverage Certificates for the HMO plans, Benefit Summaries, and Formularies
Frequently Asked Questions	Provider Search
Community Resources	Forms
Plan Benefits	Publications
Premium Rates	PEBP News

Medical Plan Comparison

Benefit Category	Consumer Driven Health Plan	Health Plan of Nevada	Hometown Health Plan
	Amount You Pay In-Network	Amount You Pay In-Network	Amount You Pay In-Network
Medical Deductible	\$1,900 individual \$3,800 family • \$2,400 Individual -when two or more family members covered	No deductible	No deductible
Annual Out-of-pocket Maximum	\$3,900 person \$7,800 family (per plan year)	\$6,800 person (per calendar year)	\$6,200 person \$12,400 family (per plan year)
Hospital Inpatient	25% coinsurance after deductible	\$200 copayment per admission	\$1,500 per admission
Outpatient Same Day Surgery	25% coinsurance after deductible	\$50 copayment per admission	\$1,000 copayment per admission
Primary Care Visit	25% coinsurance after deductible	\$15 copayment	\$25 copayment
Specialist Visit	25% coinsurance after deductible	\$15 copayment	\$45 copayment
Urgent Care Visit	25% coinsurance after deductible	\$15 copayment	\$50 copayment
Emergency Room Visit	25% coinsurance after deductible	\$75 copayment	\$300 copayment per visit
General Laboratory Services	25% coinsurance after deductible	No charge	No charge for outpatient or hospital
Chiropractic Services	25% coinsurance after deductible	\$15 copayment per visit	\$45 copayment per visit \$1,000 plan year max
Wellness/Prevention	No charge for eligible wellness benefits provided in -network	No charge	No charge
Vision Exam	25% coinsurance, U& C* after deductible	\$10 copayment every 12 months	\$15 copayment every 12 months
Hardware (frames, lenses, contacts)	No benefit	\$10 copayment lenses or frames (\$100 allowance) or contacts in lieu glasses (\$115 allowance)	15 to 20% discount

* **Usual and Customary Charge (U&C):** The charge for medically necessary services or supplies as determined by HealthSCOPE Benefits to be the prevailing charge of most other health care providers in the same or similar geographic area for the same or similar health care service or supply.

Pharmacy Plan Comparison

Benefit Category	Consumer Driven Health Plan	Health Plan of Nevada	Hometown Health Plan
	Amount You Pay In-Network	Amount You Pay In-Network	Amount You Pay In-Network
Plan Deductible	\$1,900 individual \$3,800 family • \$2,400 Individual -when two or more family members covered	No deductible	No deductible
Annual Out-Of-Pocket (OOP) Maximum*	\$3,900 person \$7,800 family (per plan year)	Contact HPN for pharmacy OOP* maximum	Contact HHP for pharmacy OOP* maximum

Retail Pharmacy - 30 day supply

Preferred Generic (Tier 1)	25% after deductible	\$7 copayment	\$7 copayment
Preferred Brand (Tier 2)	25% after deductible	\$35 copayment	\$40 copayment
Non-Formulary (Tier 3)	100% of contracted price - does not apply to deductible or OOP*	\$55 copayment	Greater of \$75 copayment per script or 40%
Specialty Drugs	25% after deductible - available in 30 day supply only through Walgreen pharmacies	Applicable retail pharmacy copayment will apply	30% coinsurance

Mail Order - 90 day supply

Preferred Generic (Tier 1)	25% after deductible	\$14 copayment	\$14 copayment
Preferred Brand (Tier 2)	25% after deductible	\$70 copayment	\$80 copayment
Non-formulary (Tier 3)	100% of contracted price - does not apply to deductible or OOP*	Not available through mail order	Greater of \$150 copayment per script or 40%
Specialty Drugs	25% after deductible, available in 30 day supply only through Walgreens mail order	Applicable retail pharmacy copayment applies	Not available through mail order

***Annual Out-of-Pocket Maximum (OOP):** 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 cease to apply. When the OOP maximum is reached, the plan will pay 100% of eligible covered expenses for the remainder of the plan year.

Consumer Driven Health Plan

Plan Feature	In-Network (participating provider benefit)	Out-of-Network Benefit
Coinsurance (plan pays)	75% after deductible	50% after deductible, Usual and Customary* applies.
Primary Care Physician (PCP) <i>PCP includes internists, general and family practitioners, pediatricians and obstetricians/gynecologists.</i>	75% after deductible	50% after deductible, Usual and Customary* applies.
Specialist Office Visits	75% after deductible	50% after deductible, Usual and Customary* applies.
Outpatient Short-Term Rehabilitative Therapy <ul style="list-style-type: none"> • Occupational therapy • Physical therapy • Speech therapy 	75% after deductible	50% after deductible, Usual and Customary* applies.
Emergency Care <ul style="list-style-type: none"> • Emergency Room Visit • Ambulance Services 	75% after deductible	75% after deductible, Usual and Customary* applies.
Urgent Care	75% after deductible	50% after deductible, Usual and Customary* applies.
Outpatient Laboratory Services <ul style="list-style-type: none"> • Outpatient laboratory services (except for pre-admission testing, urgent care facility or emergency room) performed at an acute care hospital will not be covered unless an exception is warranted and approved by the Plan Administrator. • 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 to receive your outpatient laboratory services. 	75% after deductible when testing performed at an independent free-standing laboratory.	50% after deductible, Usual and Customary* applies.

***Usual and Customary Charge (U&C):** The charge for medically necessary services or supplies as determined by HealthSCOPE Benefits to be the prevailing charge of most other health care providers in the same or similar geographic area for the same or similar health care service or supply.

Consumer Driven Health Plan

Plan Feature	In-Network (participating provider benefit)	Out-of-Network Benefit
Temporomandibular Joint Disorder (TMJ)	50% after deductible	50% after deductible, Usual and Customary applies.
<p>Prevention/Wellness Benefit</p> <p>Examples of Preventive Wellness Screenings:</p> <ul style="list-style-type: none"> ◆ Physical exam, screening lab and x-rays ◆ Well child visits and services ◆ HPV Vaccination ◆ Prostrate screening ◆ Routine sigmoidoscopy or colonoscopy ◆ Adult immunizations ◆ Screening mammograms (in the absence of a diagnosis) ◆ Pelvic exam and Pap smear lab test ◆ Osteoporosis screening ◆ Hypertension screening ◆ Skin Cancer screening ◆ Routine hearing exam ◆ Medically supervised weight loss ◆ Stress management <p>For an expanded list of covered preventive/wellness services, please refer to the Plan Year 2013 Master Plan Document available at www.pebp.state.nv.us.</p>	100% - No deductible	Not covered
Vision Exam	75% after deductible Usual and Customary applies.	75% after deductible Usual and Customary applies.

For a detailed description of benefits, refer to the Plan Year 2013 Master Plan Document available at www.pebp.state.nv.us.

Consumer Driven Health Plan Pharmacy Benefit

	Retail 30 Day Supply	Retail 90 Day Supply	Mail Order 90 Day Supply
Benefit Category	Amount You Pay In-Network	Amount You Pay In-Network	Amount You Pay In-Network
Plan Deductible	\$1,900 individual \$3,800 family • \$2,400 Individual (two or more family members)	\$1,900 individual \$3,800 family • \$2,400 Individual (two or more family members)	\$1,900 individual \$3,800 family • \$2,400 Individual (two or more family members)
Out-Of-Pocket (OOP) Maximum*	\$3,900 person \$7,800 family (per plan year)	\$3,900 person \$7,800 family (per plan year)	\$3,900 person \$7,800 family (per plan year)
	Retail 30 Day Supply	Retail 90 Day Supply	Mail Order 90 Day Supply
Preferred Generic (Tier 1)	25% after deductible	25% after deductible	25% after deductible
Preferred Brand (Tier 2)	25% after deductible	25% after deductible	25% after deductible
Non-Formulary (Tier 3)	100% of contracted price - does not apply to deductible or OOP*	100% of contracted price - does not apply to deductible or OOP*	100% of contracted price does not apply to deductible or OOP*
Specialty Medications Limited to 30 day supply—available through BrivoRx	25% after deductible - available in 30 day supply only.	90 day supply not available through retail pharmacies	90 day supply not available through mail order

Diabetic Sense - A Catalyst Rx Program 877-852-3512

Diabetic Supplies coordinated through Liberty (Catalyst Rx Preferred Mail Order) is focused on helping you achieve appropriate control of your diabetes through consistent blood glucose self-monitoring, support and education.

Program Benefits:

- Valuable savings on diabetes care supplies
- Telephone access to diabetes specialists and Registered Pharmacists during normal business hours, Monday - Friday, 8:00 a.m. to 5:00 p.m. EST.

Covered Supplies:	<ul style="list-style-type: none"> • Annual Blood Glucose Monitor • Blood Glucose Test Strips • Lancets 	<ul style="list-style-type: none"> • Spring-Powered device for Lancets • Syringes • Alcohol Pads • B-D Pens • 3cc Novo Pens 	\$50 Copay applies to each 90 day supply item. If the actual cost is less, you pay the actual cost. No cost for the blood glucose monitor.
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***Out-of-Pocket Maximum (OOP):** 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 cease to apply. When the OOP maximum is reached, the plan will pay 100% of eligible covered expenses for the remainder of the plan year.

CDHP - Diabetes Care Management Program

Opt-In Program - Accompanied with Benefit Enhancements

The Diabetes Care Management Program is a voluntary “opt-in” program. Participants, their covered spouses/domestic partners and covered dependents with diabetes or who receive a diagnosis of diabetes throughout the year are eligible to enroll in this program.

To receive the following benefit enhancements, the member must be actively engaged and accept regular telephonic engagement calls and maintain a prevention plan as prescribed by the participant’s Diabetes Care Management Program Health Coach. Note: Refer to the Plan Year 2013 Master Plan Document at www.pebp.state.nv.us for engagement requirements and benefit enhancements for children.

- Two (annual) physician office visits indicating a primary diagnosis of diabetes will be paid under the wellness benefit; not subject to deductible or coinsurance.
- Two (annual) routine laboratory blood services such as a hemoglobin (A1c) test will be paid under the wellness benefit without deductible or coinsurance.
- Diabetes related medications, such as insulin and Metformin will be eligible for copayments and will not be subject to a plan year deductible or coinsurance.

Diabetes Pharmacy Benefit Enhancement

Generic and Preferred Brand drugs are not subject to deductible or coinsurance when using in-network pharmacies; flat copayment amounts will apply. Copayments will not apply to deductible or out-of-pocket maximum

Tier	Retail 30 day Supply	Mail order 90 day Supply
Tier 1: Generic	\$5 Copayment (no deductible)	\$15 Copayment (no deductible)
Tier 2: Preferred Brand	\$25 Copayment (no deductible)	\$75 Copayment (no deductible)
Tier 3: Non-Preferred Brand	100% of the drug cost (deductible credit will not apply)	100% of the drug cost (deductible credit will not apply)

- To view or download the Preferred Drug List (formulary) or locate an in-network pharmacy, visit www.pebp.state.nv.us or www.catalystrx.com
- Catalyst Rx Prior Authorization (PA) Program is designed to manage the utilization of drugs that are relatively expensive, has significant potential for misuse / abuse and/or requires close monitoring because of potentially serious side effects. The PA Program requires approval from Catalyst Rx Customer Service or PA Team before the drug is covered. PA approval is usually contingent upon preset criteria such as documentation of specific diagnosis, documentation of dosing regimen, failure of or intolerance to first line agents, other relevant clinical characteristics that makes the drug medically necessary. The prescribing physician can contact CatalystRx at 800-799-1012 for more information.
- For a detailed description of benefits, refer to the Plan Year 2013 Master Plan Document available at www.pebp.state.nv.us.

Note: Copayments for Tier 1 and Tier 2 diabetes medications do not apply to the deductible; however, once the annual out-of-pocket maximum has been met, the plan will pay 100% for Tier 1 and Tier 2 diabetes medications.

CDHP - Obesity and Overweight Care Management Program

Opt-In Program - Accompanied with Benefit Enhancements

The Obesity and Overweight Care Management Program is a voluntary “opt-in” program open to primary CDHP participants, covered spouses/domestic partners and covered children who have been diagnosed as obese or overweight by a physician.

Obesity and Overweight Care Management is offered as a medically supervised weight loss program for CDHP participants and their covered dependents who meet certain eligibility criteria. The program provides benefits for nutritional counseling, weight-loss medications and meal replacement therapy with certain restrictions. To determine the eligibility requirements to participate in this program, refer to the [Master Plan Document](#).

Tier	Retail 30 day Supply	Mail order 90 day Supply
Tier 1: Generic	\$5 Copayment (no deductible)	\$15 Copayment (no deductible)
Tier 2: Preferred Brand	\$25 Copayment (no deductible)	\$75 Copayment (no deductible)
Tier 3: Non-Preferred Brand	100% of the drug cost (deductible credit will not apply)	100% of the drug cost (deductible credit will not apply)

- Medications for obesity or overweight management will be identified by Catalyst Rx. Before you begin your medication weight loss treatment, please contact Catalyst Rx at 800-799-1012 to make sure the medication your provider has prescribed is covered under this program.
- For a detailed description of benefits, refer to the Plan Year 2013 Master Plan Document available at www.pebp.state.nv.us.

Note: Copayments for Tier 1 and Tier 2 diabetes medications are not applied to deductible or annual out-of-pocket maximum.

NVision Health & Wellness Program

The NVision Health & Wellness Program is offered to all CDHP and HMO participants. This program is a multi-year approach to improving or maintaining the health and wellness of our members. Over the four period you will educate yourself, get active, eat right and see results. Primary participants can earn a premium incentive (beginning July 1 of the next plan year) for completing a Health Assessment Questionnaire, biometric screening, and certain action programs each Spring. Plus, NVision offers a broad range of educational materials such as health and wellness webinars, a comprehensive medical library with reliable resources about nutrition, healthy living, medical tests and procedures, and wellness activities. NVision’s online program is confidential and your personal information will never be shared with PEBP.

To learn more about the NVision Health & Wellness Program visit www.pebp.state.nv.us or call U.S. Preventive Medicine at 877-800-8144.

Consumer Driven Health Plan



The Consumer Driven Health Plan consists of a PPO network of doctors and health care facilities who agree to provide medical services at discounted rates. Claims are submitted for the services you receive and you pay 100% of the discounted amount until the deductible has been met, then you pay 25% (in-network) for the cost of those services up to the annual out-of-pocket maximum. Participants may access health care services from any provider; however, the out-of-pocket costs are lower when using PPO network providers.

Each year, before the plan begins to pay benefits, you are responsible for paying all of your 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, prescription drug and vision care expenses can be used to satisfy the plan deductible. Deductibles accumulate on a plan year basis and reset to zero at the start of each new plan year.

Plan Year Deductible

The CDHP features a \$1,900 individual (participant only) deductible and a \$3,800 family deductible (participant plus one or more family members). The family deductible includes a \$2,400 individual family member deductible (IFMD). With the IFMD, the plan will pay benefits for one individual in the family once that person meets the \$2,400 IFMD. The balance of the family deductible (\$1,400) must be met by one or more remaining family member(s) before the plan will pay benefits for the remaining family members.

Plan Year Out-of-Pocket Maximum

The annual in-network out-of-pocket maximum is \$3,900 for an individual and \$7,800 for the family. Once the out-of-pocket maximum has been met (through deductible and coinsurance), the plan will pay 100% of eligible expenses for the remainder of the plan year. *Note: A single individual within a family can be responsible for the entire family out-of-pocket maximum.*

Statewide PPO Network

The Statewide PPO Network consists of a partnership between Hometown Health Providers (northern Nevada) and Sierra Health-Care Options, Inc. (southern Nevada). Health care providers who are members of the Statewide PPO Network accept the PPO negotiated amounts in place of their standard charges for covered services. Your out-of-pocket costs are lower when medical services or supplies are received from in-network PPO providers. To locate providers in Nevada, contact the Statewide PPO Network at 800-336-0123 or search for providers online at www.pebp.state.nv.us.

Consumer Driven Health Plan



First Health

The First Health preferred provider network is the CDHP's national provider network for participants residing outside Nevada and Nevada residents who wish to access healthcare outside Nevada. Health care providers who are members of the First Health network accept the PPO negotiated amounts in place of their standard charges for covered services. Your out-of-pocket costs are lower when medical services or supplies are received from in-network PPO providers. To locate providers in the First Health network, contact First Health at 800-226-5116 or search for providers online at www.myfirsthealth.com.

Pre-certification Review

Pre-certification reviews are completed before services are provided to assure they meet or exceed acceptable standards of care and that the admission and length of stay in a hospital or skilled nursing/sub acute facility, surgery, and other health care services are medically necessary. For more information regarding the pre-certification provisions, refer to the *2013 Master Plan Document* at www.pebp.state.nv.us.

Case Management

The process whereby the patient, the patient's family, physician and/or other health care providers, and PEBP work together under the guidance of the plan's independent utilization management company to coordinate a quality, timely and cost-effective treatment plan.

Diabetes Care Management Program

The diabetes Care Management Program is available to all primary CDHP participants, spouses and domestic partners with diabetes. Participants who are diagnosed with diabetes and who are *actively engaged* in the Diabetes Care Management Program will be eligible to receive a benefit enhancement for diabetes related medications, see page 11 for details.

CDHP Pharmacy Plan

Benefits for prescription drugs are provided through the Prescription Drug Plan. This plan provides a mandatory generic program meaning that if a brand name drug is dispensed in place of a generic, regardless of whether you or your physician requests it, you will pay 100% of the discounted rate.

Consumer Driven PPO High Deductible Health Plan



Prior Authorization

Prior Authorization (pre-certification) may be required for certain drugs. Prescription drugs that require prior authorization should be reviewed prior to purchase to ensure that you do not incur additional expenses in addition to the required copayment or deductible. For information regarding prior authorizations, contact Catalyst Rx at 800-799-1012.

Retail Drugs

To obtain a 30-day supply of medication, present your ID card to any network retail pharmacy. To view a listing of in-network retail pharmacies visit: <https://www.catalystrx.com> or www.pebp.state.nv.us.

Mail Order Prescription Drug Service

The mail order service provides for a 90-day supply of non-emergency, extended-use “maintenance” prescription drugs, such as for high blood pressure, diabetes or birth control. The mail order service is administered by Walgreens. To obtain a 90-day supply, simply request a new prescription from your doctor, complete the Walgreens’ registration (included with your PPO medical ID card) and mail to Walgreens.

Retail 90 Program

The Retail 90 Program allows CDHP participants to purchase a 90 day supply of maintenance medications at in-network retail pharmacies. This program is available at all in-network major retail pharmacy chains. The out-of-pocket is the same at Mail Order. Prescriptions must be written for 90 days at a time, plus refills (same as Mail order).

Specialty Medications

Specialty medications are limited to a 30-day supply and are available through Walgreens pharmacy network only. It is essential that Specialty medications be purchased through Walgreens to ensure you do not incur out-of-pocket costs in addition to your copayment. To learn more about the Walgreens Specialty Pharmacy call 866-823-2712.

Diabetic Supplies

Catalyst Rx offers a preferred mail order service (through Liberty) for diabetic supplies. Enrollment through Liberty is required to receive up to a 90-day supply of the following items for a \$50 copayment: blood glucose monitors, test strips, insulin syringes, alcohol pads, and lancets. To enroll in this program, contact Diabetic Sense-Catalyst Rx at 877-852-3512.

Health Savings Account (HSA)

For Eligible Active Employees Enrolled in the CDHP

Health Savings Account (HSA)	Employee Only Coverage	Family (two or more family members)
PEBP HSA contribution (Employee covered on July 1, 2012) Note: New hires receive a prorated contribution based upon the coverage effective date and months remaining in the plan year.	\$700	\$700 for the employee and \$200 for each covered dependent (maximum 3 dependents or \$1,300 total for the family)
Additional one-time contribution only applies to employees and dependents with coverage effective July 1, 2012	\$400	\$100 per dependent (maximum 3 dependents)
Additional one-time contribution only applies to employees age 45 or older on June 30, 2012 with coverage effective July 1, 2012	\$200	
Calendar year contribution limits are set by the IRS. The 2012 maximum contribution limits are as follows:		
2012 Maximum Contribution	Individual	Family (two or more family members)
The maximum shown is for eligible HSA individuals with high deductible health coverage through December 31, 2012 ¹	\$3,100	\$6,250 ²

¹The total 2012 contributions (combined employee/employer) cannot exceed the limits shown.

²The Family maximum is based on your family as reported to the IRS on your federal tax return and applies regardless of whether two employees are married and eligible for the HSA. For example, if one employee is covering a dependent and the other employee is covered as self-only, the maximum for the entire family is \$6,250; therefore, the total combined contributions between both employees and PEBP's contribution cannot exceed \$6,250.

To be eligible for the family maximum, the employee and at least one other dependent on the federal tax return must be eligible for the HSA.

Note: If an employee is covering a dependent and that dependent has other coverage that is not considered a high deductible health plan, the maximum contribution allowed by IRS for the employee is based on an Individual or \$3,100.

*Maximum calendar year contribution limits are set by the Internal Revenue Service.

Note: New hires with coverage effective August 1, 2012 or later will receive a \$700 prorated contribution and \$200 prorated contribution for each dependent (maximum 3 dependents) based upon the coverage effective date and months remaining in the plan year.

Health Savings Account (HSA)

For Eligible Active Employees

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 HSA is an interest bearing account and investment options are available for account balances in excess of \$2,000. Unused dollars in the account carry over from year to year while the account value increases through tax free earned interest and investment growth. Employees who wish to contribute to their HSA may do so through pre-tax payroll deductions. The accounts are portable; therefore, should an employee leave employment or change to a non-qualifying health plan in future years, the HSA remains with the individual.

- Tax-exempt contributions provided by PEBP that provides first dollar coverage for medical expenses.
- Pre-tax employee contributions may be started, modified or discontinued at any time throughout the year.
- Employee contributions are excluded from gross income, lowering total taxable income.
- The account balance remains with the employee at termination, retirement, declination of coverage, change of coverage to an HMO, and in the event of death may generally be passed to a beneficiary(ies).
- Interest and investment earnings are tax free and amounts used for qualifying health care expenses are also tax free. Note: HSA funds withdrawn for purposes other than qualified health care expenses may be taxable and subject to a 20% excise penalty.
- Employees 55 years or older by December 31st of the current tax year may contribute \$1,000 in excess of the regular IRS calendar year limit.
- HSA must be established as individual accounts; IRS does not allow joint accounts. However, HSAs may be used to pay for qualifying health care expenses for other members of the tax-family whether or not they are covered on an employee's health plan.
- No administrative fees for eligible employees.
- Investment options for account balances in excess of \$2,000.

Important

You must meet certain eligibility requirements to *establish* the HSA as follows:

- You must be an active employee enrolled in the CDHP
- You cannot have secondary coverage unless your secondary coverage is also a high deductible health plan
- You cannot be claimed on another person's tax return (excludes joint returns)
- Your spouse (if applicable) cannot have a Medical FSA or HRA that can be used to pay for your out-of-pocket medical expenses
- You cannot be enrolled in COBRA

Health Reimbursement Arrangement (HRA) For Eligible Active Employees

The PPO-Health Reimbursement Arrangement (PPO-HRA) is an employer-owned account established on behalf of employees enrolled in the CDHP who are not eligible for the HSA.

PPO-HRAs may be used to pay for qualified healthcare expenses for the participant and members of the participant's tax-family. PPO HRAs are owned by PEBP and employee contributions are not allowed. If the participant is no longer covered under the CDHP (terminates employment, declines coverage or passes away) any remaining funds in the HRA are returned to PEBP.

For more information regarding the PPO-HRA, please refer to the Plan Year 2013 Master Plan Document at www.pebp.state.nv.us.

Employees enrolled in the CDHP and who are not eligible for the HSA will receive HRA contributions as shown below:

HRA	Individual	Family (two or more family members)
PEBP HRA contribution (Employee covered on July 1, 2012) Note: New hires receive a prorated contribution based upon the coverage effective date and months remaining in the plan year.	\$700	\$700 for the employee and \$200 for each covered dependent (maximum 3 dependents or \$1,300 total for the family)
Additional one-time contribution for employees and dependents with coverage effective July 1, 2012	\$400	\$100 per dependent (maximum 3 dependents)
Additional one-time contribution for employees with coverage effective July 1, 2012 and who are age 45 on or before June 30, 2012	\$200	

Hometown Health Plan Northern Nevada HMO Plan



Category	Member Responsibility
Deductible	No Deductible
Out-of-Pocket Maximum	\$6,200 Individual \$12,400 Family
Coinsurance <ul style="list-style-type: none"> • Special Pharmaceuticals • Separate out-of-pocket maximum \$2,000 Individual/\$6,000 Family 	30% Coinsurance
Primary Care Visit	\$25 Copayment
Specialist Visit	\$45 Copayment
Urgent Care Visit	\$50 Copayment
Emergency Room Visit	\$300 Copayment Waived if admitted as an inpatient
Ambulance - Ground & Air	\$150/\$200 Copayment
Hospital Services (inpatient)	\$1,500 Copayment per admission
Outpatient Surgery	\$1,000 Copayment
Diagnostic Endoscopy	\$150 Copayment
Chiropractic Visit <ul style="list-style-type: none"> • \$1,000 plan year maximum 	\$45 Copayment
General Laboratory Services	No charge
Durable Medical Equipment <ul style="list-style-type: none"> • \$3,500 plan year maximum • Pre-authorization in excess of \$250 	No charge
Mental Health Visit (outpatient)	\$25 Copayment
X-ray & Diagnostic Services	
CT Scan, MRI & Nuclear Medicine	\$250 Copayment per service
Pet Scan	\$350 Copayment
All other X-rays: <ul style="list-style-type: none"> • PCP or specialist • Hospital or outpatient 	-- Included in office visit copay -- \$75 Copayment
Diagnostic Mammogram	\$45 Copayment

Hometown Health Plan Northern Nevada HMO Plan



Category	Member Responsibility
Wellness Benefit	

Wellness visit, pap smear, PSA, colorectal screening & mammogram	No charge
Healthy Tracks Program Online tools to improve your health Includes: Health Risk Assessment, Biometric Screenings, preventive exams, healthy living programs, online seminars, quarterly wellness challenges, nutritional information and recipes/grocery list	No charge
Health Management Services <ul style="list-style-type: none"> • Diabetes • Asthma • Quit Tobacco • Pulmonary Rehabilitation • Heart and Nutrition/Weight Management Programs 	No charge

VSP Vision Plan

Eye Exam every 12 months	\$15 Copayment
Prescription Glasses	20% discount off doctor's U & C fee for prescription glasses when a complete pair is purchased
Contact Lenses	15% discount off contact lens fitting/evaluation fees
Laser Vision Care	Discounts & Preferred pricing for PRK and LASIK

HMO Prescription Benefits - Catalyst Rx 888-341-8574

Category	Retail - 30 Day Supply	Mail - 90 Day Supply
Tier 1 - Formulary Generic Drug	\$7 Copayment	\$14 Copayment
Tier 2 - Formulary Brand Drug	\$40 Copayment	\$80 Copayment
Tier 3 - Non-Formulary Brand Drug	Greater of \$75 or 40% coinsurance	Greater of \$150 or 40% coinsurance
Special Pharmaceuticals	30% coinsurance per script	30% coinsurance per script
Diabetic Supplies	\$7 Generic \$40 Brand	\$14 Generic \$80 Brand
HTH Diabetic Sense Program 866-896-7303 Administered through Liberty Medical Supply - Member must enroll in this program to receive benefits	No charge for glucose meter (Bayer HealthCare Ascensia & Roche Diagnostic Accu-Check), test strips, lancets, syringes and alcohol pads	

Hometown Health Plan Northern Nevada HMO Plan



Hometown Health Plan is a health maintenance organization (HMO) available to participants in Carson City, Churchill, Douglas, Elko, Eureka, Lander, Lincoln, Lyon, Humboldt, Mineral, Pershing, Storey, Washoe, and White Pine Counties. This plan features medical, prescription drug, and vision coverage (Hometown Health participants receive dental coverage through the PPO dental plan). Medical services must be received from a network provider. In addition, a primary care provider must be selected at initial enrollment.

Important Plan Information

Hometown Health Plan offers members Open Access (self-referral) to select specialists contracted with Hometown Health Plan (HMO). In many cases, this feature gives members the ability to see contracted specialists without obtaining a primary care physician's (PCP) referral. However, the following services require PCP referral:

Services that require PCP referral and Hometown Health Plan authorization include:

- All out-of-area services
- Any non-contracted provider or service
- Plastic surgery services
- Gastric bypass or lap banding services
- Anesthesiology and Psychiatry services including pain management
- Genetic Counseling and testing
- Second-opinion services

Prior Authorization required for the following:

- All inpatient services in any facility type, including acute and skilled care, mental healthcare, drug and alcohol detoxification, or rehabilitation
- Surgical services performed while an inpatient, same day surgery or outpatient office
- Home Health Care
- Durable Medical Equipment, prosthetic and orthopedic devices over \$100
- Transplant services, including the evaluation process
- Medications specified by Hometown Health Plan as Special Pharmaceuticals
- Botox injections

Hometown Health Plan

Northern Nevada HMO Plan



Primary Care Physician (PCP)

The Primary Care Physician plays an important role when coordinating health care and arranging for covered services available to Hometown Health members. These include x-rays, laboratory tests, therapies, hospital admissions, follow-up care and prior authorizations.

My Hometown Benefits - personalized online access to information

“My Hometown Benefits” at www.hometownhealth.com provides personalized, real-time information, on the following items:

- Claims and authorizations
- Benefit status
- Prescription drug benefits
- Obtain directions to one of more than 1,300 providers
- Healthcare related topics, including self help tools for asthma and diabetes provided by My Health Zone, a leading health information website

Retail Prescription Drugs

The retail prescription drug program allows participants to fill prescriptions up to a 30 day supply. Hometown Health Plan’s prescription drug formulary and listing of participating pharmacies can be found at www.hometownhealth.com.

Mail-Order Drug Program

The mail-order drug program is for maintenance medications that a person would need to take for more than a 90-day period. When using this benefit for new prescriptions, request your Physician to write two prescriptions: one for a 30-day supply to take to the retail pharmacy and one for a 90-day supply with refills for the mail-order program. If you are already taking a maintenance medication and getting your refills at a retail pharmacy, simply request a 90-day prescription with refills from your physician.

VSP Vision Care for Life

Hometown Health utilizes VSP as the Vision Plan Administrator. For a summary of vision benefits available through Hometown Health Plan turn to page 21. For a listing of VSP providers, visit: www.hometownhealth.com.

Hometown Health Plan Northern Nevada HMO Plan



Selecting and changing your Primary Care Physician (PCP)

To choose your Primary Care Physician (PCP) follow these steps:

Choose a specific PCP from the Hometown Health Plan Provider list at www.hometownhealth.com. Be sure to select the HMO providers.

- Primary Care Physicians include: General Practice Physician, Internal Medicine, and Pediatrics.
- When you have selected the PCP, you will find the identifying PCP number for the PCP. Please use the PCP number in the space provided on your Benefit Enrollment and Change Form to identify the PCP for each member enrolling in the Hometown Health Plan.
- If you wish to change your PCP, contact Hometown Health Customer Service at 775-982-3232 or 800-336-0123, Monday through Friday 7:30 a.m. until 5:30 p.m. Your PCP change will be effective immediately.
- You will not need a referral to a specialist except for specific services. Please refer to the Hometown Health Evidence of Coverage Certificate (EOC) for more information on this topic. The EOC is available at www.pebp.state.nv.us.

HMO Reciprocity

Participants enrolled in Hometown Health Plan are eligible for expanded statewide provider access. Hometown Health Plan and Health Plan of Nevada (southern Nevada HMO plan) have a special network reciprocity agreement that allows HMO members to utilize both networks under certain circumstances. Reciprocity applies when traveling to/from northern/southern Nevada, and for dependents who are away at school in either the northern or southern part of the state. Expanded access is based on Hometown Health Plan's plan provisions. Hometown Health Plan's pre-authorization requirements and referral guidelines still apply as described in the Hometown Health Plan Evidence of Coverage Certificate.

NVision Health & Wellness Program

The NVision Health & Wellness Program is offered to all CDHP and HMO participants. This program is a multi-year approach to improving or maintaining the health and wellness of our members. Over the four period you will educate yourself, get active, eat right and see results. Primary participants can earn a premium incentive (beginning July 1 of the next plan year) for completing a Health Assessment Questionnaire, biometric screening, and certain action programs each Spring. Plus, NVision offers a broad range of educational materials such as health and wellness webinars, a comprehensive medical library with reliable resources about nutrition, healthy living, medical tests and procedures, and wellness activities. NVision's online program is confidential and your personal information will never be shared with PEBP.

To learn more about the NVision Health & Wellness Program visit <http://nvision.pebp.state.nv.us/> or call U.S. Preventive Medicine at 877-800-8144.

Health Plan of Nevada (HPN) Southern Nevada HMO Plan

Category	Member Responsibility
Deductible	No Deductible
Out-of-Pocket Maximum	\$6,800 per person per calendar year
Primary Care Visit	\$15 Copayment per visit
Specialist Visit	\$15 Copayment per visit
Urgent Care Facility	\$15 Copayment per visit
Emergency Services <ul style="list-style-type: none"> • Emergency Room • Hospital Admission • Ground Ambulance 	<ul style="list-style-type: none"> • \$75 Copayment per visit • \$200 per admission • No charge
Hospital Services—Elective Procedures	
Inpatient Hospital Outpatient	\$200 Copayment per admission \$50 Copayment per admission
Physician Surgical Services	
Inpatient Hospital Outpatient Physician’s Office (in addition to office visit copayment) <ul style="list-style-type: none"> • Primary Care Physician • Specialist • Anesthesia 	No charge No charge No charge \$15 per visit No charge
Wellness Services	
Preventative Health Services	No charge
Retail Prescription Drug Benefit - Up to a 30 Day Therapeutic Supply	
Tier I: Preferred Generic Covered Drug Tier II: Preferred Brand Name Covered Drug* Tier III: Non-Preferred Generic /Brand Name Covered Drug*	\$7 Copayment \$35 Copayment \$55 Copayment
Mail Order Plan Pharmacy	
Preferred Maintenance Covered Drugs	The Member pays two (2) of the applicable copayments as outlined above for up to a 90-day Maintenance Supply for Preferred Maintenance Covered Drugs.

* If a Generic Covered Drug equivalent is available, Member pays the Tier I Covered Drug copayment plus the difference between the eligible medical expenses (EME) of the Generic Covered Drug and the EME of the Brand Name Covered Drug to the Plan Pharmacy for each Therapeutic supply. For more information regarding HPN’s Prescription Drug benefit, contact HPN at 702-242-7300 or 800-777-1840.

Health Plan of Nevada (HPN) Southern Nevada HMO Plan

Vision Benefit

Covered Services

Member Pays

<p>Examination</p> <p>One vision examination by a Plan Provider to include complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities will be provided each 12 consecutive calendar month period.</p>	<p>\$10 Copayment</p>
<p>Lenses</p> <p>One pair of Lenses will be provided during any 12 consecutive calendar month period, without charge, if a prescription change is determined to be Medically Necessary by a Plan Provider. Lenses are limited to plastic lenses, including single vision, bifocal, trifocal, lenticular and other complex Lenses.</p>	<p>\$10 Copayment</p>
<p>Frames</p> <p>One pair of Frames will be provided during any 24 consecutive calendar month period from an approved frame selection. Charges for Frames in excess of the maximum allowance shall be the responsibility of the Member. Discounts may be available through the Plan Provider for those charges in excess of the maximum allowance.</p>	<p>All charges over \$100 maximum allowance</p>
<p>Medically Necessary Contact Lenses</p> <p>One pair of Contact Lenses will be provided during any 12 consecutive calendar month period when visual acuity cannot be corrected to 20/70 in the better eye except for the use of Contact Lenses. Contact Lenses are limited to single vision spherical Lenses. Discounts may be available through the Plan Provider for those charges in excess of the maximum allowance.</p>	<p>All charges over \$250 maximum allowance</p>
<p>Elective Contact Lenses</p> <p>One pair of Contact Lenses will be provided in any 12 consecutive month period in lieu of all other benefits except the annual vision examination (as described above).</p>	<p>All charges over \$115 maximum allowance</p>

Health Plan of Nevada (HPN) Southern Nevada HMO Plan



The Health Plan of Nevada (HPN) service area includes Clark, Esmeralda and Nye Counties. Health Plan of Nevada allows participants to access dependable care at fixed copayments. HPN offers a wide selection of physicians, hospitals, pharmacies and other health care providers.

Important Plan Information

HPN requires that you select a primary care physician (PCP) at initial enrollment. The employee (primary member) and each covered dependent may select a different PCP. A female member may select two (2) PCP's: A general practice Physician and an Obstetrician or Gynecological Physician.

To select a primary care physician, or to review *HPN's Evidence of Coverage*, visit the PEBP website at www.pebp.state.nv.us, or contact HPN at (702) 242-7300 or (800) 777-1840.

Services Requiring Prior-Authorization

All covered services not provided by the PCP require Prior Authorization from the PCP and HPN's Managed Care Program. The following Covered Services require Prior Authorization and Review through HPN's Managed Care Program:

- Non-emergency inpatient admissions and extensions of stay in a hospital, skilled nursing facility, or hospice
- Outpatient surgery provided in any setting, including technical and professional services
- Diagnostic and therapeutic services
- Home healthcare services
- Mental health, severe mental illness, and substance abuse services
- All specialist visits or consultations
- Prosthetic devices, orthotic devices, and durable medical equipment
- Courses of treatment, including allergy testing or treatment (e.g., skin, RAST); angioplasty; home health care services; physiotherapy or manual manipulation; rehabilitation therapy (physical, speech, occupational)

Vision - Eye Med Vision Care

Benefits are only available through participating providers who have agreed to provide services to Health Plan of Nevada members. For a complete list of providers, hours, and locations, contact EyeMed Vision Care at 877-226-1115. For a summary of vision benefits available through HPN, turn to page 26.

Health Plan of Nevada (HPN) Southern Nevada HMO Plan



HPN Pharmacy Benefits

Health Plan of Nevada provides you with access to a wide range of effective and affordable prescription medications. You can view the Preferred Drug Benefit Guide at <http://stateofnv.healthplanofnevada.com>. The list is periodically updated and includes covered generic and brand name medications which are available at plan pharmacies for your specific plan copayment. Health Plan of Nevada's generic substitution policy requires your pharmacist to dispense generic drugs when available, unless otherwise directed by your provider. Generic drugs are effective equivalents of their brand name counterparts. However, if a brand name drug is dispensed when a generic equivalent is available, you will pay the generic copayment plus the difference between the generic and brand name contracted cost. Please refer to the Health Plan of Nevada Prescription Drug Benefit Rider at <http://stateofnv.healthplanofnevada.com> for specific details.

Mail Order Pharmacy Program

Preferred maintenance medications may be obtained through HPN's contracted mail order pharmacy, Medco By Mail (maintenance medications are used to treat a chronic illness or life threatening long-term condition such as asthma, diabetes, high blood pressure, arthritis or cardiovascular disease). For the drug to be available through the mail order pharmacy it must be on the Health Plan of Nevada's (HPN) Preferred Drug List AND be considered maintenance by HPN. For mail order inquiries, call 877-417-0536.

Health Education and Wellness (HEW)

HPN's Health Education and Wellness (HEW) offers health education in a face-to-face setting and on the internet. **MyHEWOnline** programs include: Diabetes, Heart Health, Pregnancy, Preventive Healthcare, Stop Smoking, and Weight Management. Another feature of **MyHEWOnline** is the Health Risk Assessment (HRA). The HRA is your first step to better health. It is designed to help you identify your health and lifestyle profile. After completing the questionnaire, you will receive a personalized profile with recommendations to help improve your overall health. To learn more about HPN's Education and Wellness (HEW) program visit: <http://www.stateofnvhpnbenefits.com/>



Health Plan of Nevada (HPN) Southern Nevada HMO Plan



We're At Your Service

Health Plan of Nevada offers members 24-hour access to an online member center, We're At Your Service. This service is easy to use and allows you to obtain information about your benefits, claims and more, such as:

- Verify your prescription drug coverage
- Locate participating pharmacies
- Ask a pharmacist questions anytime, day or night
- Inquire on the status of a claim
- Verify the name of your Primary Care Physician
- Change your address (address must also be changed with PEBP)
- Request a new ID card



HMO Reciprocity

Participants enrolled in Health Plan of Nevada are eligible for expanded statewide provider access. HPN and Hometown Health Plan (Northern Nevada HMO Plan) have a special network reciprocity agreement that allows HMO members to utilize both networks under certain circumstances. Reciprocity applies when traveling to/from northern/southern Nevada, and for dependents who are away at school in either the northern or southern part of the state. Expanded access is based on the primary participant's designated HMO plan provisions. HPN's pre-authorization requirements and referral guidelines still apply as described in the HPN Evidence of Coverage Certificate.

NVision Health & Wellness Program

The NVision Health & Wellness Program is offered to all CDHP and HMO participants. This program is a multi-year approach to improving or maintaining the health and wellness of our members. Over the four period you will educate yourself, get active, eat right and see results. Primary participants can earn a premium incentive (beginning July 1 of the next plan year) for completing a Health Assessment Questionnaire, biometric screening, and certain action programs each Spring. Plus, NVision offers a broad range of educational materials such as health and wellness webinars, a comprehensive medical library with reliable resources about nutrition, healthy living, medical tests and procedures, and wellness activities. NVision's online program is confidential and your personal information will never be shared with PEBP.

To learn more about the NVision Health & Wellness Program visit www.pebp.state.nv.us or call U.S. Preventive Medicine at 877-800-8144.

Dental Plan

All PPO and HMO Eligible Participants

Benefit Category	In-Network	Out-of-Network
Individual Plan Year Maximum	\$1,000 per person	\$1,000 per person
Plan Year Deductible (applies to Basic and Major services only)	\$100 per person or \$300 per family (3 or more)	\$100 per person or \$300 per family (3 or more)
Preventive Services Four cleanings/plan year, exams, bitewing X-rays (2/plan year) Preventive Services are not subject to the \$1,000 Individual Plan Year Maximum	100% of allowable fee schedule, no deductible	80% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the plan will reimburse at the U & C
Basic Services Periodontal, fillings, extractions, root canals, full-mouth X-rays	75% of allowable fee schedule, after deductible	50% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the plan will reimburse at the U & C
Major Services Bridges, crowns, dentures, tooth implants	50% of allowable fee schedule, after deductible	50% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the plan will reimburse at the U & C

- **Family Deductible: Could be met by any combination of eligible dental expenses of three or more members of the same family coverage tier.** No one single family member would be required to contribute more than the equivalent of the individual deductible toward the family deductible. Both in-network and out-of-network deductibles are combined to meet your deductible each plan year.
- **Under no circumstances will the combination of PPO and Non-PPO benefit payments exceed the plan year maximum benefit \$1,000**

Group Basic Life and Long Term Disability Insurance Included with all plan options

Benefit Description	Benefit Features All Eligible Participants
Group Basic Life Insurance	<p>Employees enrolled in a PEBP-sponsored medical plan receive \$10,000 Basic Life Insurance coverage. Refer to the Life Insurance Certificate at http://www.standard.com/mybenefits/nevada/life_add.html for more information about this benefit.</p> <p>The Accelerated Benefit for Basic Life is available under certain circumstances. To exercise this option, or to learn more, contact The Standard at 888-288-1270.</p>
Beneficiary Financial Counseling	<p>The beneficiary of a deceased active employee may be eligible to receive comprehensive and objective financial counseling through an arrangement with PricewaterhouseCoopers. Services include a beneficiary guide about settling an estate and other important topics, personal financial counseling, financial analysis, 12 months of unlimited toll-free telephone access to financial counselors, a financial web site and newsletter "Your Money, Your Future." See the Beneficiary Counseling Brochure at http://www.standard.com/mybenefits/nevada/life_add.html#ben for more information.</p>
Medex Travel Assist	<p>Medex Travel Assist is designed to respond to most medical care situations and many other emergencies you and your family experience when you travel 100 miles or more from your home. Medex provides a wide range of information, referral, coordination, and assistance services. These services include pre-trip assistance, medical assistance, emergency transportation, travel and technical assistance, legal services, and medical supplies. Assistance is available 24 hours a day, 365 days a year whether you are 100 or 10,000 miles away from home. Simply print and carry the Medex Travel Assist Card available at http://www.standard.com/mybenefits/nevada/life_add.html#ben</p>
Long Term Disability (LTD) Insurance	<p>Long Term Disability Insurance is designed to help protect you against a loss of income in the event you become disabled and are unable to work for an extended period of time. If your LTD claim is approved, benefits become payable at the end of the 180-day Benefit Waiting Period (no benefits are paid during the Benefit Waiting Period). The monthly LTD benefit is based on your earnings from the State of Nevada or participating public agency. Your monthly LTD benefit is 60 percent of the first \$12,500 of your monthly earnings, as defined by the group insurance policy, reduced by deductible income. For more information about the LTD benefit, see the LTD Certificate of Insurance at http://www.standard.com/mybenefits/nevada/ltd.html.</p>

Group Life Insurance Portability and Conversion Options

Benefit Description	Benefit Features All Eligible Participants
Portability of Life Insurance	<p>You may be eligible to buy portable Group Life Insurance if your employment terminates. Important! You must apply in writing and pay the first premium to the Standard within 31 days after the date your employment terminates.</p> <p>To be eligible, you must meet the following requirements:</p> <ul style="list-style-type: none"> • You must have been continuously insured under your employer’s Group Life Insurance plan for at least 12 consecutive months on the date your employment terminates. • You must be able to perform with reasonable continuity the material duties of at least one gainful occupation for which you are reasonably fitted by education, training and experience on the date your employment terminates. • You must be under age 65 on the date your employment terminates. <p>For information regarding Portability of Group Life Insurance, refer to the Group Life Insurance Certificate available at http://www.standard.com/mybenefits/nevada/ or contact The Standard Insurance Company at 888-288-1270.</p>
Conversion of Group Life Insurance	<p>A conversion right is the right given to an insured person under a group life insurance plan to convert coverage (without evidence of insurability) to an Individual Policy upon termination of the group coverage. To convert coverage, the insured person must apply for conversion by obtaining, completing and returning a conversion application to The Standard Insurance Company within 31 days after the date of employment termination, or the date the insured person and/or his dependents are no longer eligible to participate in group life insurance coverage.</p> <p>For information regarding Conversion of Group Life Insurance, refer to the Group Life Insurance Certificate available at http://www.standard.com/mybenefits/nevada/ or contact The Standard Insurance Company at 888-288-1270.</p>

State Active Rates

Effective July 1, 2012 - June 30, 2013

State Active Employees	Statewide PPO	Statewide HMO
	Consumer Driven Health Plan	Hometown Health Plan and Health Plan of Nevada
	Participant Premium	Participant Premium
Employee Only	44.93	134.75
Employee + Spouse	206.96	391.99
Employee + Child(ren)	96.31	246.59
Employee + Family	258.34	503.83

State Active with <i>Domestic Partner</i> Rates	Statewide PPO		
	Consumer Driven Health Plan		
	Participant Premium	Pre-Tax Deduction	Post-Tax Deduction
Employee + DP	206.96	44.93	162.03
Employee + DP's Child(ren)	96.31	44.93	51.38
Employee + Children of both	96.31	96.31	-
Employee + DP + EE's Child(ren)	258.34	96.31	162.04
Employee + DP + DP's Child(ren)	258.34	44.93	213.42
Employee + DP + Children of both	258.34	96.31	162.04

State Active with <i>Domestic Partner</i> Rates	Statewide HMO		
	Hometown Health Plan <u>and</u> Health Plan of Nevada		
	Participant Premium	Pre-Tax Deduction	Post-Tax Deduction
Employee + DP	391.99	134.75	257.24
Employee + DP's Child(ren)	246.59	134.75	111.84
Employee + Children of both	246.59	246.59	-
Employee + DP + EE's Child(ren)	503.83	246.59	257.24
Employee + DP + DP's Child(ren)	503.83	134.75	369.08
Employee + DP + Children of both	503.83	246.59	257.24

Non-State Active Rates
Effective July 1, 2012 - June 30, 2013

Non-State Active Employee Rates	Statewide PPO	Statewide HMO
	Consumer Driven Health Plan	Hometown Health Plan and Health Plan of Nevada
	Participant Premium	Participant Premium
Employee Only	846.62	623.98
Employee + Spouse	1,651.57	1,247.96
Employee + Child(ren)	1,229.01	930.55
Employee + Family	2,033.96	1,554.53

COBRA Rates
State and Non-State Employee

	Statewide PPO	Statewide HMO
	Consumer Driven Health Plan	Hometown Health Plan & Health Plan of Nevada
State Employee		
Participant	654.62	624.73
Participant + Spouse/DP	1,266.75	1,249.46
Participant + Child(ren)	848.74	896.35
Participant + Family	1,460.86	1,521.08
Spouse/DP Only	654.62	624.73
Spouse/DP + Child(ren)	848.74	896.35
Non-State Employee		
Participant	863.55	636.46
Participant + Spouse/DP	1,684.60	1,272.92
Participant + Child(ren)	1,253.59	949.16
Participant + Family	2,074.64	1,585.62
Spouse/DP Only	863.55	636.46
Spouse/DP + Child(ren)	1,253.59	949.16

-- COBRA participants do not qualify for Life Insurance and Long Term Disability.
-- Participants on Regular COBRA do not receive a subsidy.

Completing the Employee Benefit Enrollment and Change Form (E-BECF)

Employees without access to the Internet can call the PEBP office at 775-684-7000 or 800-326-5496 to request the Employee Benefit Enrollment and Change Form (E-BECF)

Section 1: Select your employee category, e.g., New Hire, Rehire or Reinstatement
Date of Event: Enter the effective date of your coverage

Section 2: Enter Participant information

Section 3: Select your health plan, e.g., Consumer Driven Health Plan, Hometown Health Plan or Health Plan of Nevada.

If declining coverage, place a check-mark in the Decline/waive coverage box.

Note: By declining coverage, you lose your eligibility for all PEBP medical benefits, including Basic Life and Long-Term Disability Insurance.

Section 4: HMO plans only: Enter the Primary Care Physician Code (to locate the PCP code, visit www.pebp.state.nv.us, select Plan Contacts, then select the applicable HMO plan).

Section 5: Choose your coverage tier

- Participant Only
- Participant + Spouse
- Participant + Participant's Child(ren)
- Participant + Family (employee, spouse and children)
- Participant + Domestic Partner (DP)
- Participant + DP's Child(ren)
- Participant + DP + Participant's Child(ren) + DP's Child(ren)
- Participant + Participant's Child(ren) + DP's Child(ren)
- Participant + DP + DP's Child(ren)
- Participant + DP + Participant's Child(ren)

Section 6: Enter the information for any dependents you are adding. Refer to page 4 for supporting documentation requirements.

Section 7: Read, sign and date the form using black or blue ink

Return the completed E-BECF and copies of supporting document(s) to:

Public Employees' Benefits Program

901 South Stewart Street, Suite 1001

Carson City, NV 89701

Copies and facsimiles of forms will not be accepted

Group Basic Life Insurance Beneficiary Designation



The enclosed Beneficiary Designation and Change Form is required for all *enrolled* PEBP participants. This designation applies to Basic Life and Voluntary Life (if purchased separately) insurance under the Group Insurance Policy. Designations are not valid unless signed, dated, and delivered to Standard Insurance Company during your lifetime.

Note: This beneficiary designation form is separate from the survivor's beneficiary designation form available from the Public Employees' Retirement System (PERS).

Mail completed Beneficiary Designation and Change Forms to:

State of Nevada Life Insurance Team
Mestmaker Insurance Services
P.O. Box 2302
Bakersfield, CA 93303-2302

Beneficiary Information

- Your designation revokes all prior designations (applies to Reinstated or Rehired employees who previously submitted a designation).
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).

Designating Beneficiaries:

- Two or more surviving beneficiaries will share equally, unless divided into unequal shares.
- If you provide for unequal shares in a class, and two or more beneficiaries in that class survive, The Standard will pay each surviving beneficiary his or her designated share. Unless you provide otherwise, The Standard will then pay the share(s) otherwise due to any deceased beneficiary(ies) to the surviving beneficiary(ies) pro-rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving beneficiaries.
- If only one beneficiary in a class survives, The Standard will pay the total death benefit to that beneficiary.
- If a minor (a person not of legal age), or your estate, is the beneficiary, it may be necessary to have a guardian or legal representative appointed by the court before any death benefit can be paid. If the beneficiary is a trust or trustee, the written trust must be identified in the beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated xx-xx-xx."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a beneficiary designation. If you have questions, consult your legal advisor.

Voluntary Flexible Spending Accounts (FSA) For State Active Employees Only



The Medical FSA is a tax-free account that allows you to pay for essential health care expenses that are not covered, or are partially covered, by your medical, pharmacy, dental and vision insurance plans. By contributing a portion of your payroll dollars into your FSA on a pre-tax basis, you can save on the cost of eligible expenses you are already incurring.

When you enroll in an FSA, you decide how much to contribute to each account for the remaining months in the plan year which ends on June 30th). The amount you elect to contribute is then deducted from your second monthly paycheck, pre-tax (before Federal & State income taxes and FICA taxes are deducted) in equal amounts over the course of the months remaining in the plan year. After you incur expenses that qualify for reimbursement, you submit reimbursement requests (claims) to ASIFlex to request tax-free withdrawals from your Medical FSA.

The Medical FSA allows you to contribute up to \$2,500 for this FSA plan year (July 1, 2012 through June 30, 2013). Your election amount is typically fixed for the entire plan year (unless you have a qualifying event).

- Any funds you are unable to submit valid claims for at the end of the claims run out period (September 15th) will be forfeited, so estimate your expenses carefully and set money aside accordingly.
- Expenses for any of your tax dependents are eligible for reimbursement even if they are not covered on your health plan.

Who is eligible for the Medical Flexible Spending Account (FSA)?

If you are employed by a state agency and receive your paycheck through Central Payroll (generally, if you have access to NEATS), see the PEBP Flexible Spending Account Summary Plan Description available at www.pebp.state.nv.us for more details. Otherwise, contact your employer's human resources department.

IMPORTANT!

Employees who contribute to an HSA **cannot** contribute to a Medical FSA, but may be eligible to contribute to a Limited Use or Limited Scope FSA. A Limited Scope FSA can only be used to pay for dental or vision expenses. For more information regarding the Limited Scope FSA, contact ASIFlex at 800-659-3035.

Domestic Partner Eligibility

The expenses of an employee's spouse qualify for reimbursement under the Health Care FSA. However, the IRS does not recognize a qualified domestic partner for tax purposes. A domestic partner does not generally qualify for the Health Care FSA unless they qualify as a dependent under the definition of a qualifying relative. If you have questions regarding your eligibility to enroll in an FSA, please contact ASI Flex at 800- 659-3035.

Voluntary Flexible Spending Accounts (FSA) For State Active Employees Only



Dependent Care FSA

The Dependent Care FSA creates a tax break for dependent care expenses (typically child care or day care expenses) that enable you to work. Additionally, if you have an older dependent who lives with you at least 8 hours per day and requires someone to come into the house to assist with day-to-day living, you can claim these expenses through your Dependent Care FSA. If you are married, your spouse must be working, looking for work or be a full-time student. If you have a stay-at-home spouse, you should not enroll in the Dependent Care FSA.

- IRS regulations disallow Dependent Care FSA reimbursement for services that have not yet been provided. You can only claim service periods that have already occurred.
- Eligible expenses include day care and baby sitting for dependents under the age of 13; or for older dependents that live with you at least 8 hours each day and are incapable of self-care.
- The IRS allows no more than \$5,000 per household (\$2,500 if you are married and file a separate tax return) be set-aside in the Dependent Care FSA in a calendar year.

To learn more about Flexible Spending Accounts, visit www.pebp.state.nv.us, www.asiflex.com or call ASIFlex at 800-659-3035.

Voluntary Life Insurance & Short-Term Disability (STD) Insurance



Voluntary Life Insurance

Once you are enrolled in a PEBP medical plan you will receive a basic amount of Life insurance to help protect your loved ones in the event of your death. Since everyone's needs are different, the State of Nevada also provides you with the opportunity to apply for Voluntary Life Insurance from Standard Insurance Company — a simple, easy way to further help protect your family. It allows you to apply for the additional coverage you need, with premiums deducted directly from your paycheck.

You can purchase the following Voluntary Life, AD & D and Dependents Life Insurance at group rates. To qualify for guarantee issue, you must apply for Voluntary Life Insurance within 60 days of your coverage effective date; otherwise, you may be required to provide satisfactory proof of evidence of insurability.

Voluntary Life and Accidental Death and Dismemberment (AD & D) Insurance

Employees	Any multiple of \$10,000 to a maximum of \$500,000
Spouses/Domestic Partners	Any multiple of \$10,000 to a maximum of \$250,000
Child(ren)	Any multiple of \$2,500 to a maximum of \$10,000

Voluntary Short Term Disability (STD)

Short Term Disability (STD) Insurance is designed to pay a weekly benefit to you in the event you cannot work because of a covered illness or injury. If you enroll when first eligible, and your STD claim is approved by The Standard, STD benefits become payable at the end of the elected Benefit Waiting Period for disabilities caused by accidents, physical disease, pregnancy or mental disorder.

If you do not apply for Voluntary STD coverage when you are initially eligible, then during the first year you are insured under the Voluntary STD plan, the Benefit Waiting Period will be 60 days from the date of your disability. This is called Late Enrollment Penalty. Late Enrollment Penalty does not apply to a disability resulting from an accidental injury.

Benefit Waiting Period Option	Weekly STD Benefit
Option A - 7 days	60% of the first \$2,500 of your weekly earnings (as defined in the group insurance policy), reduced by deductible income. The maximum STD benefit is \$1,500 per week.
Option B - 14 days	
Option C - 30 days	

It's easy to enroll for Voluntary Life and STD Insurance coverage, simply complete the form available for download at http://www.standard.com/mybenefits/nevada/vol_std.html and mail to the address indicated on the form. For more information about these voluntary coverage options, contact The Standard at 888-288-1270.

Voluntary Auto, Home, RV and Renters Insurance and Long-Term Care Insurance

Employees have the option of purchasing a variety of insurance products, such as auto, home, renters, condo, boat, RV, etc., at special group discounts. Both carriers offer convenient payment options, such as automatic deductions from your checking account, payroll deduction and online payments. To receive an insurance quote or for additional information, contact the carrier directly.



Liberty Mutual
800-637-7026

Travelers' Insurance
888-695-4640



Long-term Care Insurance Offered By UNUM Provident

Long term care is the assistance received when someone needs help with two or more Activities of Daily Living such as dressing, bathing, going to the bathroom, eating or moving about or when someone suffers a severe cognitive impairment. This care could be provided in the home, in an assisted living or residential care facility, or in a skilled nursing facility such as a nursing home.

As a new eligible employee you have 30 days to sign up for Guarantee Issue coverage once your PEBP coverage becomes effective. If you wait to enroll after 30 days following your medical plan coverage effective date, or if you choose benefits over the Guarantee Issue limits, you will be required to complete a medical questionnaire.

All Family Members must complete the Benefit Election form, the Long-Term Care Insurance application (medical questionnaire) and must be approved for coverage in order to enroll.

For questions regarding the Voluntary Long Term Care plan, please call UNUM Provident at 800-227-4165.



Benefit Duration	3 Years	6 Years	Unlimited Duration
Facility Benefit Amount In Increments of \$1,000	\$1,000 to \$8,000	\$1,000 to \$8,000	\$1,000 to \$8,000
Assisted Living Facility Percent	60%	60%	60%
Lifetime maximum Per \$1,000 Increments	\$36,000	\$72,000	Unlimited
Professional Home Care	50%	50%	50%
Total Home Care Option	50%	50%	50%
Inflation Protection Option	Simple Capped	Simple Capped	Simple Capped

Important Information About Your Coverage

Dual PEBP Coverage Not Permitted

PEBP participants (employees and/or their dependents) are not permitted to be covered under two PEBP accounts. If a dependent becomes eligible for coverage as a primary insured, that individual must select primary coverage and be deleted from PEBP coverage as a dependent.

Moving Outside the Plan's Coverage Area

HMO participants who move outside of their designated HMO plan's coverage area may select a new medical plan to coincide with their new coverage area. To change medical plans, the participant must complete the Employee Benefit Enrollment and Change Form. The effective date of the change will be the first day of the month following the date of the move. If the move occurs on the first day of the month, the change will be effective on that day.

Open Enrollment

The annual Open Enrollment period provides employees the opportunity to change existing medical plan elections, e.g., from/to PPO/HMO plan and/or add new or delete existing covered dependents. Changes made during Open Enrollment become effective on the first day of the new plan year. The Open Enrollment period is held annually in May with the new plan year beginning on July 1. Open Enrollment announcements are mailed to employees' homes approximately 2 - 3 weeks before the scheduled Open Enrollment period.

Pre-Existing Conditions

Pre-existing conditions do not apply to employees and/or to covered dependents.

Family Medical Leave of Absence

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 working for a participating local government will need to contact their Human Resources office for FMLA eligibility.

Important Information About Your Coverage

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 affect prior to taking that leave.

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

- Employees on active military service (for up to 31 days) may elect to continue health care coverage during that leave period by paying any premium contributions due for that coverage while on leave.
- If the employee goes into active military service for 31 days or more, the employee is eligible to enroll him/herself and family in health care coverage provided by the military the day the employee is activated for military duty. The employee is also eligible to purchase continued health coverage for him/herself and their family 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.

Workers' Compensation Leave

Employee health care coverage during a period of Workers' Compensation leave will automatically be continued for a period of up to 9 months. The employee may continue coverage for employee and dependents by paying premiums directly to PEBP. At the end of the 9-month period during which the employer has contributed to the employer's cost share for health care coverage during that leave period, the employer's portion of the payments for such coverage will cease, and the employee is now required to make the full payment for health care coverage for themselves and their dependents. When the employee returns to work, insurance coverage will be reinstated exactly the way it was before the employee was placed on Workers' Compensation leave.

It is the employee's responsibility to inform the participating public agency (employer) whether or not they want to continue coverage for themselves and/or their dependents at the *initial start* of a leave. If the employee fails to inform the participating public agency (employer) of their intent to continue coverage for themselves and their dependents covered under the plan before taking the leave, the participating public agency shall inform PEBP to continue coverage for the employee and their covered dependents (if applicable) in the same coverage/tier that the employee had in place before taking the leave.

Public Employees' Benefits Program

901 S. Stewart Street, Suite 1001

Carson City, NV 89701

Initial COBRA Notification

To Covered Participant, Covered Spouse/Domestic Partner, and all Covered Dependents

It is important that all covered individuals (employee, spouse/domestic partner and eligible dependent children) take the time to read this notice carefully and be familiar with its contents. If there is a covered dependent whose legal address is not yours, please provide written notification with the attached COBRA Address Notification Form to PEBP so a notice can be sent to them as well.

Under the federal Consolidated Omnibus Reconciliation Act (COBRA) laws, PEBP is required to offer covered employees and covered family members the opportunity for a temporary extension of health coverage (called "Continuation Coverage") at group rates when coverage under the health plan (a medical and/or dental plan) would otherwise end due to certain qualifying events. This notice is intended to inform you (and your covered dependents), in a summary fashion, of your potential future options and obligations under the continuation coverage provisions of the COBRA law. Should an actual qualifying event occur in the future, PEBP will send you additional information. Please take special note of your notification obligations which are detailed on the next page.

Qualifying Events for a Covered Employee – If you are the covered employee, you may have the right to elect health plan continuation coverage if you lose your Public Employees' Benefits Program (PEBP) group health coverage because of a termination of your employment (for reasons other than gross misconduct on your part) or reduction in your hours of employment.

Qualifying Events for a covered spouse/domestic partner– If you are the covered spouse/domestic partner of an employee, you may have the right to elect health plan continuation coverage for yourself if you lose your PEBP group health coverage because of any of the following reasons:

- A termination of your spouse/domestic partner's employment (for reasons other than gross misconduct) or reduction in your spouse/domestic partner's hours of employment;
- The death of your spouse/domestic partner;
- Divorce;
- Your spouse/domestic partner becomes entitled to Medicare.

Qualifying Events For Covered Dependent Children – If you are the covered dependent child of an employee, you may have the right to elect health plan continuation coverage for yourself if you lose your PEBP group health coverage because of any of the following reasons:

Initial COBRA Notification

- A termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment;
- The death of the employee;
- Parents divorce;
- The employee becomes entitled to Medicare;
- You cease to be a "dependent child" under the terms of the health plan.

Important Employee, Spouse/Domestic Partner and Dependent Notifications Required.

Under the law, the employee, spouse/domestic partner, or other family member has the responsibility to notify PEBP of a divorce or a child losing dependent status while covered by a group health plan. This notification must be made within 60 days from the date of the event or the date on which health plan coverage would be lost under the terms of the insurance contract because of the event whichever date is later. The notification may be made through your Agency Representative who has the necessary form; if this is not possible, you may notify PEBP **in writing**, including the following information: the name and address of the covered employee, the name and address of the covered dependent(s), documentation must accompany the notification, such as a HIPAA certificate from another employer, or a copy of a divorce decree.

If this notification is not completed according to the above procedures and within the required 60-day notification period, then rights to continuation coverage will be forfeited. Please familiarize yourself with the dependent eligibility rules contained in the Master Plan Document. PEBP will notify the PEBP-sponsored health plan of the employee's termination of employment, reduction in hours, or death.

Election Period and Coverage. Once PEBP has received notice that a qualifying event has occurred, PEBP will then notify covered individuals (also known as qualified beneficiaries) of their rights to elect continuation coverage. Each qualified beneficiary has independent COBRA election rights and will have 60 days to elect continuation coverage. The 60 day election window is measured from the date health plan coverage is lost due to the event or from the date of COBRA notification whichever is later. **This is the maximum period allowed to elect COBRA as the plan does not provide an extension of the election period beyond what is required by law.** If a qualified Beneficiary does not elect continuation coverage within this election period, then rights to continue health insurance will end and they cease to be a qualified beneficiary.

If a qualified beneficiary elects continuation coverage, they will be required to pay the entire cost for the medical and/or dental insurance, plus a 2% administration fee. PEBP is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the plan to similarly situated non-COBRA participants and/or covered dependents. Should coverage change or be modified for non-COBRA participants, then the change and/or modification will be made to your coverage as well.

Length of Continuation Coverage – 18 months. If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in hours, then each qualified beneficiary will have the opportunity to continue coverage for 18 months from the date of the qualifying event.

Initial COBRA Notification

Social Security Disability. The 18 months of continuation coverage can be extended for an additional 11 months of coverage, to a maximum of 29 months, for all qualified beneficiaries if the Social Security Administration determines a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act on the date of the qualifying event or at any time during the first 60 days of continuation coverage. It is the qualified beneficiary's responsibility to obtain this disability determination from the Social Security Administration and provide a copy of the determination to PEBP within 60 days after the date of determination and before the original 18 months expire.

This extension applies separately to each qualified beneficiary. If the disabled qualified beneficiary chooses not to continue coverage, all other qualified beneficiaries are still eligible for the extension. If coverage is extended, and the disabled qualified beneficiary has elected the extension, then the applicable premium rate is 150% of the premium rate. If only the non-disabled qualified beneficiaries extend coverage, the premium rate will remain at 102% level. It is also the qualified beneficiary's responsibility to notify PEBP within 30 days if a final determination has been made that they are no longer disabled.

Secondary Events. Another extension of the 18 month continuation period can occur, if during the 18 months of continuation coverage, a second event takes place (divorce, death, Medicare entitlement, or a dependent child ceasing to be a dependent). If a second event occurs, then the original 18 months of continuation coverage can be extended to 36 months from the date of the original qualifying event date for the eligible dependent qualified beneficiaries. If a second event occurs, it is the qualified beneficiary's responsibility to notify PEBP in writing within 60 days of the second event and within the original 18 month COBRA timeline. In no event, however, will continuation coverage last beyond three years from the date of the event that originally made the qualified beneficiary eligible for continuation coverage. A reduction in hours followed by a termination of employment is not considered a second event for COBRA purposes.

Length of Continuation Coverage – 36 months. If the original event causing the loss of coverage was the death of the employee, divorce, Medicare entitlement, or a dependent child ceasing to be a dependent child under a PEBP sponsored group health plan, then each qualified beneficiary will have the opportunity to continue coverage for a total of 36 months from the date of the qualifying event.

Eligibility, Premiums, and Potential Conversion Rights. A qualified beneficiary does not have to show they are insurable to elect continuation coverage; however, they must have been actually covered by the plan to be eligible for COBRA continuation coverage. An exception to this rule is if while on continuation coverage a baby is born or adopted by a covered employee qualified beneficiary. If this occurs, the newborn or adopted child can be added to the plan and will gain the rights of all other qualified beneficiaries. The COBRA timeline for the newborn or adopted child is measured from the date of birth or date of adoption. Please contact PEBP for the procedures and timelines for adding these individuals to your coverage. PEBP reserves the right to verify COBRA eligibility status and terminate continuation coverage retroactively if you are determined to be ineligible or if there has been a material misrepresentation of facts.

Initial COBRA Notification

A qualified beneficiary will have to pay all of the applicable premium plus a 2% administration charge for continuation coverage. These premiums will be adjusted in the future if the applicable premium amount changes. In addition, there will be a maximum grace period of 30 days for the regularly scheduled monthly premiums. There is no option with your plan to enroll in an individual conversion health plan at the end of the 18 months or three years of continuation coverage.

Cancellation of Continuation Coverage. The law provides COBRA continuation coverage will end prior to the maximum continuation period for any of the following reasons:

- PEBP ceases to provide any group health plan to any of its participants;
- Any required premium for continuation coverage is not paid in a timely manner;
- After the date of COBRA election, a qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to pre-existing condition of such beneficiary other than such an exclusion or limitation which does not apply to or is satisfied by such beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996;
- After the date of the COBRA election, a qualified beneficiary becomes entitled to Medicare;
- A qualified beneficiary extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled;
- A qualified beneficiary notifies PEBP that they wish to cancel COBRA continuation coverage;
- For cause, on the same basis that the plan terminates the coverage of similarly situated non-COBRA participants.

Notification of Address Change - To ensure all covered individuals receive information in a timely manner, it is important you promptly notify PEBP of any address change as soon as possible. Failure on your part to do so will result in delayed COBRA notifications or a loss of continuation coverage options.

If you are a covered individual and do not understand the information in this summary notice, the Plan Year 2013 Master Plan Document can supply more information concerning your obligations. Please contact PEBP Member Services at 775-684-7000 or 800-326-5496. This document is also available on the PEBP website at www.pebp.state.nv.us.

Public Employees' Benefits Program

901 S. Stewart Street, Suite 1001
Carson City, NV 89701

COBRA ADDRESS NOTIFICATION FORM

If you have a dependent who is covered by PEBP and whose legal residence is not yours (dependent child covered by court order, living with an ex-spouse/domestic partner, etc.) you are required to provide us with the proper address so an initial COBRA notice can be sent to them as well. This does NOT include a dependent child whose legal residence is still yours, but is away at school. Should you have any questions, please call PEBP Member Services at 775-684-7000 or 800-326-5496.

This information must be provided to PEBP upon commencement of coverage:

1. COVERED DEPENDENT ADDRESS INFORMATION

Name of covered dependent: _____

Name of Guardian, ex-spouse/domestic partner,
etc.: _____

Street Address: _____

City: _____ State: _____ Zip: _____

2. COVERED DEPENDENT ADDRESS INFORMATION

Name of covered dependent: _____

Name of Guardian, ex-spouse/domestic partner,
etc.: _____

Street Address: _____

City: _____ State: _____ Zip: _____

3. COVERED DEPENDENT ADDRESS INFORMATION

Name of covered dependent: _____

Name of Guardian, ex-spouse/domestic partner, etc.: _____

Street Address: _____

City: _____ State: _____ Zip: _____

CDHP Vendor Contact List

Medical, Dental and Pharmacy Contacts

<p>CDHP Medical and PPO Dental Claims Administrator</p> <ul style="list-style-type: none"> • Claim status inquiries • Plan benefit information • HSA/PPO-HRA Administration • Network Providers • ID cards 	<p>HealthSCOPE Benefits P.O. Box 91603 Lubbock, TX 79490-1603 Customer Service: 888-7NEVADA 888-763-8232 Group Number: NVPEB www.healthscopebenefits.com</p>
<p>In-State PPO Medical Network</p> <ul style="list-style-type: none"> • Network Providers • Provider directory • Additions/deletions of providers 	<p>PEBP Statewide PPO Network Administered by Hometown Health Partners and Sierra Healthcare Options Customer Service: (800) 336-0123 www.pebp.state.nv.us</p>
<p>National Provider Network</p> <ul style="list-style-type: none"> • For participants accessing healthcare outside Nevada 	<p>First Health Network P.O. Box 91603 Lubbock, TX 79490-1603 Customer Service: 800-226-5116 www.myfirsthealth.com</p>
<p>Dental PPO Network</p> <ul style="list-style-type: none"> • Statewide dental PPO providers • Dental provider directory 	<p>Diversified Dental Services Northern Nevada: (866) 270-8326 Southern Nevada: (800) 249-3538</p>
<p>CDHP Pharmacy Plan Administrator</p> <ul style="list-style-type: none"> • Prescription drug information • Retail network pharmacies • Prior authorization • Non-network retail claims payment • Mail order service and mail order forms 	<p>Retail Pharmacy Services Catamaran (800) 799-1012 (702)933-4521 (Las Vegas) Walgreens Mail Order (866) 845-3590 https://www.catalystrx.com/www/home.jsp</p>
<p>APS Healthcare</p> <ul style="list-style-type: none"> • Pre-certification • Case Management 	<p>APS Healthcare Pre-certification and Customer Service (888) 323-1461 www.apshealthcare.com</p>
<p>U.S. Preventive Medicine</p> <ul style="list-style-type: none"> • Live Well, Be Well Prevention Plan • Diabetes Care Management • Obesity Care Management Program 	<p>U.S. Preventive Medicine (USPM) NVision Health & Wellness Program (877) 800-8144 http://nvision.pebp.state.nv.us/</p>

HMO and Voluntary Products Vendor Contact List

<p>Northern HMO Plan</p> <ul style="list-style-type: none"> • Provider network • Provider directories • Appeals • Benefit Information • Additions/deletions of providers 	<p>Hometown Health Plan</p> <p>Customer Service: (775) 982-3232 or (800) 336-0123 http://stateofnv.hometownhealth.com or www.pebp.state.nv.us</p>
<p>Southern HMO Plan</p> <ul style="list-style-type: none"> • Provider network • Provider directories • Benefit Information/Appeals • Additions/deletions of providers 	<p>Health Plan of Nevada</p> <p>Customer Service: (702) 242-7300 (800) 777-1840 www.stateofnvhpnbenefits.com or www.pebp.state.nv.us</p>
<p>Life and AD&D Insurance</p> <ul style="list-style-type: none"> • Life insurance benefits information • Claim filing • MEDEX travel assistance • Beneficiary designation forms 	<p>Standard Insurance Company</p> <p>Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html or www.pebp.state.nv.us</p>
<p>Voluntary Product Contacts</p>	
<p>Life Insurance</p> <ul style="list-style-type: none"> • Voluntary Life Insurance • Voluntary Short-Term Disability Insurance 	<p>Standard Insurance Company</p> <p>Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html or www.pebp.state.nv.us</p>
<p>Long-Term Care Insurance</p>	<p>Colonial Life UNUM</p> <p>Customer Service: (877) 433-5334 www.pebp.state.nv.us</p>
<p>Flexible Spending</p> <ul style="list-style-type: none"> • Medical • Dependent Care <p>Enrollment forms: www.asiflex.com or www.pebp.state.nv.us</p>	<p>ASI Flex</p> <p>Customer Service: (800) 659-3035 Fax: (866) 381-9682 P.O. Box 6044, Columbia, MO 65205 www.asiflex.com</p>
<p>Home and Auto Insurance</p>	<p>Liberty Mutual</p> <p>Customer Service: (800) 637-7026 gary.bishop@libertymutual.com</p> <p>Travelers'</p> <p>Customer Service: (888) 695-4640 www.travelers.com/nevada</p>