

Public Employees' Benefits Program Introduction to Employee Benefits



Plan Year 2018

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

STATE OF NEVADA

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Plan Year 2018
July 1, 2017 - June 30, 2018

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contained herein and the *Plan Year 2018 Master Plan Document/HMO Evidence of Coverage Certificates* shall be superseded by the plans' official documents.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, \$25,000 basic life, and long-term disability insurance. In addition to these core benefits, employees enrolled in a PEBP medical plan are eligible to purchase voluntary products such as supplemental life insurance, short-term disability, long-term care and auto/homeowners' insurance. State employees may also enroll in Medical, Limited Purpose and Dependent Care Flexible Spending accounts.

The information contained herein is intended to provide a summary of the main features of the benefits available to eligible employees. For a detailed description of benefits, visit the PEBP website at www.pebp.state.nv.us.

Every effort has been made to ensure the accuracy of the information contained in this document. In the event of any discrepancies between the information in this document and the Master Plan Document or Evidence of Coverage applicable to each plan, the plan documents will govern. Should you have any questions regarding your benefits and/or eligibility contact the PEBP office at (775) 684-7000 or (800) 326-5496.

Completing Enrollment

As a new benefits-eligible employee you must enroll or decline coverage and submit any required supporting documents (if adding dependents) within 15 days after the first day of employment or no later than the last day of the month that coverage is scheduled to become effective.

Default Enrollment

Failure to enroll or decline coverage within the specified timeframe will result in your coverage being defaulted to the Consumer Driven Health Plan (CDHP) with a Health Reimbursement Arrangement (HRA) and self-only coverage. Employees enrolled in the CDHP will pay a monthly premium for that coverage.

Complete your enrollment by doing one of the following:

- **Enroll online**

Go to www.pebp.state.nv.us and click on the orange “Login” button at the top right of the webpage. After creating your User ID and Password, follow the instructions to complete your enrollment.

- **Complete the Employee Benefit Enrollment and Change Form (BECF)**

If you do not have internet access, please contact PEBP to request the Employee Benefit Enrollment and Change Form at (775) 684-7000 or (800) 326-5496. Mail the completed BECF to the following address:

Public Employees' Benefits Program

901 South Stewart Street, Suite 1001

Carson City, NV 89701

Forms must be original. No copies or facsimiles accepted.

Start of Coverage

Employees working in a full-time position for a state agency or a participating non-state agency are eligible for benefits on:

- The first day of full-time employment, if that date is the first day of the month; or
- The first day of the month immediately following the first day of full-time employment, if the date of hire is not on the first day of the month.

Professional employees of the Nevada System of Higher Education (NSHE) who have annual employment contracts are eligible for benefits on:

- The effective date of an employee's respective employment contract, if that date is on the first day of a month; or
- The first day of the month immediately following the effective date of an employee's respective employment contract, if that date is not on the first day of a month.

Examples of Enrollment Requirements

Date of Hire/ Contract Date	Coverage Effective Date	Date Enrollment Must be Completed	Date Supporting Documents Must be Submitted (if any)	Default Coverage Date
June 1st	June 1st	June 30th	June 30th	June 1st
June 2nd - 30th	July 1st	July 31st	July 31st	July 1st

Failure to Enroll When Eligible

PEBP requires eligible employees to enroll in a medical plan or decline benefits within 15 days of their hire date or no later than the last day of the month coverage is scheduled to become effective. Employees who fail to enroll or decline coverage as specified above will automatically be enrolled in the Consumer Driven Health Plan (CDHP) with a Health Reimbursement Arrangement (HRA), in the "Employee-Only" tier, without coverage for dependents.

New Hire Employee enrolled as a dependent child of a PEBP Participant

A dependent child of a PEBP primary participant who becomes eligible for PEBP benefits as a new hire may decline coverage as an "active employee" and retain coverage as a "dependent child" of a PEBP primary participant. If the new hire elects coverage as an employee rather than a dependent child, the employee shall be deleted as a dependent.

By declining coverage as an employee, you are also declining all PEBP-sponsored benefits including Long-Term Disability and Basic Life Insurance benefits.

Note: A spouse or domestic partner who becomes eligible for PEBP coverage as an employee must enroll as an employee and cannot be covered as a dependent of another PEBP primary participant.

Dependent Eligibility

A dependent of two PEBP participants cannot be covered under more than one PEBP medical plan at the same time.

A child that is covered as a dependent under a PEBP participant who becomes eligible for PEBP coverage as a primary participant may enroll as a primary participant or waive primary participant coverage and remain as a dependent of another PEBP primary participant's plan.

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).

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

Legal guardianship An unmarried child who is under age 19 and under a permanent legal guardianship may be enrolled as a dependent. To continue coverage after age 19 (to age 26), the child must be unmarried, either reside with the participant or is enrolled as a full-time student at an accredited institution and satisfy the following conditions:

1. Is eligible to be claimed as a dependent on the federal income tax return of the participant or his spouse/domestic partner for the preceding calendar year; and
2. Dependent is a grandchild, brother, sister, step-brother, step-sister, or descendent of such relative.

The IRS allows the premiums for coverage of a person under age 19 (24 if a full time student) to be paid on a pre-tax basis (excluded from gross income) if certain criteria are met. If the criteria are met, the coverage will be provided on a pre-tax basis. If they are not met, or the dependent is over age 24 as of the end of the calendar year, the subsidies associated with the coverage of the dependent are taxable and the payroll deductions must be done after income tax is calculated. If the subsidies are deemed taxable, they will be included as income on your Form W-2.

Disabled child A child of any age with a disability, mental illness or intellectual, or other developmental disability who is 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.

Spouse or domestic partner A spouse or domestic partner who is eligible for other employer-group health coverage is not eligible for coverage under this plan.

Exceptions may apply if the employer-group health coverage is determined to be significantly inferior. Significantly inferior plans offer limited benefits such as a mini-med plan or a catastrophic plan with a \$5,000 or greater individual deductible and the plan is not coupled with a HSA or HRA.

The above is only a summary of the eligibility requirements for dependents. For complete details, view the [Master Plan Document for the PEBP Enrollment and Eligibility](http://www.pebp.state.nv.us) available at www.pebp.state.nv.us.

HIPAA Special Enrollment Notice

If you are declining enrollment for yourself or your Dependents (including your Spouse or Domestic Partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents' lose eligibility for that other coverage (or if the employer stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within 60 days after your or your Dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within 60 days after that coverage ends; or
- If your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this Plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Special enrollment rights are subject to certain circumstances.

To request special enrollment or obtain more information, contact PEBP at 775-684-7000 or 800-326-5496 or email mservices@peb.state.nv.us.

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 employer 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.

All foreign documents must be translated to English.

The list above is not exhaustive. To view a complete list of supporting document requirements, refer to the PEBP Enrollment and Eligibility Master Plan Document available at www.pebp.state.nv.us. Note: 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, Standard HMO (Southern NV) offered in Clark, Esmeralda and Nye Counties	√	√	√
Health Plan of Nevada, Alternate HMO (Southern NV) Only offered in Clark, Esmeralda and Nye Counties	√	√	√
Hometown Health Plan, Standard HMO (Northern NV) offered in all counties except Nye, Esmeralda, and Clark county	√	√	√
Hometown Health Plan, Alternate HMO (Northern NV) Only offered in Washoe, Storey, Churchill, Carson, Douglas, Lyon Counties	√	√	√
Dental Benefits			
Dental Plan	√	√	√
Voluntary Insurance Options			
Short-term Disability Insurance	√	√	√
Home and Auto Insurance	√	√	√
Health Care Flexible Spending	√		√
Dependent Care Flexible Spending	√		√
Voluntary Life Insurance	√	√	√
Voluntary Long-Term Care Insurance	√	√	√

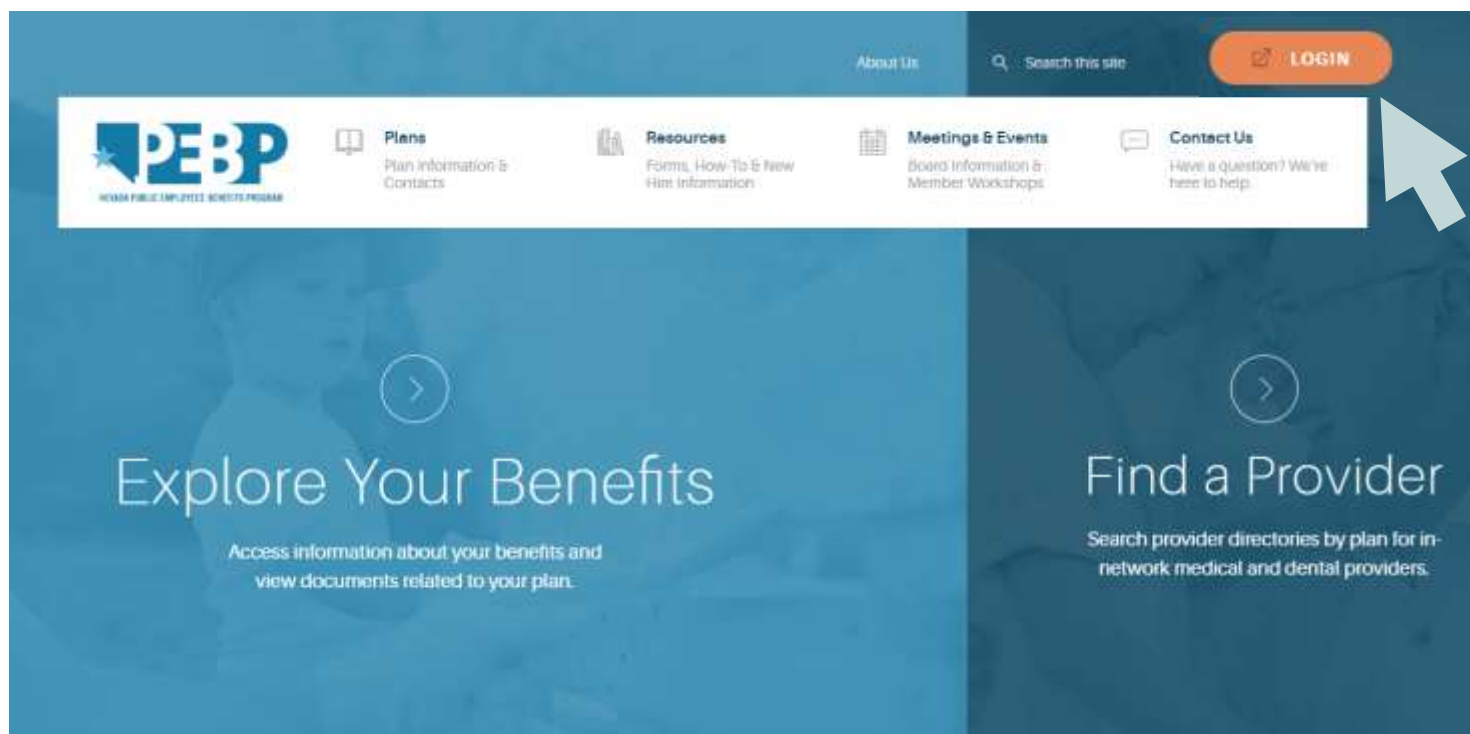
Summary of Benefits and Coverage Document (SBC)

The SBC provides a summary of the key features of the benefits of each health plan option such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions.

To view the SBC for the Consumer Driven Health Plan, Hometown Health Plan or Health Plan of Nevada visit www.pebp.state.nv.us or contact PEBP for a hardcopy at (775) 684-7000 or (800) 326-5496.

New Hire Resources

www.pebp.state.nv.us



To learn more about your medical, pharmacy, dental and voluntary benefits, visit the PEBP website at www.pebp.state.nv.us

Plan Documents

- Consumer Driven Health Plan
- Health Plan of Nevada—Standard and Alternate
- Hometown Health Plan—Standard and Alternate
- Enrollment and Eligibility
- Wellness Benefits Summary
- Summary of Benefits and Coverage - Individual and Family
- Flexible Spending Account Summary Plan Description
- PPO Dental Plan
- Glossary of Medical Terms
- Basic Life, Long Term Disability, Voluntary Life and Short Term Disability Insurance

Providers

- Statewide PPO Network (Consumer Driven Health Plan)
- Aetna National Network (Consumer Driven Health Plan)
- Express-Scripts (Pharmacy Benefit Manager - Consumer Driven Health Plan)
- Health Plan of Nevada
- Hometown Health Plan
- Diversified Dental (PPO Dental Network)

Resources

- What's New/FAQs/How to
- How-To Information
- New Hire Resources
- Forms
- Newsletters
- Publications

Completing the Employee Benefit Enrollment and Change Form (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 (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 (ID number) (to locate the PCP ID number, 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 5 for supporting documentation requirements.

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

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

Public Employees' Benefits Program
901 South Stewart Street, Suite 1001
Carson City, NV 89701

Plan Year 2018 Health Plan Comparison

PLAN DESIGN FEATURES	CONSUMER DRIVEN HEALTH PLAN (CDHP - PPO)		STANDARD HMO PLAN (Hometown Health and Health Plan of Nevada)		ALTERNATE HMO PLAN (Hometown Health and Health Plan of Nevada)	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Service Areas	Global	Global	Statewide	None	HHP: Washoe, Carson, Douglas, Storey, Lyon, Churchill, HPN: Clark, Nye, & Esmeralda Counties	None
Annual Deductible	\$1,500 Individual \$3,000 Family • \$2,600 Individual Family Member Deductible	\$1,500 Individual \$3,000 Family • \$2,600 Individual Family Member Deductible	N/A		N/A	
Medical Coinsurance	20% after Deductible	20% to 50% after Deductible	N/A		N/A	
Out-of-Pocket Maximum	\$3,900 Individual \$7,800 Family • \$6,850 Individual Family Member Deductible	\$10,600 Individual \$21,200 Family	\$7,150 Individual \$14,300 Family	N/A	\$7,150 Individual \$14,300 Family	N/A
Specialist Care Physician Referral Required	No	No	No	N/A	Yes	N/A
Primary Care Office Visit	20% after Deductible	50% after Deductible – Subject to Usual and Customary Limits	\$25 Copay Per visit	N/A	\$5 Copay Per Visit	N/A
Specialist Care Office Visit	20% after Deductible	50% after Deductible – Subject to Usual and Customary Limits	\$45 Copay (no referral required)	N/A	\$25 Copay Per visit (referral required)	N/A
Urgent Care Visit	20% after Deductible	50% after Deductible – Subject to Usual and Customary Limits	\$50 Copay Hometown Health \$30 Copay Health Plan of Nevada	\$50 Copay Hometown Health \$30 Copay Health Plan Of Nevada	\$25 Copay Per visit	\$25 Copay Per visit

PLAN DESIGN FEATURES	CONSUMER DRIVEN HEALTH PLAN (CDHP - PPO)		STANDARD HMO PLAN (Hometown Health and Health Plan of Nevada)		ALTERNATE HMO PLAN (Hometown Health and Health Plan of Nevada)	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Service Areas	Global	Global	Statewide	None	HHP: Washoe, Carson, Douglas, Storey, Lyon, Churchill, HPN: Clark, Nye, & Esmeralda Counties	None
Emergency Room Visit	20% after Deductible	20% after Deductible – Subject to U & C Limits	\$300 Copay per visit	\$300 Copay Per visit	\$1,000 Copay Per visit	\$1,000 Copay Per visit
In-Patient Hospital	20% after Deductible	50% after Deductible – Subject to U & C Limits	\$500 per admit	N/A	\$1,000 per day not to exceed \$3,000 per admission	N/A
Outpatient Surgery	20% after Deductible Requires Pre-Authorization	20% after Deductible – Subject to U & C Limits Requires Pre-Authorization	\$350 Copay Hometown Health \$50 Copay Health Plan of Nevada	N/A	\$1,000 Copay per visit	N/A
Affordable Care Act Preventive Services	\$0 (Covered at 100%)	No Benefit	\$0 (Covered at 100%)	No Benefit	\$0 (Covered at 100%)	No Benefit
HSA/HRA Funding	\$700 Primary \$200 per Dependent (max 3) **\$200 Primary after completion of PEBP's Prevention Program	N/A	N/A	N/A	N/A	N/A

**The \$200 additional HSA/HRA contribution will be credited to the primary participants HSA/HRA when PEBP's Third Party Administrator, HealthSCOPE Benefits, verifies through medical/dental claims that the participant has completed all of the following requirements:

1. Annual Preventive Exam
2. Annual Preventive Lab Work
3. Annual Dental Exam
4. One Dental cleaning (of the 4 available per year).

Primary participants have until June 30, 2018 to accomplish all four requirements to receive the additional \$200 contribution from PEBP. Activities before July 1, 2017 will not count towards these requirements. All four requirements are covered at 100% under the preventive wellness benefits when using an in-network provider.

Plan Year 2018 Prescription Plan Comparison

PLAN DESIGN FEATURES	CONSUMER DRIVEN HEALTH PLAN (CDHP - PPO)		STANDARD HMO PLAN Hometown Health and Health Plan of Nevada		ALTERNATE HMO PLAN Hometown Health and Health Plan Of Nevada	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
PRESCRIPTION DRUGS						
Preferred Generic	20% after Deductible*	N/A	\$7 Copay	N/A	\$25 Copay	N/A
Preferred Brand	20% after Deductible	N/A	\$40 Copay	N/A	\$50 Copay	N/A
Non-Formulary	20% after Deductible	N/A	\$75 Copay	N/A	\$75 Copay	N/A
Specialty	20% after Deductible	N/A	40% Coinsurance	N/A	40% Coinsurance	N/A
ACA Preventive Medications	\$0	No Benefit	\$0	N/A	\$0	N/A
CDHP Preventive Medications	20% Coinsurance Not subject to Deductible	20% Coinsurance after Deductible	N/A	N/A	N/A	N/A

Preventive Drug Program (CDHP only)*

The Preventive Drug Benefit provides plan participants access to certain preventive medications without having to meet a deductible, and will instead only be subject to coinsurance. Coinsurance paid under the benefit will not apply to the deductible, but will apply to the out-of-pocket maximum. The drugs covered under this benefit include categories of prescription drugs that are used for preventive purposes or conditions, such as hypertension, asthma or high cholesterol. This benefit only applies if using an in-network provider. For a list, refer to page 12-13. For more information contact Express Scripts at (855) 889-7708.

*For more detailed information on coverage and benefits, please refer to the PEBP Master Plan Document for the CDHP or the HMO's respective Evidence of Coverage Certificate (EOC) Document. These can be located at www.pebp.state.nv.us.



Consumer Driven Health Plan Preventive Medication List

The new plan year 2018 Preventive Drug benefit provides CDHP plan participants access to certain preventive medications without having to meet a deductible, and will instead only be subject to coinsurance. Coinsurance paid under the benefit will not apply to the deductible, but will apply to the out-of-pocket maximum. The drugs covered under this benefit include categories of prescription drugs that are used for preventive purposes or conditions, such as hypertension, asthma or high cholesterol. For more information on this program, contact Express Scripts at (855) 889-7708.

ASTHMA/COPD:

ZAFIRLUKAST
ADVAIR DISKUS
ANORO ELLIPTA
ARCAPTA NEOHALER
ARNUITY ELLIPTA
ASMANEX HFA
BEVESPI AEROSPHERE
BREO ELLIPTA
CINQAIR
COMBIVENT RESPIMAT
CROMOLYN ORAL INHALATION
DULERA
FLOVENT DISKUS
INCRUSE ELLIPTA
NUCALA
PROAIR HFA, VENTOLIN HFA
BUDESONIDE
QVAR
SEEBRI NEOHALER
SEREVENT DISKUS
MONTELUKAST
SPIRIVA RESPIMAT
STIOLTO RESPIMAT
STRIVERDI RESPIMAT
SYMBICORT
UTIBRON NEOHALER
XOLAIR
ZYFLO CR
RESPIRATORY SUPPLIES
NEBULIZERS AND INHALER
ASSISTIVE DEVICES

ANGIOTENSIN II RECEPTOR ANTAGONISTS:

CANDESARTAN
IRBESARTAN
LOSARTAN
VALSARTAN

ANGIOTENSIN II RECEPTOR ANTAGONISTS/ DIURETIC

COMBINATIONS:
CANDESARTAN/HCTZ
IRBESARTAN/HCTZ
VALSARTAN/HCTZ
LOSARTAN/HCTZ

BETA BLOCKERS:

BYSTOLIC
INNOPRAN XL
PROPRANOLOL
ATENOLOL
METOPROLOL
BISOPROLOL

BETA BLOCKERS/DIURETIC

COMBINATIONS:
PROPRANOLOL/HCTZ
NADOLOL/
BENDROFLUMETHIAZIDE
METOPROLOL/HCTZ
TENORETIC
ATENOLOL/
CHLORTHALIDONE
BISOPROLOL/HCTZ

CALCIUM CHANNEL

BLOCKERS:

NIFEDIPINE
VERAPAMIL
DILTIAZEM
AMLODIPINE

BONE DISEASE AND FRACTURES:

RISEDRONATE
IBANDRONATE
RALOXIFENE
ALENDRONATE
ZOLEDRONIC ACID

CAVITIES:

CLINPRO, PREVIDENT
SODIUM FLUORIDE RINSE
AND GEL
STANNOUS FLUORIDE PASTE
AND RINSE

COLONOSCOPY PREPARATION*

GOLYTELY, MOVIPREP
POLYETHYLENE GLYCOL
OSMOPREP
PREPOPIK
SUPREP

HEART DISEASE AND STROKE

BLOOD THINNER MEDICINES:
ASPIRIN, 81 MG OR 325 MG
ASPIRIN-DIPYRIDAMOLE ER
BRILINTA
WARFARIN
DURLAZA ER
EFFIENT
ELIQUIS
DIPYRIDAMOLE
CLOPIDOGREL
PRADAXA
SAVAYSA
TICLOPIDINE
XARELTO
ZONTIVITY

*Please note that some of these medications are also subject to the Affordable Care Act (ACA) and may be covered by your plan at 100%.



Consumer Driven Health Plan Preventive Medication List

CHOLESTEROL LOWERING

MEDICINES

HMG-COA REDUCTASE

INHIBITORS:

ROSUVASTATIN

FLUVASTATIN

ATORVASTATIN

LOVASTATIN

PRAVASTATIN

SIMVASTATIN

OTHER AGENTS:

COLESTIPOL

GEMFIBROZIL

PREVALITE

CHOLESTYRAMINE

FENOFIBRATE

FENOFIBRIC ACID

VTORIN

WELCHOL

HIGH BLOOD PRESSURE

ACE INHIBITORS:

QUINAPRIL

BENAZEPRIL

LISINAPRIL

ENALAPRIL

ACE INHIBITORS/DIURETIC

COMBINATIONS:

QUINAPRIL/HCTZ

BENAZEPRIL/HCTZ

ENALAPRIL/HCTZ

LISINAPRIL/HCTZ

DIURETICS:

CHLORTHALIDONE

HYDROCHLOROTHIAZIDE

INDAPAMIDE

METOLAZONE

OTHER HIGH BLOOD

PRESSURE

MEDICINE COMBINATIONS:

AMLODIPINE/ATORVASTATIN

AMLODIPINE/VALSARTAN/

HCTZ

AMLODIPINE/BENAZEPRIL

PRESTALIA

TRANSDOLAPRIL/VERAPAMIL

AMLODIPINE/TELMISARTAN

RESPIRATORY SYNCYTIAL

VIRUS:

SYNAGIS

MALARIA:

CHLOROQUINE

MEFLOQUINE

PRIMAQUINE

ATOVAQUONE/PROGUANIL

OBESITY:

PHENTERMINE

BELVIQ

CONTRAVE

DIETHYLPROPION

BENZPHETAMINE

PHENDIMETRAZINE

SAXENDA

XENICAL

SMOKING-CESSATION *

CHANTIX

NICOTROL

NICOTINE PRODUCTS

BUPROPION SR 150MG

IMMUNIZATION: *

ANTHRAX

DIPHTHERIA

PERTUSSIS

TETANUS

HAEMOPHILUS INFLUENZAE B

HEPATITIS A AND B

JE-VAX

TYPHIM

VARICELLA

ZOSTER

HUMAN PAPILLOMAVIRUS

INFLUENZA

MEASLES

MENINGOCOCCAL

MUMPS

PNEUMOCOCCAL

POLIOVIRUS

ROTAVIRUS

RUBELLA

VITAMINS OR MINERALS:

FOLIC ACID*

PEDIATRIC MULTIVITAMINS

WITH FLUORIDE*

Express Scripts manages your prescription benefit for the CDHP plan. For specific questions on coverage, please call the phone number on your ID card or visit the website at www.express-scripts.com.

Note: Brand names are shown in italics in each category. If generics are available, they are listed under the brand name.

All rights in the product names of all third-party products appearing here, whether or not appearing with the trademark symbol, belong exclusively to their respective owners.

*Please note that some of these medications are also subject to the Affordable Care Act (ACA) and may be covered by your plan at 100%.

Plan Year 2018 Vision Plan Comparison

PLAN DESIGN FEATURES	CONSUMER DRIVEN HEALTH PLAN (CDHP - PPO)	STANDARD and ALTERNATE HMO PLAN Health Plan of Nevada	STANDARD and ALTERNATE HMO PLAN Hometown Health
Vision Exam	\$25 Copay with a maximum benefit of \$95 per annual exam*	EyeMed Vision Plan \$10 Copayment every 12 months	EyeMed Vision Plan \$15 Copayment every 12 months
Hardware (frames, lenses, contacts)	No Benefit	\$10 Copayment for glasses (\$100 allowance) or contacts in lieu of glasses (\$115 allowance)	• Frames: 35% off retail price • Standard plastic lenses: \$50 to \$135 copayment depending on lens type; • Conventional contact lenses: 15% off retail

*PEBP does not maintain a network specific to vision care. Out-of-network providers will be paid at Usual and Customary (U&C). One annual vision exam, maximum annual benefit \$95 per plan year after the \$25 copayment.

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.

For Plan Limitations and Exclusions, refer to the CDHP Master Plan Document or the HMO Evidence of Coverage Certificates available at www.pebp.state.nv.us.

Consumer Driven Health Plan

How the Consumer Driven Health Plan (CDHP) Works:

Your plan has an annual deductible and an annual maximum out-of-pocket. Both the medical and prescription drug expenses apply to the annual deductible and out-of-pocket maximum. The deductible must be paid before the plan will help pay for medical and prescription drug expenses. Under this plan, eligible preventive/wellness benefits are paid at 100% when using in-network providers.

How the plan works before and after you meet your deductible:

- **Deductible:** When you access healthcare, such as a doctor's visit, you will pay the entire cost of the visit while in the deductible phase of your benefits. The amount you pay will be applied to both your deductible and out-of-pocket maximum. Exceptions may apply.
- **Coinsurance** - Once you have met your deductible, the plan will start to pay coinsurance. With coinsurance, the plan shares the cost of expenses with you. The plan will pay a percentage of your eligible expenses and you will pay the rest. For example, the plan pays 80% of the cost and you will pay 20%.
- **Out-of-Pocket Maximum** - The out-of-pocket maximum protects you from major expenses. If you reach your annual out-of-pocket maximum the plan will pay 100% of your eligible healthcare expenses for the remainder of the plan year.

About the Consumer Driven Program:

CDHP Pharmacy Plan

The pharmacy benefit manager for the CDHP is Express Scripts. The prescription drug benefit is subject to deductible. This means, you will pay 100% of the cost of the in-network discounted amount for prescription drugs listed on the Express Scripts drug formulary until you meet your deductible. For information about the prescription drug program, refer to the Plan Year 2018 Medical, Vision and Prescription Drug Master Plan Document at www.pebp.state.nv.us.

Preventive Drug Program

The Preventive Drug Benefit provides plan participants access to certain preventive medications without having to meet a deductible, and will instead only be subject to coinsurance. Coinsurance paid under the benefit will not apply to the deductible, but will apply to the out-of-pocket maximum. The drugs covered under this benefit include categories of prescription drugs that are used for preventive purposes or conditions, such as hypertension, asthma or high cholesterol. For a list, refer to pages 12-13 or contact Express Scripts at (855) 889-7708.

Doctor on Demand

Connects you face-to-face with a board-certified doctor or licensed psychologist (by appointment) on your smartphone, tablet or computer through live video. The cost for a medical visit is \$49; the cost for a behavioral health visit is \$79 for a 25 minute appointment. If appropriate, their doctors will also prescribe you non-narcotic drugs called in to your designated pharmacy to help you recover from your illness. Please refer to www.pebp.state.nv.us for more information on this benefit.

Consumer Driven Health Plan

Diabetes Care Management Program

The Diabetes Care Management Program is administered by HealthSCOPE Benefits and is available to all primary CDHP participants and their covered spouses/domestic partners, and children with diabetes. Participants who are diagnosed with diabetes and enroll in the Diabetes Care Management Program are eligible to receive benefit enhancements on diabetes related medications. For eligibility requirements, refer to the Diabetes Care Management section of the Plan Year 2018 Medical, Vision and Prescription Drug Master Plan Document available at www.pebp.state.nv.us.

Obesity Care Management Program

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. For eligibility requirements, refer to the Obesity and Overweight Care Management section of the Plan Year 2018 Medical, Vision and Prescription Drug Master Plan Document available at www.pebp.state.nv.us.

Aetna Signature Administrators

The Aetna Signature Administrators network is the CDHP's national network for participants residing outside Nevada or Nevada residents who wish to access health care outside Nevada. Providers in the Aetna network accept the PPO negotiated amounts in place of their standard charges for covered services. Out-of-pocket costs are lower when medical services or supplies are received from in-network PPO providers. To locate an Aetna network provider, call (888) 763-8232 or search for providers online at www.pebp.state.nv.us.

Pre-certification Review

Pre-certification reviews are completed before certain medical services are provided to assure the services meet medical necessity criteria. For more information regarding the pre-certification provisions, refer to the Plan Year 2018 Medical, Vision and Prescription Drug 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.

Prior Authorization (PA)

Medications that require prior authorization should be reviewed by Express Scripts prior to purchase to ensure that you do not incur additional expenses in addition to the required copayment or deductible. The prior authorization process may be started by your provider, pharmacist as well as yourself. Express Scripts will fax the prior authorization to your provider. After the form is completed and faxed back by your provider, Express Scripts will review the criteria based on the CDHP's prescription drug benefits. For information regarding prior authorizations, contact Express Scripts at (855) 889-7708.

Health Savings Account (HSA)

For Eligible Active Employees Enrolled in the CDHP

Health Savings Accounts (HSA) 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. Employees who wish to contribute to their HSA may do so through pre-tax payroll deductions. Election amounts may be modified 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.
- HSAs 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.

You must meet certain eligibility requirements to establish and contribute to an HSA.

- 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 Medicare or COBRA
- If you do not qualify for an HSA at initial enrollment or on the first day of the Plan Year (July 1), you cannot change from an HRA to an HSA mid-year.
- If you are enrolled in Medicare, you cannot establish or contribute to an HSA.

IMPORTANT

Section 326 of the USA PATRIOT Act requires financial institutions to verify the identity of each employee who opens a Health Savings Account (HSA). If an employee's identity cannot be verified, the employee will be required to provide additional documentation to establish their identity. If additional verification is not provided within 14 days of the employee's health coverage effective date, the HSA will not be opened. Failure to comply with the identity verification requirement within the stated timeframe will result in the conversion from an HSA to a Health Reimbursement Arrangement (HRA) for the remainder of the plan year. The next opportunity to establish an HSA will be during the open enrollment period for the subsequent plan year.

Health Savings Account (HSA) Contribution

For Eligible State and Non-State Active Employees Enrolled in the CDHP

The following contributions are provided to participants who are enrolled in the CDHP on July 1, 2017:

<u>State Participant/Non-State Participant</u> with coverage effective July 1, 2017	Base Contribution	One-time Additional Contribution	Total Contribution for participant only
Participant Only	\$700	\$200*	\$900 after completion of Preventive Program
Per Dependent (maximum 3 dependents)	\$200		

State and Non-State employees with a coverage effective date of August 1, 2017 or later receive a prorated HSA base contribution based on the employee's coverage effective date and the number of months remaining in the current plan year. Note: One-time supplemental contributions are available regardless of coverage effective date given all the requirements are met by the required timeframes.

* The \$200 additional HSA/HRA contribution will be provided to the primary participant when PEBP's Third Party Administrator, HealthSCOPE Benefits, verifies through medical/dental claims that the participant has completed the following:

1. Annual Preventive Exam
2. Annual Preventive Lab Work
3. Annual Dental Exam
4. One dental cleaning (of the four available per year).

Participants have until June 30, 2018 to complete all four requirements to receive the additional \$200 contribution from PEBP. Any activities completed before July 1, 2017 will not count towards these requirements. All four requirements are funded by PEBP at no cost to the participant if using in network providers. For more information on this benefit, please refer to www.pebp.state.nv.us.

Calendar Year 2017 HSA Contribution Limits

Calendar Year 2017 Maximum Contribution Allowed by the Internal Revenue Service (IRS)	Individual	Family (two or more family members)
The maximum shown is for eligible HSA individuals with high deductible health coverage through December 31, 2017	\$3,400	\$6,750

- The total calendar year 2017 contributions (combined employee/employer) cannot exceed the limits shown above.
- To be eligible for the family maximum, the employee and at least one eligible tax dependent must be covered under the plan.
- Employees who have Medicare or other secondary coverage that is not considered a high deductible health plan are not eligible to establish or contribute to an HSA.

HSA holders can choose to save up to \$3,400 for an individual and \$6,750 for a family. Eligible individuals, aged 55 and older may contribute an additional \$1,000 each calendar year. These contributions are 100% tax deductible from gross income.

Health Reimbursement Arrangement (HRA)

For Eligible State and Non-State Active Employees Enrolled in the CDHP

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

PEBP contributes funds to the HRA on behalf of eligible employees. HRAs are pass-through accounts and are owned by PEBP; employee contributions are not allowed. HRA funds may be used to pay for qualified healthcare expenses for both the employee and the employee's tax dependents. If the participant is no longer covered under the CDHP (terminates employment, declines coverage or passes away) or converts from an HRA to an HSA, any remaining funds in the HRA are returned to PEBP.

Important!

- If you are enrolled in an HRA, you cannot change to an HSA until the annual open enrollment period.
- If you are enrolled in Medicare, please submit a copy of your Medicare card to the PEBP office.

HRA contributions for state employees with coverage effective July 1, 2017:

<u>State Participant/Non-State Participant with coverage effective July 1, 2017</u>	Base Contribution	One-time Additional Contribution	Total Contribution for participant only
Participant Only	\$700	\$200*	\$900 after completion of Preventive Program
Per Dependent (maximum 3 dependents)	\$200		

State and Non-State employees with a coverage effective date of August 1, 2017 or later receive a prorated HRA base contribution based on the employee's coverage effective date and the number of months remaining in the current plan year. Note: One-time supplemental contributions are available regardless of coverage effective date given all the requirements are met by the required timeframes.

* The \$200 additional HSA/HRA contribution will be provided to the primary participant when PEBP's Third Party Administrator, HealthSCOPE Benefits, verifies through medical/dental claims that the participant has completed the following:

1. Annual Preventive Exam
2. Annual Preventive Lab Work
3. Annual Dental Exam
4. One teeth cleaning (of the four available per year).

Participants have until June 30, 2018 to complete all four requirements to receive the additional \$200 contribution from PEBP. Any activities completed before July 1, 2017 will not count towards these requirements. All four requirements are funded by PEBP at no cost to the participant if using in network providers. For more information on this benefit, please refer to www.pebp.state.nv.us.

University of Nevada, Reno School of Medicine

Enhanced Primary Care Model Provider

The Public Employees' Benefits Program has partnered with the University of Nevada, Reno School of Medicine to offer the choice of a new primary care practice to members enrolled in the CDHP. This practice is located in Reno and will be available to Reno and Carson City area residents.

The *Enhanced Primary Care Practice Model* serves to provide comprehensive adult Internal Medicine care, unparalleled access and chronic disease management. The General Internal Medicine Faculty directly supervise and oversee specifically selected resident physicians who have interest in establishing a long-term relationship with their patients. The *Enhanced Primary Care Practice* emphasizes the importance of preventive health measures and represents a new collaborative health care model between physicians and their patients to a more personalized level.

PEBP members who elect to use this provider can expect numerous benefits within the *Enhanced Primary Care Practice*. Foremost, is the *Personalized Prescriptive Health Assessment*, a comprehensive visit designed to review one's current health status while providing clients a descriptive 10-year guide of future recommended screenings. Other benefits include longer visits, same day access for acute illness and utilization of a secure site which allows patients to communicate non-emergent issues to staff. For urgent medical issues after hours, patients will be able to directly communicate by phone with resident physicians, whom will have remote access to a patient's record providing a full range of patient care. PEBP members enrolled on the CDHP will be able to join the new practice model beginning July 1, 2017.

For more information or to enroll as a patient, please contact the provider at (775) 982-5000 and ask for the UNR MED Enhanced Primary Care Practice or visit the Provider section of the PEBP website at www.pebp.state.nv.us

Hometown Health Plan

Health Maintenance Organization (HMO)



For Plan Year 2018, Hometown Health Plan is pleased to offer two separate plan designs, referred to as the *Standard* and *Alternate* plans. Hometown Health Plan is an HMO that offers fixed copayments for primary care, specialty, and urgent care visits. Both options feature medical, prescription drug, and vision coverage. If selecting one of these plans, you will need to select a primary care provider (PCP) at initial enrollment. If no PCP selection is made, one will be assigned to you by Hometown Health. To locate a PCP visit:

<http://stateofnv.hometownhealth.com/>

Hometown Health Plan—Northern Nevada Standard HMO

Hometown Health's Standard HMO plan is an open access plan available to all eligible participants residing in all Nevada counties, with the exception of Nye, Clark and Esmeralda counties. Members utilizing the standard HMO will have full access to the Hometown Health Plan and One-Health networks. One-Health is Hometown Health's new Southern Nevada network.

For emergency care outside of Nevada members should utilize the PHCS/Multiplan network. The Standard plan requires the member to choose a Primary Care Physician but does not require a referral to see a specialist.

Hometown Health Plan—Northern Nevada Alternate HMO

The Alternate HMO plan is only available to eligible participants residing in **Carson City, Churchill, Douglas, Lyon, Storey and Washoe Counties**. The plan is a closed access plan where a **PCP referral is required. This plan requires you to select a Renown Primary Care Provider and requires referrals by a Renown Primary Care physician to see a specialist** (except for pediatricians and OB/GYN). Emergency coverage is available through One-Health in Southern Nevada and PHCS/Multiplan outside of Nevada. This plan is not right for everyone. If your primary care provider is not a Renown provider or if your covered dependent(s) live outside of the coverage area, this plan may not be right for you.

For information on basic coverage and benefits for this plan, refer to the plan comparison chart on pages 9-14. For questions on benefits and coverage, contact Hometown Health at (775) 982-3232 or (800) 336-0123

Health Plan of Nevada

Health Maintenance Organization (HMO)



HEALTH PLAN OF NEVADA

A UnitedHealthcare Company

Health Plan of Nevada is pleased to offer two separate plan designs, referred to as the ***Standard*** and ***Alternate*** plans. Health Plan of Nevada is an HMO that offers fixed copayments for primary care, specialty, and urgent care visits. The plan features medical, prescription drug, and vision coverage. This plan requires its members to select a primary care provider (PCP) at initial enrollment. If a PCP is not selected, you will be assigned one by HPN. To locate a PCP visit: <http://stateofnv.healthplanofnevada.com/>

Health Plan of Nevada—Southern Nevada Standard HMO

Health Plan of Nevada Standard HMO is an open access plan available to all eligible participants residing in the service area of Clark, Nye and Esmeralda Counties. Referrals are not required to see an in-network specialist.

Health Plan of Nevada—Southern Nevada Alternate HMO

Health Plan of Nevada Alternate HMO is a closed access plan available to all eligible participants residing in the service area of Clark, Nye and Esmeralda counties. Referrals are required to see an in-network specialist.

Both plans feature:

Eligible dependents enrolled in an accredited college, university or vocational school anywhere in the United States will now be able to access a plan contracted network provider for needed PCP or urgent/emergent services at the in-network level of benefits. With the exception of Urgent or Emergent Services, Prior Authorization will still be required for all covered services outside of the HPN Service Area to receive in plan benefits. While attending school in Northern Nevada, students are able to directly access the Northern Nevada HPN HMO Network of physicians.

Participants and their dependents will now be able to access a contracted network provider for certain covered services while traveling in the United States, or when unanticipated healthcare issues occur. Other than Urgent or Emergent services, Prior Authorization will be required or the member may be subject to non-plan benefits. While traveling from Southern Nevada to Northern Nevada, HPN Members are allowed to directly access the Northern Nevada HPN HMO Network of physicians.

For information on basic coverage and benefits for this plan, refer to the plan comparison chart on pages 9-14. For questions on benefits and coverage, contact HPN at (702) 242-7300 or (800) 777-1840

Dental Plan

All PPO and HMO Eligible Participants

Benefit Category	In-Network	Out-of-Network
Individual Plan Year Maximum	\$1,500 per person for Basic and Major services	\$1,500 per person for Basic and Major services
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 \$1,500 Individual Plan Year Maximum	100% of allowable fee schedule, no deductible	80% of allowable fee schedule for the Las Vegas area for participants using an out-of-network provider <i>within the in-network</i> service area; or For services received out-of-network, outside of Nevada, the plan will reimburse at the U&C rates
Basic Services Periodontal, fillings, extractions, root canals, full-mouth X-rays	80% of allowable fee schedule, after deductible	50% (after deductible) of allowable fee schedule for the Las Vegas area for participants using an out-of-network provider <i>within the in-network</i> service area; or For services received out-of-network, outside of Nevada, the plan will reimburse at the U&C rates
Major Services Bridges, crowns, dentures, tooth implants	50% of allowable fee schedule, after deductible	50% (after deductible) of allowable fee schedule for the Las Vegas area for participants using an out-of-network provider <i>within the in-network</i> service area; or For services received out-of-network, outside of Nevada, the plan will reimburse at the U&C rates

- **Family Deductible may 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.
- **Under no circumstances will the combination of PPO and Non-PPO benefit payments exceed the plan year maximum benefit of \$1,500.**

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

Benefit Description	Benefit Features All Eligible Participants
Group Basic Life Insurance	Employees enrolled in a PEBP-sponsored medical plan receive \$25,000 Basic Life Insurance coverage. Refer to the Life Insurance Certificate at https://www.standard.com/mybenefits/nevada/ for more information about this benefit. 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.
Beneficiary Financial Counseling	The beneficiary of a deceased active employee may be eligible to receive comprehensive and objective financial counseling through an arrangement with Pricewaterhouse Coopers. 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 https://www.standard.com/mybenefits/nevada/ for more information.
Life Services Toolkit	Employees enrolled in a PEBP-sponsored medical plan have access to a tool to address important life matters via The Standard’s Life Services Toolkit: • Estate Planning Assistance: online tools that walk you through the steps to prepare a will and create other documents, such as living wills, powers of attorney and health care agent forms. • Financial Planning: Online services to help you manage debt, calculate mortgage and loan payments, and take care of other financial matters with confidence. • Health and Wellness: Timely articles about nutrition, stress management and wellness. • Identity Theft Prevention: Online tools that provide ways to thwart identity thieves and resolve issues if identity theft occurs. • Funeral Arrangements: Use the website to calculate funeral costs, find funeral-related services and make decisions about funeral arrangements in advance. For more information, visit https://www.standard.com/mybenefits/nevada/.

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

Benefit Description	Benefit Features (Provided to employees who are enrolled in a PEBP-sponsored medical plan)
Travel Assistance	Travel Assistance 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. Travel Assistance 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 Travel Assistance Card available at https://www.standard.com/mybenefits/nevada/ .
Long Term Disability (LTD) Insurance	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 https://www.standard.com/mybenefits/nevada/ .

Group Life Insurance Portability and Conversion Options

Benefit Description	Benefit Features All Eligible Participants
Portability of Life Insurance	You may be eligible to buy portable Group Life Insurance if your employment terminates. You must apply in writing and pay the first premium to the Standard within 31 days after the date your employment terminates. To be eligible, you must meet the following requirements: • 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. For information regarding Portability of Group Life Insurance, refer to the Group Life Insurance Certificate available at https://www.standard.com/mybenefits/nevada/ or contact The Standard Insurance Company at (888) 288-1270.
Conversion of Group Life Insurance	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. For information regarding Conversion of Group Life Insurance, refer to the Group Life Insurance Certificate available at https://www.standard.com/mybenefits/nevada/ or contact The Standard Insurance Company at (888) 288-1270.

State Active Rates

Effective July 1, 2017 - June 30, 2018

Consumer Driven Health Plan State Employee Rates	Statewide PPO		
	Consumer Driven High Deductible Health Plan		
	Unsubsidized Rate	Base Subsidy	Participant Premium
Employee Only	599.29	557.38	41.91
Employee + Spouse	1,087.38	915.88	171.50
Employee + Child(ren)	793.17	700.45	92.72
Employee + Family	1,281.03	1,058.94	222.09
Standard HMO State Employee Rates	Standard HMO Plan		
	Hometown Health Plan <u>and</u> Health Plan of Nevada		
	Unsubsidized Rate	Base Subsidy	Participant Premium
Employee Only	825.66	652.03	173.63
Employee + Spouse	1,603.10	1,117.20	485.90
Employee + Child(ren)	1,193.68	873.79	319.89
Employee + Family	1,976.12	1,338.97	637.15
Alternate HMO State Employee Rates	Alternate HMO Plan		
	Hometown Health Plan <u>and</u> Health Plan of Nevada		
	Unsubsidized Rate	Base Subsidy	Participant Premium
Employee Only	793.24	625.15	168.09
Employee + Spouse	1,533.21	1,063.46	469.75
Employee + Child(ren)	1,139.44	831.20	308.24
Employee + Family	1,879.41	1,269.50	609.91

State active Legislators, employees on leave without pay (LWOP) and employees on military leave do not receive a premium subsidy and are subject to the full unsubsidized rate. Please refer to the unsubsidized rate column in the table that most accurately reflects your employee status.

State Active Rates

Effective July 1, 2017 - June 30, 2018

Consumer Driven Health Plan State Employee with Domestic Partner Rates	Statewide PPO					
	Consumer Driven High Deductible Health Plan					
	Unsubsidized Rate	Base Subsidy	Taxable Subsidy	<i>Participant Premium</i>	Pre-Tax Deduction	Post-Tax Deduction
Employee + DP	1,087.38	557.38	358.50	171.50	41.91	129.59
Employee + DP's Child(ren)	793.17	557.38	143.07	92.72	41.91	50.81
Employee + Children of both	793.17	700.45	-	92.72	92.72	-
Employee + DP + EE's Child(ren)	1,281.03	700.45	358.49	222.09	92.72	129.37
Employee + DP + DP's Child(ren)	1,281.03	557.38	501.56	222.09	41.91	180.18
Employee + DP + Children of both	1,281.03	700.45	358.49	222.09	92.72	129.37

Standard HMO State Employee with Domestic Partner Rates	Standard HMO Plan					
	Hometown Health Plan & Health Plan of Nevada					
	Unsubsidized Rate	Base Subsidy	Taxable Subsidy	<i>Participant Premium</i>	Pre-Tax Deduction	Post-Tax Deduction
Employee + DP	1,603.10	652.03	465.17	485.90	173.63	312.27
Employee + DP's Child(ren)	1,193.68	652.03	221.76	319.89	173.63	146.26
Employee + Children of both	1,193.68	873.79	-	319.89	319.89	-
Employee + DP + EE's Child(ren)	1,976.12	873.79	465.18	637.15	319.89	317.26
Employee + DP + DP's Child(ren)	1,976.12	652.03	686.94	637.15	173.63	463.52
Employee + DP + Children of both	1,976.12	873.79	465.18	637.15	319.89	317.26

Alternate HMO State Employee with Domestic Partner Rates	Alternate HMO Plan					
	Hometown Health Plan & Health Plan of Nevada					
	Unsubsidized Rate	Base Subsidy	Taxable Subsidy	<i>Participant Premium</i>	Pre-Tax Deduction	Post-Tax Deduction
Employee + DP	1,533.21	625.15	438.31	469.75	168.09	301.66
Employee + DP's Child(ren)	1,139.44	625.15	206.05	308.24	168.09	140.15
Employee + Children of both	1,139.44	831.20	-	308.24	308.24	-
Employee + DP + EE's Child(ren)	1,879.41	831.20	438.30	609.91	308.24	301.67
Employee + DP + DP's Child(ren)	1,879.41	625.15	644.35	609.91	168.09	441.82
Employee + DP + Children of both	1,879.41	831.20	438.30	609.91	308.24	301.67

State active Legislators, employees on leave without pay (LWOP) and employees on military leave do not receive a premium subsidy and are subject to the full unsubsidized rate. Please refer to the unsubsidized rate column in the table that most accurately reflects your employee status.

Non-State Active Rates

Effective July 1, 2016 - June 30, 2017

Consumer Driven Health Plan Non-State Active Employees	Statewide PPO		
	Consumer Driven High Deductible Health Plan		
	Unsubsidized Rate	Base Subsidy	Participant Premium
Employee Only	1,118.77		1,118.77
Employee + Spouse/DP	2,129.17		2,129.17
Employee + Child(ren)	1,994.33		1,994.33
Employee + Family	3,004.73		3,004.73

Standard HMO Non-State Active Employee Rates	Standard HMO Plan		
	Hometown Health Plan & Health Plan of Nevada		
	Unsubsidized Rate	Base Subsidy	Participant Premium
Employee Only	886.48		886.48
Employee + Spouse/DP	1,734.74		1,734.74
Employee + Child(ren)	1,322.90		1,322.90
Employee + Family	2,171.16		2,171.16

Alternate HMO Non-State Active Employee Rates	Alternate HMO Plan		
	Hometown Health Plan & Health Plan of Nevada		
	Unsubsidized Rate	Base Subsidy	Participant Premium
Employee Only	829.29		829.29
Employee + Spouse/DP	1,620.36		1,620.36
Employee + Child(ren)	1,231.52		1,231.52
Employee + Family	2,022.59		2,022.59

COBRA Rates

State and Non-State Employee and Retiree

	Statewide PPO PPO Consumer Driven High Deductible Health Plan	Standard HMO Plan Hometown Health Plan & Health Plan of Nevada	Alternate HMO Plan Hometown Health Plan & Health Plan of Nevada
State Employee			
Participant	611.28	842.17	809.10
Participant + Spouse/DP	1,109.13	1,635.16	1,563.87
Participant + Child(ren)	809.03	1,217.55	1,162.23
Participant + Family	1,306.65	2,015.64	1,917.00
State Retiree			
Participant	593.42	818.81	786.96
Participant + Spouse/DP	1,088.72	1,616.89	1,513.49
Participant + Child(ren)	787.25	1,199.29	1,136.18
Participant + Family	1,283.99	1,997.37	1,885.09
Spouse/DP Only	593.42	818.81	786.96
Spouse/DP + Child(ren)	787.25	1,199.29	1,136.18
Non-State Employee			
Participant	1,141.15	904.21	845.88
Participant + Spouse/DP	2,171.75	1,769.43	1,652.77
Participant + Child(ren)	2,034.22	1,349.36	1,256.15
Participant + Family	3,064.82	2,214.58	2,063.04
Non-State Retiree			
Participant	1,122.88	885.94	832.60
Participant + Spouse/DP	2,153.49	1,751.17	1,623.27
Participant + Child(ren)	2,015.95	1,331.09	1,243.84
Participant + Family	3,046.56	2,196.32	2,034.50
Spouse/DP Only	1,122.88	885.94	832.60
Spouse/DP + Child(ren)	2,015.95	1,331.09	1,243.84

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

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

Health Care FSA

The Health Care 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 monthly from your paycheck, pre-tax (before Federal & State income taxes and FICA taxes are deducted). The amount you elect to contribute is deducted in equal amount over the course of the months remaining in the plan year. Eligible expenses that you incur may be paid using the FSA debit card or through the submission of a claim for reimbursement to HealthSCOPE Benefits.

For Plan Year 2018, you may contribute up to the IRS maximum of \$2,600. 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.

HealthSCOPE Benefits will charge a \$3.25 per month administration fee for participating in the Health Care and/or Dependent Care FSA. There is no fee for the FSA debit card.

Who is eligible for Flexible Spending Account (FSA)?

Employees working for a state agency (NDOT, LCB, PERS, etc.), State Boards, and Commissions are eligible to enroll in Flexible Spending. Employees working for a non-state agency and the Nevada System of Higher Education will need to contact their human resources benefits office for information about the availability of Flexible Spending Accounts offered by their employer.

IMPORTANT!

Employees with an HSA are not eligible to contribute to the Health Care FSA, but may contribute to a Limited Scope FSA for eligible dental and vision expenses only. For more information regarding the Limited Scope FSA, contact HealthSCOPE Benefits at (888) 763-8232.

Domestic Partner Eligibility

The health care expenses of a domestic partner are generally not eligible for reimbursement using the Health Care FSA unless the domestic partner qualifies as a dependent under the IRS's definition of a qualifying relative. If you have questions regarding your eligibility to enroll in an FSA, please contact HealthSCOPE Benefits at (888) 763-8232.

Voluntary Flexible Spending Accounts (FSA) Continued

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.

Flexible Spending enrollment forms are available at www.pebp.state.nv.us. To enroll, complete the form and fax it to HealthSCOPE Benefits within 60 days of your initial coverage effective date.

Auto, Home, RV and Renters' Insurance

Employees and Retirees have the option of purchasing a variety of insurance products, such as auto, home, renters, condo, boat, RV, etc., at special group discounts. Liberty Mutual offers 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 Liberty Mutual at (800) 637-7026

Long-Term Care Insurance

Long-term care is the assistance received when someone needs help with two or more *Activities of Daily Living* (i.e. dressing, bathing, going to the bathroom, eating, etc.) This care may be provided in the home, in an assisted living or residential care facility, or in a skilled nursing home facility.

New hires have 30 days to enroll to receive *Guarantee Issue* coverage (measured from the date PEBP coverage becomes effective). After the initial enrollment period, employees will be required to complete a medical questionnaire. For information about Long-Term Care, contact UNUM 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

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 <https://www.standard.com/mybenefits/nevada/> and mail to the address indicated on the form. For more information about these voluntary coverage options, contact The Standard at (888) 288-1270.

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 child becomes eligible for coverage as a primary insured, that individual may select primary coverage in lieu of being covered as a dependent of another primary insured.

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 CDHP/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 will NOT pay any amount of the cost of premium or contributions for health insurance for the 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.

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, PEBP will continue the same medical plan and coverage tier that the employee had in affect prior to taking that leave. An employee who wishes to continue coverage while on LWOP will pay the full cost of premiums for their coverage. An employee on LWOP is not eligible for coverage as a dependent of another PEBP covered participant (spouse/domestic partner, child, etc.).

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.

PEBP Initial COBRA Notice - COBRA Continuation Rights

This notice contains important information about your right to continue your health care coverage (called “Continuation Coverage” or COBRA coverage). This notice also contains important information about health coverage alternates that may be available to you through the Health Insurance Marketplace when coverage under the Public Employees’ Benefits Program (PEBP) would otherwise end.

This notice provides a brief overview of your rights and obligations under current law. (Note: the PEBP-sponsored group health plan is referred to as “Plan” in this notice.) The Plan offers no greater COBRA rights than what the COBRA statute requires and this notice should be construed accordingly.

There may be other coverage options for you and your family through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums. You can also see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. For information on the Nevada Silver State Health Insurance Exchange (Marketplace), call (855) 768-5465. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse’s plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Both you (the employee or retiree) and your spouse or domestic partner should read this notice carefully and keep it with your records.

Qualifying Events

If you are the **employee/retiree** and are covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any one of the two “qualifying events”:

1. Termination of employment (for reasons other than gross misconduct), or
2. Reduction in the hours of your employment.

If you are the **spouse or the domestic partner** of an employee or retiree covered by the Plan, you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the four qualifying events:

1. The death of your spouse or domestic partner.
2. A termination of your spouse’s or domestic partner’s employment (for reasons other than gross misconduct) or reduction in your spouse’s or domestic partner’s hours of employment with the PEBP participating employer.
3. Divorce from your spouse or the dissolution of your domestic partnership. (Also, if an employee or retiree eliminates coverage for his or her spouse or domestic partner in anticipation of a divorce or the dissolution of domestic partnership, and a divorce or dissolution of domestic partnership later occurs, then the later divorce or dissolution of domestic partnership will be considered a qualifying event even though the ex-spouse or ex-domestic partner lost coverage earlier. If the ex-spouse or ex-domestic partner notifies PEBP within 60 days after the later divorce or dissolution of domestic partnership, then COBRA coverage may be available for the period after the divorce or dissolution of domestic partnership.)

4. Your spouse or domestic partner becomes entitled to Medicare benefits.

In the case of a **dependent child** of an employee or retiree covered by the Plan, the dependent child has the right to elect continuation coverage if group health coverage under the Plan is lost because of any of the following five qualifying events:

1. The death of the employee/retiree.
2. The termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee hours of employment with the employer.
3. Parent's divorce or dissolution of domestic partnership.
4. The employee/retiree becomes entitled to Medicare benefits.
5. The dependent ceases to be a "dependent child" under the Plan.

Your IMPORTANT Notice Obligations

If your spouse/domestic partner or dependent child loses coverage under the Plan because of divorce, dissolution of domestic partnership or the child ceases to be a dependent under the Plan, then you (the employee) or your spouse/domestic partner or dependent has the responsibility to notify PEBP no later than 60 days after the date coverage terminates under the Plan.

If you, your spouse/domestic partner or your dependent fail to notify PEBP during this 60-day notice period, the spouse/domestic partner or dependent child who loses coverage will NOT be offered continuation coverage. Any claims paid by the Plan on behalf of your spouse/domestic partner or dependent child after the coverage termination date must be reimbursed to the Plan.

If PEBP receives timely notification of a divorce/dissolution of domestic partnership or of a child who ceases to be a dependent which results in a loss of coverage, then PEBP will notify the affected family member of the right to elect continuation coverage (but only to the extent that PEBP has been notified in writing of the affected family member's current mailing address).

PEBP will also notify you (the employee or retiree), your spouse/domestic partner and dependent children of the right to elect continuation coverage after it receives notice of the following events that result in a loss of coverage: the employee's termination of employment (other than for gross misconduct), reduction in hours, the death of the employee or retiree, or the employee's or retiree's becoming entitled for Medicare.

Election Procedures

You (the employee or retiree) and/or your spouse/domestic partner and/or dependent children must elect continuation coverage within 60-days after Plan coverage ends or 60 days after PEBP provides you or your family member with the COBRA Continuation Coverage Election Form. If you or your spouse/domestic partner and/or dependent children do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage. A COBRA election that is mailed to PEBP is considered received on the date of the mailing. You and/or your spouse/domestic partner and dependent children may elect continuation coverage for all qualifying family members. You, your spouse/domestic partner and dependent children each have an independent right to elect continuation coverage (spouse/domestic partner or dependent child may elect continuation coverage even if the covered employee does not (or is not deemed to) elect it). You and/or your spouse/domestic partner and dependent children may elect continuation coverage even if covered under another employer-sponsored group health plan or entitled to Medicare.

Type of Coverage

Ordinarily, the continuation coverage that is offered will be the same coverage that you, your spouse/domestic partner or dependent children had on the day before the qualifying event. An employee or retiree, spouse/domestic partner or dependent child who is not covered under the Plan on the day before the qualifying event generally is not entitled to COBRA coverage except, for example, when there is no coverage because it was *eliminated in anticipation* of a qualifying event such as divorce. If the coverage is modified for similarly situated employees or their spouses/domestic partners or dependent children, then COBRA coverage will be modified in the same way.

If you (employee) are enrolled in a PEBP-sponsored health flexible spending arrangement (health FSA) under which you are reimbursed for medical expenses, you (or your spouse or dependent children) may elect to continue the health FSA coverage under COBRA, but only if there is a positive account balance (*i.e.*, year-to-date contributions exceed year-to-date claims) on the day before the qualifying event (taking into account all claims submitted by that date). COBRA coverage under the health FSA will continue only for the remainder of the Plan year in which the qualifying event occurred.

If there is a negative account balance (*i.e.*, year-to-date contributions are less than year-to-date claims), then no qualified beneficiary may elect COBRA coverage under the health FSA.

COBRA Premiums That You Must Pay

The premium payments for the “initial premium months” must be paid for you (the employee) and for any spouse/domestic partner or dependent children by the 45th day after electing continuation of coverage. The initial premium months are the months that end on or before the 45th day after the election of continuation coverage is made.

Once continuation of coverage is elected, the right to continue coverage is subject to timely payment of the required COBRA premiums. Coverage will not be effective for any initial premium month until the month’s premium is paid within the 45-day period after the election of continuation of coverage is made.

Paying for COBRA Continuation of Coverage (The Cost of COBRA)

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

Grace Period

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

A premium payment that is mailed is considered to be received on the date it is postmarked. If full premium payment is not received by the due date or within the 30-day grace period, then COBRA coverage will be canceled retroactively to the first day of the month, with no possibility of reinstatement.

Maximum Coverage Periods

The maximum duration for COBRA coverage is described below. COBRA coverage terminates before the maximum coverage period in certain situations described later under the heading “Termination of COBRA Coverage Before the End of the Maximum Coverage Period.”

36 Months

If you (the spouse/domestic partner or dependent child) lose group health coverage because of the employee’s death, divorce, legal separation, or the employee’s becoming entitled to Medicare, or because you lose your status as a dependent child under the Plan, then the maximum coverage period (for spouse/domestic partner and dependent child) is three years from the date of the qualifying event.

18 Months

If you (the employee, spouse/domestic partner or dependent child) lose group health coverage because of the employee’s termination of employment (other than for gross misconduct) or reduction in hours, then the maximum continuation coverage is 18 months from the date of termination or reduction in hours. There are three exceptions:

1. If an employee or family member is disabled at any time during the first 60 days after the date of termination of employment or reduction in hours, then the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours.

The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) of the Social Security Act that the disability exists and when it began. For the 29-month continuation coverage period to apply, notice of the determination of disability under the Social Security Act must be provided to the Plan Administrator within the 18-month coverage period and 60 days after the date of the determination.

2. If a second qualifying event that gives rise to a 36-month maximum coverage period for the spouse or dependent child (for example, the employee dies or becomes divorced) occurs within an 18-month or 29-month coverage period, then the maximum coverage period (for a spouse or dependent child) becomes three years from the date of the initial termination or reduction in hours. For the 36-month maximum coverage period to apply, notice of the second qualifying event must be provided to the Plan Administrator within 60 days after the date of the event. If no notice is given within the required 60-day period, no extension of COBRA coverage will occur.
3. If the qualifying event occurs within 18 months after the employee becomes entitled to Medicare, then the maximum coverage period (for the spouse and the dependent child) is three years from the date the employee became entitled to Medicare.

Health FSA

If you enroll in a Health FSA and your coverage terminates because of a qualified event, i.e. termination of employment (does not include retirement), you may continue your FSA coverage if you elect COBRA. The maximum COBRA period for a health FSA (if there is a positive account balance including the remaining monthly administrative fee and the 2% COBRA administrative fee as of the date of the qualifying event) ends on the last day of the Plan year in which the qualifying event occurred. If there is a negative balance as of the date of the qualifying event, no COBRA coverage will be offered. If COBRA is elected, it will be available only for the remainder of the applicable plan year. Such continuation coverage shall be subject to all conditions and limitations under COBRA. Employees who have incurred a COBRA qualifying event as a result of no longer being actively employed will be responsible for the monthly administration fee. The monthly administration fee will be paid on an after tax basis.

COBRA FSA benefits will end on the earlier of:

- You cease paying the monthly administration fee;
- Your remaining FSA balance is depleted, or;
- At the end of the applicable plan year.

For more information on continuing your Health FSA, contact your FSA plan administrator within 31 days of your coverage end date.

Children Born to or Placed for Adoption With the Covered Employee During COBRA Period

A child born to, adopted by or placed for adoption with a covered employee during a period of continuation of coverage is considered to be a qualified beneficiary, provided that the covered employee has elected continuation of coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Open Enrollment Rights and HIPAA Special Enrollment Rights

Qualified beneficiaries who have elected COBRA will be given the same opportunity available to similarly-situated active employees to change their coverage options or to add or eliminate coverage for dependents at open enrollment. In addition, HIPAA's special enrollment rights will apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA certain rights to add coverage for dependents if such person acquires a new dependent (through marriage, registered domestic partnership, birth, adoption or placement for adoption), or if an eligible dependent declines coverage because of other coverage and later loses such coverage due to certain qualifying reasons. Except for certain children described above under "Children born to or Placed for Adoption With the Covered Employee During COBRA Period," dependents who are enrolled in a special enrollment period or open enrollment period do not become qualified beneficiaries and their coverage will end at the same time that coverage ends for the person who elected COBRA and later added them as dependents.

Alternate Recipients Under QMCSOs

A child of yours (the employee's) who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the PEBP during your (the employee's) period of employment with the employer is entitled to the same rights under COBRA as a dependent child of yours, regardless of whether that child would otherwise be considered your dependent.

Termination of COBRA Coverage Before the End of Maximum Coverage Period

Continuation of coverage of the employee, spouse/domestic partner and/or dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following six events occurs.

1. The Employer no longer provides group health coverage to any of its employees.
2. The premium for the qualified beneficiary's COBRA coverage is not timely paid.
3. After electing COBRA, you (the employee, spouse/domestic partner or dependent child) become covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable exclusions or limitations, then your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group health plan. (Note that under HIPAA, an exclusion or limitation of the group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other group health plan.)
4. After electing COBRA coverage, you (the employee, spouse/domestic partner or dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
5. You (the employee, spouse/domestic partner or dependent child) became entitled to a 29-month maximum coverage period due to disability of qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation of coverage will not end until the month that begins more than the 30 days after the determination).
6. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered employees or their spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of federal law.

You Must Notify Us About Address Changes, Marital Status/Domestic Partnership Changes, Dependent Status Changes and Disability Status Changes

If you or your spouse's/domestic partner's address changes, you *must* promptly notify PEBP in writing (PEBP needs up-to-date addresses in order to mail important COBRA notices and other information). Also, if your marital/domestic partnership status changes or if a dependent ceases to be a dependent eligible for coverage under the Plan terms, you or your spouse or your dependent *must* promptly notify PEBP in writing (such notification is necessary to protect COBRA rights for your spouse/domestic partner and dependent children). In addition, you must notify us if a disabled employee or family member is determined to be no longer disabled.

PEBP is the Plan Administrator. All notices and other communications regarding the Plan and regarding COBRA must be directed to PEBP.

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: _____

Group Life and Long-Term Care Portability and Conversion Options

Important Notice regarding the Active Employee Basic Life Insurance and/or Voluntary Life Insurance.

If you terminate your active employment you may have the option to convert or port your Basic and/or Voluntary Life Insurance (if applicable). If you want to maintain coverage for any of the applicable coverages, you must apply directly with the Standard Insurance within 31 days of the date your PEBP-sponsored active employee coverage ends; otherwise, you may lose your right to convert or port these coverages.

Portability of Basic and/or Voluntary Life Insurance

You must apply in writing and pay the first premium to Standard Insurance within 31 days after the date your employment terminates.

To be eligible, you must meet the following requirements:

- 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.

Conversion of Basic and/or Voluntary Life Insurance

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 you must apply for conversion by completing and returning a conversion application to Standard Insurance within 31 days after the date of employment termination.

For information regarding the Portability and Conversion provisions, refer to the Group Life Insurance Certificate available at <http://www.standard.com/mybenefits/nevada/> or contact Standard Insurance at (888) 288-1270.

Long-Term Care Insurance Policy #508396

If you have Long-Term Care Insurance through UNUM, you may wish to port or convert your coverage if you terminate your active employment. To convert/port your coverage, you must apply within 31 days following the date your PEBP-sponsored active employee coverage ends. To request the portability/conversion forms contact Karla Decrescenzo at (775) 722-5907 or Nikki Pecorino at (775) 813-5309 or UNUM at (800) 227-4165.

Important Notices

HIPAA Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) (Privacy Rule) provides Federal protection for personal health information and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other purposes. For more information, please visit the following website: <http://www.hhs.gov/ocr/office/index.html>

Women's Health and Cancer Rights Act of 1998

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services. This includes all stages of reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy, including lymphedema. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you have questions about coverage of mastectomies and reconstructive surgery, please call your plan administrator for additional information:

- Consumer Driven Health Plan: 888-7NEVADA (888-763-8232)
- Health Plan of Nevada: (702) 242-7300 or (800) 777-1840
- Hometown Health Plan: (775) 982-3232 or (800) 336-0123

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). For more information, please visit the following website <http://www.dol.gov/index.htm>.

Important Notices

Michelle's Law

Under the Public Employees' Benefits Program ("PEBP"), most dependent children are eligible for health coverage until age 26. However, dependent children under a legal guardianship who are unmarried are generally eligible for health coverage until age 19. Eligibility for dependent children under a legal guardianship may be extended beyond age 19 to age 26 if the child satisfies all of the following conditions:

- Remains unmarried;
- Is either enrolled as a full-time student at an accredited institution or resides with the Participant;
- Is eligible to be claimed as a dependent on the Participant's or his/her Spouse's or Domestic Partner's federal income tax return for the preceding calendar year; and
- Is a grandchild, brother, sister, step-brother, step-sister, or descendent of such relative.

Because eligibility may be conditioned on maintaining full-time student status, Michelle's Law applies only to the extended eligibility for dependent children under a legal guardianship from ages 19 -26 who meet the conditions above.

Should a dependent child under a legal guardianship (as described above) take a medically necessary leave of absence for a serious illness or injury that causes loss of full-time student status, his or her coverage cannot be terminated before the date that is the earlier of - (1) one year after the first day of the medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the PEBP. A written certification stating that the dependent child is suffering from a serious illness or injury and that the leave of absence is medically necessary must be provided by a treating physician of the dependent child to PEBP in order for eligibility and coverage to continue.

Important Notices

Discrimination is Against the Law

The State of Nevada Public Employees' Benefits Program's (PEBP) Consumer Driven Health Plan (CDHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The PEBP CDHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The PEBP CDHP provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as: qualified interpreters
- Information written in other languages

If you need these services, contact the PEBP Civil Rights Coordinator at 775-684-7020 or mservices@peb.state.nv.us.

If you believe that the PEBP CDHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: PEBP Civil Rights Coordinator, 901 South Stewart Street, Suite 1001, Carson City, NV 89701, Phone: 775-684-7020 (TTY: 1-800-545-8279), Fax: 775-684-7028, Email: mservices@peb.state.nv.us. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the civil rights coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Important Notices

Discrimination is Against the Law (con't)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-326-5496 (TTY: 1-800-545-8279)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-326-5496 (TTY: 1-800-545-8279)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-326-5496 (TTY: 1-800-545-8279)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-326-5496 (TTY: 1-800-545-8279) 번으로 전화해 주십시오.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800326-5496 (TTY: 1-800-545-8279)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-326-5496 (መስማት ለተሳናቸው፡1-800-545-8279)።

เรียน: ถ้าคุณพูด ภาษา ไทยคุณสามารถ ใช้บริการช่วยเหลือทางภาษา ได้ฟรี โทร 1-800-326-5496 (TTY: 1-800-545-8279)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-326-5496 (TTY: 1-800-545-8279) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-326-5496 (رقم هاتف الصم والبكم: 1-800-545-8279).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-326-5496 (телетайп: 1-800-545-8279).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-326-5496 (ATS : 1-800-545-8279).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-326-5496 (TTY: 5496-800-545-8279) تماس بگیرید.

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-800-326-5496.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-326-5496 (TTY: 1-800-545-8279).

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyan. Awagan ti 1-800-326-5496 (TTY: 1-800-545-8279).

Vendor Contact List

CDHP Medical and PPO Dental Claims Administrator • Claim status inquiries • Plan benefit information • HSA/PPO-HRA Administration • Network Providers • ID cards • Diabetes Care Management • Obesity Care Management	HealthSCOPE Benefits P.O. Box 91603 Lubbock, TX 79490-1603 Customer Service: 888-7NEVADA (888) 763-8232 Group Number: NVPEB www.HealthSCOPEbenefits.com
In-State PPO Medical Network • Network Providers • Provider directory • Additions/deletions of providers	PEBP Statewide PPO Network Administered by Hometown Health Partners and Sierra Healthcare Options Customer Service: (800) 336-0123 www.pebp.state.nv.us
National Provider Network For participants who reside outside Nevada or who reside in Nevada and access healthcare services outside of Nevada	Aetna Signature Administrators by HealthSCOPE Benefits P.O. Box 91603 Lubbock, TX 79490-1603 Customer Service: 888-7NEVADA (888) 763-8232 Group Number: NVPEB www.HealthSCOPEbenefits.com
CDHP Pharmacy Plan Administrator • Prescription drug information • In-network pharmacies • Prior authorization • Non-network retail claims payment • Price and Save Tool • Mail order service and mail order forms • Diabetic supplies mail order program	Express Scripts, Inc. PO Box 66566 St. Louis, MO 63166-6566 Customer Service: (855) 889-7708 www.Express-Scripts.com (available 7/1) Price a Medication Tool www.Express-Scripts.com/NVPEBP (available for price comparison) Specialty Pharmacy Accredo (800) 803-2523
Hometown Health Providers • Utilization Management and Case Management	Hometown Health Providers Pre-certification and Customer Service (775) 982-3232 (888) 323-1461 www.stateofnv.hometownhealth.com
Dental PPO Network • Statewide dental PPO providers • Dental provider directory	Diversified Dental Services Northern Nevada: (866) 270-8326 Southern Nevada: (800) 249-3538 www.ddspgo.com

Vendor Contact List

Northern HMO Plan • Provider network • Provider directories • Appeals • Benefit Information • Additions/deletions of providers • Pharmacy Benefits	Hometown Health Plan HMO Customer Service: (775) 982-3232 or (800) 336-0123 http://stateofnv.hometownhealth.com/
Southern HMO Plan • Provider network • Provider directories • Benefit Information/Appeals • Additions/deletions of providers	Health Plan of Nevada Customer Service: (702) 242-7300 (877) 545-7378 www.stateofnvhpnbenefits.com
Life and AD&D Insurance • Life insurance benefits information • Claim filing • Travel assistance • Beneficiary designation forms	Standard Insurance Company Customer Service: (888) 288-1270 https://www.standard.com/mybenefits/nevada/
Flexible Spending • Medical • Dependent Care	HealthSCOPE Benefits Customer Service: (888) 763-8232 Fax: (877) 240-0135 P.O. Box 3627 Little Rock, AR 72203 Email: pebphsahra@HealthSCOPEbenefits.com www.HealthSCOPEbenefits.com
Long-Term Care Insurance	UNUM Long Term Care Policy #584040 In-State Local Customer Service: Karla DeCrescenzo (775) 722-5907 Karla.Descrescenzo@coloniallife.com Nevada System of Higher Education: Nikki Pecorino (775) 813-5309 or Nikki.pecorino@coloniallife.com Nationwide Customer Service for enrollees: (855) 328-8055 all other questions (877) 485-2318 www.unuminfo.com/stateofnevada
Home and Auto Insurance	Liberty Mutual Customer Service: (800) 637-7026 gary.bishop@libertymutual.com