Plan Year 2018 Open Enrollment

Open Enrollment

- Compare Plan Options
- Learn About Your Benefits
- Review New Premium Rates
- Read Important Notices

Making changes? Don't wait — Open Enrollment ends May 31, 2017

NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

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Effective July 1, 2017- June 30, 2018

Plan Year 2018 Open Enrollment

Welcome to the Public Employees' Benefits Program Open Enrollment for Plan Year 2018. Open Enrollment gives you the opportunity to review your benefit options and make changes to your coverage based on your current needs.

The information in this guide is for informational purposes only. Any discrepancies between the benefits described herein and the PEBP Master Plan Document for Plan Year 2018 or the HMO Plan Evidence of Coverage Certificate(s) shall be superseded by the plan's official documents.

04-04-2017

Introduction to Open Enrollment

Open Enrollment is May 1 - May 31, 2017. Open Enrollment gives you the opportunity to reevaluate your benefits and make changes for the plan year beginning July 1, 2017. This Open Enrollment is a passive enrollment, meaning you are not required to complete an election unless you wish to make changes or enroll in a voluntary product as shown below:

You MUST take action if you want to do any of the following:

⇒ Change your current plan election (e.g., CDHP to/from HMO plan)
⇒ Change to/from the HSA to/from HRA
⇒ Enroll in or update voluntary HSA contributions (CDHP participants only)
⇒ Add or delete your dependent(s)
⇒ Decline coverage
⇒ Enroll in a voluntary product (e.g., Voluntary Life Insurance, Short-Term Disability Insurance)
⇒ Enroll/re-enroll in Flexible Spending (new elections are required each plan year)
⇒ Enroll in PEBP dental coverage (this option is only available to individuals enrolled in medical coverage through OneExchange)
⇒ Decline PEBP dental coverage (this option is only available to individuals enrolled in medical coverage through OneExchange)

You DO NOT need to take action if you:

⇒ Want to remain on the CDHP with a Health Savings Account (HSA)
⇒ Want to remain on the CDHP with a Health Reimbursement Arrangement (HRA)
⇒ Want to remain on your current Hometown Health Plan
⇒ Want to remain on your current Health Plan of Nevada Health Plan
⇒ Want to remain in declined coverage status
⇒ Do not want to add or delete dependents

Open Enrollment Deadline

Open Enrollment changes may be completed online through the PEBP website or by submitting the Open Enrollment form to the PEBP office. Open Enrollment submissions must be received in the PEBP office or postmarked by May 31, 2017.

If you are adding dependents, please submit copies of the required supporting certified documents to the PEBP office by June 15, 2017. Supporting documents may be faxed to (775) 684-7028, emailed to mservices@peb.state.nv.us or mailed to the PEBP office at the address located on the front of this guide.

Online Changes

Changes that may be completed online:

√ Change health plan option

√ Add or delete a dependent

√ Designate a beneficiary for your Health Savings Account (HSA)

√ Modify voluntary HSA contributions

√ Update address/contact information

Changes that may not be completed online:

√ Enroll in Flexible Spending (medical, dental and/or dependent care)

√ Enroll in a voluntary product

√ Cancel a voluntary product

√ Initial enrollment in retiree coverage

√ Initial enrollment in COBRA

√ Name change

Spouse or Domestic Partner Coverage

Spouses and domestic partners, as determined by the laws of the State of Nevada, are eligible for coverage under the PEBP Plan. Spouses and domestic partners that are eligible for health coverage through their current employer are typically not eligible for coverage under the PEBP Plan. If your spouse's or domestic partner's employer-sponsored health coverage satisfies PEBP's definition of "significantly inferior coverage" you may be able to enroll or continue coverage for your spouse or domestic partner. For more information, contact Member Services at (775) 684-7000 or (800) 326-5496 or email mservices@peb.state.nv.us.

Your Responsibilities

To ensure you receive and maintain benefits for which you are eligible, please familiarize yourself with these important guidelines:

- If you **do not** make any changes during Open Enrollment, your current coverage will continue after July 1, 2017 and you will be responsible for paying the Plan Year 2018 premium rates for coverage.
- If adding dependent(s) during Open Enrollment, you must submit a copy of the required supporting documents (certified marriage certificate, certified birth certificate, etc.) to the PEBP office by June 15, 2017.
- If you experience a change of address, you must submit your new address to PEBP within 30 days of the change.
- If you experience a mid-year qualifying family status change that affects your benefits, you must notify PEBP within 60 days.
- Declining PEBP coverage (CDHP, HMO or medical coverage through OneExchange) will result in termination of Basic Life, Long-Term Disability, Voluntary Life and Short-Term Disability Insurance, and HSA/HRA funding (if applicable). Additionally, if you are a retiree you may permanently lose the option to re-enroll in PEBP.
- If your Voluntary Life insurance ends or reduces for any reason other than failure to pay premiums, the Right to Convert provision allows you to convert your Voluntary Life coverage to certain types of individual polices without having to provide evidence of insurability. You must apply for conversion with your carrier and pay the required premium within 31 days after group coverage ends or reduces.
- PEBP does not require active employees to obtain Medicare. If you do become eligible for Medicare, you must provide a copy of your Medicare card to PEBP.
- **If you are an active employee with an HSA and enroll in Medicare, or your spouse has an HRA you are no longer eligible to contribute to an HSA.**

Completing Changes for Open Enrollment

1. PEBP Online Enrollment Tool

Go to www.pebp.state.nv.us and click the orange **"Login"** button at the top right of the webpage. Follow the instructions to complete enrollment changes before May 31, 2017.

2. Open Enrollment Form

Open Enrollment forms may be requested by calling (775) 684-7000 or (800) 326-5496 or via email at mservices@peb.state.nv.us.

Completed forms (originals only) must be received in the PEBP office by May 31, 2017 or postmarked no later than May 31, 2017 for changes or updates to apply. Late forms, faxed forms, or scanned copies will not be accepted.

3. Documentation to Add Dependents

If you wish to add dependents to your coverage during Open Enrollment for coverage effective July 1, 2017, you will be required to submit supporting documentation (e.g., copy of certified marriage certificate, certified birth certificate, etc.) to the PEBP office by June 15, 2017. For more information regarding supporting documents and eligibility, please refer to the PEBP Enrollment and Eligibility Document at www.pebp.state.nv.us.

4. Flexible Spending Accounts (FSA) Enrollment

Active employees who wish to enroll in the Health Care, Limited Purpose or Dependent Care Flexible Spending Account must complete the paper Flexible Spending Account (FSA) form. Completed forms must be submitted to HealthScope Benefits by May 31, 2017 or postmarked by May 31, 2017. To download the FSA form which contains mailing and faxing information, visit www.pebp.state.nv.us.

5. Voluntary Life and Short-Term Disability Insurance

To enroll or make changes to Voluntary Life or Short-Term Disability Insurance, visit https://www.standard.com/mybenefits/nevada/ or call The Standard at (888) 288-1270.

Health Savings Account (HSA)

Employees who are currently contributing money to their HSA through automatic payroll deductions will continue with the same deduction amount after July 1, 2017 for Plan Year 2018.

Exception: ANY change made to an employee's coverage during Open Enrollment (via online or paper form) will automatically reset the HSA election to zero. However, employees may enter a new HSA election online when completing the Open Enrollment event or by contacting HealthScope Benefits at (888)763-8232.

Consumer Driven Health Plan Overview

The Consumer Driven Health Plan (CDHP) is a high deductible health plan combined with a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA). HSAs and HRAs allow individuals to pay for qualifying out-of-pocket health care expenses on a tax-free basis. Under the CDHP, both medical and pharmacy costs are subject to the annual deductible. Deductibles accumulate on a plan year basis and reset to zero at the start of each new plan year.

Consumer Driven Health Plan Deductibles and Out-of-Pocket Maximums:

Deductible Type	In-Network Deductible (participating provider benefit)	Out-of-Network Deductible
Annual Medical and Prescription Drug 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
Annual Out-of-Pocket Maximum	$3,900 Individual $7,800 Family • $6,850 Individual Family Member Deductible	$10,600 Individual $21,200 Family

- The deductibles for Individual and Family coverage accumulate separately for in-network provider expenses and out-of-network provider expenses.

- The *Individual Deductible* applies when only <u>one</u> person is covered under the CDHP.

- The *Family Deductible* applies when an employee/retiree covers at least one other individual on the their plan. For example, when an employee/retiree covers a spouse or a child. An individual family member on a family plan will be subject to a $6,850 out-of-pocket max.

The *Family Deductible* can be met by any combination of eligible medical and prescription drug expenses from two or more members of the same family coverage unit. For the Family Deductible, under no circumstances will a single individual be required to pay more than $2,600 toward the deductible (this is called the $2,600 *Individual Family Member Deductible*).

The *Annual Out-of-Pocket Maximum* is a combination of covered out-of-pocket expenses, including deductibles and coinsurance. The *Family Out-of-Pocket Maximum* can be met by one covered family member or by any combination of expenses incurred by all covered family members. In and Out-of-Network Maximums are <u>not</u> combined to reach the *Annual Out-of-Pocket Maximum.*

Services received from out-of-network providers are subject to Usual and Customary (U&C) provisions, meaning charges are subject to the maximum allowance under the plan and covered individuals will be responsible for any amount the providers charge in excess of the maximum allowance.

<u>CDHP Summary of Benefits and Coverage (SBC)</u>

The SBC provides a summary of the key features of the CDHP's covered benefits, cost-sharing provisions, coverage limitations and exceptions. The SBC is available on the PEBP website at <u>www.pebp.state.nv.us</u>.

Consumer Driven Health Plan Overview

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.

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.

Health Reimbursement Arrangement (HRA)

HRAs are funded by PEBP; participant contributions are not allowed. **If the CDHP medical coverage terminates for any reason, any remaining funds in the HRA account revert to PEBP.**

2017 HSA Limits

The IRS limits how much you can deposit into your HSA each year. The 2017 limits are:

- $3,400 for individual coverage
- $6,750 for family coverage

Are You 55 Years Old or Older?

You can deposit an extra $1,000 during the year. This is called a catch-up contribution.

Note: Employees who wish to contribute the maximum, must reduce the above limits by PEBP's contribution amount.

HSA Eligibility

- You must be an active employee covered under the CDHP;
- You cannot have other coverage (Medicare, Tricare, Tribal, HMO, etc.) unless the other coverage is also a high deductible health plan;
- You do not qualify if your spouse has an HRA
- You *cannot* be claimed on someone else's tax return (excludes joint returns), or you or your spouse have a Medical FSA that can be used to pay for your medical expenses; and
- You cannot be covered under COBRA

Overview of Plan Design Changes for the Consumer Driven Health Plan

The plan design for the Consumer Driven Health Plan will remain the same for Plan Year 2018 with the exception of the following:

Calendar Year 2017 Maximum HSA Contributions

For tax year 2017 (January 2017 - December 2017), the Internal Revenue Service has set the HSA contribution limits for an Individual at $3,400 and the Family maximum contribution at $6,750. The catch-up contribution limit for those over 55 will also remain at $1,000.

Plan Year 2018 CDHP HSA/HRA Contributions

PEBP contributes funds into an HSA/HRA on behalf of eligible employees. The following contributions are provided to participants who are enrolled in the CDHP on July 1, 2017:

State Participant/Non-State Participant 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		

*The $200 additional HSA/HRA contribution will be provided to the primary participant only 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 (performed at a free standing lab such as Lab Corp)
3. Annual Dental Exam
4. One Dental Cleaning (of the four available per year).

Primary participants have until June 30, 2018 to complete all four requirements to receive the additional $200 contribution from PEBP. Activities completed before July 1, 2017 will not count towards these requirements. All four requirements are covered at 100% under the preventive wellness benefits when using in-network providers. More information on this benefit can be found at www.pebp.state.nv.us.

Preventive Drug Benefit

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 is only available when using an in-network provider. For a list of covered drugs, refer to page 8 of this guide or contact Express Scripts at (855) 889

Medicare Part B Premium Credit Increase

The Part B premium credit for retirees/surviving spouses enrolled in the CDHP or HMO plan and have submitted proof of Medicare Part B enrollment to PEBP will increase to $134.

CDHP National Provider Network

For participants who reside outside of Nevada or travel outside of Nevada for their health care, First Health Network will be replaced with Aetna Signature Administrators. Healthscope Benefits will be the third party administrator responsible for claims. New Medical ID cards will be mailed to you with the new logo on the back of the card.

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

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 co-insurance. 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
VYTORIN
WELCHOL

HIGH BLOOD PRESSURE

ACE INHIBITORS:

QUINAPRIL
BENAZEPRIL
LISINOPRIL
ENALAPRIL

ACE INHIBITORS/DIURETIC COMBINATIONS:

QUINAPRIL/HCTZ
BENAZEPRIL/HCTZ
ENALAPRIL/HCTZ
LISINOPRIL/HCTZ

DIURETICS:

CHLORTHALIDONE
HYDROCHLOROTHIAZIDE
INDAPAMIDE
METOLAZONE

OTHER HIGH BLOOD PRESSURE MEDICINE COMBINATIONS:

AMLODIPINE/ATORVASTATIN
AMLODIPINE/VALSARTAN/HCTZ
AMLODIPINE/BENAZEPRIL
PRESTALIA
TRANDOLAPRIL/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.

*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%.

Overview of Plan Changes for the HMO

Hometown Health Plan

Standard Plan

- No referral required to see an in-network specialist
- Out-of-pocket maximum increase from $6,000 Individual/$12,000 Family to $7,150 Individual/$14,300 Family
- Specialty drug increase to 40%

Alternate Plan

- Added new alternate plan design option
- Coverage is **only** available to members residing in Carson City, Churchill, Douglas, Lyon, Storey, and Washoe Counties
- Referral required to see an in-network specialist

Health Plan of Nevada

Standard Plan

- No referral required to see an in-network specialist
- Out-of-pocket maximum increase from $6,000 Individual/$12,000 Family to $7,150 Individual/$14,300 Family
- Primary care office visit increase from $15 copayment to $25 copayment
- Specialist care office visit increase from $25 to $45
- Emergency room visit increase from $150 copayment per visit to $300
- Inpatient hospital visit increase from $300 copayment per admission to $500 per admission
- Specialty drug increase to 40%
- Retail 30 day pharmacy increase from $7/$35/$55 to $7/$40/$75

Alternate Plan

- Added new alternate plan design option
- Referral required to see an in-network specialist
- Plan is available to all eligible participant residing in Clark, Nye and Esmeralda County

Hometown Health Plan Overview

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.

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 questions on benefits and coverage, contact Hometown Health at (775) 982-3232 or (800) 336-0123.

Health Plan of Nevada Overview

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.

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 plan contracted network provider for certain covered services while traveling in the United States, and 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 questions on benefits and coverage, contact HPN at (702) 242-7300 or (800) 777-1840

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-NET-WORK
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 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	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 (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
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 Copay 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	50% 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 complete 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 Benefit *NEW*

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 8 - 9. For more information on this contact Express Scripts at (855) 889-7708.

*For more detailed information on coverage and benefits, please refer to the PEBP CDHP 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

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*	$10 Copayment every 12 months	$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.

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.

Dental Plan

All PPO, HMO and Medicare Exchange 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 *within the in-network* 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 *within the in-network* 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 *within the in-network* 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 will 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.**

Health Plan Options for Retirees with Medicare Parts A and B

	Medicare Status		Enrollment Options
1.	Retiree is covered under Medicare Parts A and B; with no covered dependents	→	Retiree must enroll in a medical plan offered through Towers Watson's OneExchange.
2.	Retiree is covered under Medicare Parts A and B; and also covers at least one non-Medicare dependent	→	Retiree may enroll in a medical plan through Towers Watson's OneExchange; and the non-Medicare dependent may retain coverage under the CDHP or HMO plan as an unsubsidized dependent; or Retiree and dependent(s) may remain covered under the CDHP or HMO plan.
3.	Retiree is covered under Medicare Parts A and B; and also covers a spouse/domestic partner with Medicare Parts A and B.	→	Both the retiree and spouse/domestic partner must enroll in a medical plan offered through Towers Watson's OneExchange.
4.	Retiree is under age 65 and not eligible for Medicare; and also covers a spouse/domestic partner with Medicare Parts A and B	→	Retiree may retain coverage under the CDHP or HMO coverage; and Spouse/domestic partner may enroll in medical coverage through Towers Watson's OneExchange as an unsubsidized dependent; or Retiree and spouse/domestic partner may retain coverage under the CDHP or HMO plan.

Retirees and their covered dependents may only retain CDHP or HMO coverage until such time that all covered family members are entitled to premium free Medicare Part A.

Medicare Enrollment Reminder:

At age 65, retirees and their covered dependents are required to purchase Medicare Part B regardless of their eligibility for premium free Part A.

Retirees and covered dependents under age 65 who have been approved for disability benefits by the Social Security Administration (SSA) are required to enroll in Medicare Part A and purchase Part B coverage.

Flexible Spending Account

Health Care and Dependent Care FSA

Available to all state employees*

Health Care FSA
The Health Care Flexible Spending Account is a tax-free account that allows you to pay for qualified health care expenses that are not covered, or are partially covered, by your medical plan.

When you enroll in a Flexible Spending Account, you decide how much to contribute for the entire Plan Year. The money is then deducted from your paycheck, pre-tax (before taxes are deducted) in equal amounts over the course of the plan year. After you incur expenses that qualify for reimbursement, you submit claims (reimbursement requests) to HealthScope Benefits to request tax-free withdrawals from your Flexible Spending Account to reimburse yourself for these expenses.

For calendar year 2017, the maximum contribution limit for the Health Care FSA is $2,600. Note: This is a per employee limit, not a household limit. If an employee and his or her spouse are eligible for the Health Care FSA, each individual can establish their own Health Care FSA with a $2,600 Calendar Year maximum.

Limited Purpose FSA
If you are enrolled in the Consumer Driven Health Plan with a Health Savings Account (HSA), you cannot enroll in the Health Care FSA; however, you may enroll in the Limited Purpose FSA for reimbursement of qualified dental and vision care expenses *only*.

Dependent Care FSA
Dependent Care Flexible Spending Accounts create a tax break for dependent care expenses (typically child care or day care expenses) that enable you to work. 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 Flexible Spending Account. The IRS allows no more than $5,000 per household ($2,500 if you are married and file a separate tax return) to be set aside in the Dependent Care Flexible Spending Account in a calendar year.

Please note that IRS regulations disallow reimbursement for services that have not yet been provided, so even if you pay in advance for your expenses, you can only claim service periods that have already occurred.

*Employees of the Nevada System of Higher Education (NSHE) are ineligible for the PEBP sponsored FSA, but may be eligible through a similar program offered by the NSHE or their local government employer.

Basic Life Insurance

All Eligible Primary Retirees and Employees

Employee 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/index.html or for more information about this benefit or call The Standard at (888) 288-1270.
Long-Term Disability (LTD) for Active Employees	Long-Term Disability Insurance is provided to active employees enrolled in a PEBP sponsored medical plan. This benefit is designed to help protect you against a loss of income in the event you become disabled and are unable to work for an extended period of time. If your LTD claim is approved, benefits become payable at the end of the 180 day Benefit Waiting Period (no benefits are paid during the Benefit Waiting Period). The monthly LTD benefit is based on your earnings from the State of Nevada or participating public agency. Your monthly LTD benefit is 60 percent of the first $12,500 of your monthly earnings, as defined by the group insurance policy, reduced by deductible income. For more information about the LTD benefit, see the LTD Certificate of Insurance at http://www.standard.com/mybenefits/nevada/.
Retiree Basic Life Insurance	Eligible retirees enrolled in the CDHP, HMO plan or a qualifying medical plan through OneExchange receive $12,500 Basic Life insurance coverage. Refer to the Life Insurance Certificate at http://*www*.standard.com/mybenefits/nevada for more information about this benefit.
Travel Assistance from The Standard for Active Employees and Retirees enrolled in the CDHP, HMO Plan or a qualifying medical plan through OneExchange.	Travel Assistance is designed to respond to most medical care situations and many other emergencies you and your family may 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. Travel Assistance is available 24 hours a day, 365 days a year whether you are 100 or 10,000 miles away from your home. Simply print out and carry the Travel Assistance Card available at https://www.standard.com/mybenefits/nevada/life_add.html.
Life Services Toolkit	The Life Services Toolkit is automatically available to those insured under a Group Life insurance policy from The Standard. Online tools and services can help you create a will, make advance funeral plans and put your finances in order. After a loss, beneficiaries can consult experts by phone or in person, and obtain other helpful information online. For beneficiary services, please visit www.standard.com/mytoolkit with username of "support" or call 800.387.5742 for assistance.

Voluntary Life and Short-Term Disability Insurance

Annual Enrollment Period: May 1 - 31, 2017

Life and Disability Insurance can give you a greater sense of financial security by enabling you to protect your income now and in the future from an unexpected event. During our annual enrollment period, you may enroll or increase your coverage subject to the requirements noted below:

Any benefits elected during this enrollment period that do not require evidence of insurability, will take effect July 1, 2017, subject to the active work requirement. Full details are available online at www.standard.com/mybenefits/nevada.

Active Employee Voluntary Life Insurance

Because everyone's needs are different, you may also elect to purchase Voluntary Life, Accidental Death & Dismemberment (AD&D) and Dependents Life insurance at group rates from The Standard. The coverage limits for each family member are noted in the chart below.

Active 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

If you are already insured for Voluntary Life Insurance, during the annual enrollment period you may elect up to $50,000 of coverage or increase existing coverage by $50,000 up to the guarantee issue amount of $500,000 without submitting evidence of insurability (proof of good health)*. Late applications and requests for coverage increases (except as noted above) require you to provide satisfactory evidence of insurability.

Evidence of Insurability is not required to insure your eligible dependent children. However, all late applications and requests for coverage increases for your eligible Spouse/Domestic Partner require satisfactory evidence of insurability.

Voluntary Short-Term Disability Insurance

If you are eligible but not enrolled in Voluntary STD Insurance or you would like to reduce the length of your Benefit Waiting Period (e.g., change from Option C to Option B or to Option A), you may enroll in the following plan options without answering any medical questions; however, you may be subject to a late enrollment penalty. Late enrollment penalty consists of a disability caused by anything other than an accidental injury that begins during your first year of coverage and will be subject to a benefit waiting period of 60 days, regardless of the Benefit Waiting Period option you select below.

Option A: 7-day Benefit Waiting Period
Option B: 14-day Benefit Waiting Period
Option C: 30-day Benefit Waiting Period

Those who select the 30-day benefit waiting period (Option C) will not be subject to the late enrollment penalty that applies to the 7-day and 14-day benefit waiting period plans.

Retiree Voluntary Life Insurance

Life Insurance may be elected in multiples of $5,000 to a maximum of $50,000. Late application or increases in coverage require you to provide satisfactory evidence of insurability.

* Applies only if not previously denied Voluntary Life Insurance from the Standard.

State Employee 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 and 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 and 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 Employee with Domestic Partner 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	***Participant Premium***	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	***Participant Premium***	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	***Participant Premium***	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 Rates For State Active Legislators, Employees on Leave without Pay, and Employees on Military Leave

Effective July 1, 2017 - June 30, 2018

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 Retiree and Survivor Rates

Effective July 1, 2017 - June 30, 2018

Consumer Driven Health Plan State Retiree and Survivor Rates	Statewide PPO		
	Consumer Driven High Deductible Health Plan		
	Unsubsidized Rate	Base Subsidy	Participant Premium
Retiree only	581.78	372.70	209.08
Retiree + Spouse	1,067.37	589.51	477.86
Retiree + Child(ren)	771.82	459.22	312.60
Retiree + Family	1,258.81	676.03	582.78
Surviving/Unsubsidized Dependent	581.78	-	581.78
Surviving/Unsubsidized Spouse + Child(ren)	771.82	-	771.82

Standard HMO State Retiree and Survivor Rates	Standard HMO Plan		
	Hometown Health Plan & Health Plan of Nevada		
	Unsubsidized Rate	Base Subsidy	Participant Premium
Retiree only	802.75	404.76	397.99
Retiree + Spouse	1,585.19	642.79	942.40
Retiree + Child(ren)	1,175.77	518.24	657.53
Retiree + Family	1,958.21	756.27	1,201.94
Surviving/Unsubsidized Dependent	802.75	-	802.75
Surviving/Unsubsidized Spouse + Child(ren)	1,175.77	-	1,175.77

Alternate HMO State Retiree and Survivor Rates	Alternate HMO Plan		
	Hometown Health Plan & Health Plan of Nevada		
	Unsubsidized Rate	Base Subsidy	Participant Premium
Retiree only	771.53	391.01	380.52
Retiree + Spouse	1,483.81	615.29	868.52
Retiree + Child(ren)	1,113.90	496.44	617.46
Retiree + Family	1,848.13	720.72	1,127.41
Surviving/Unsubsidized Dependent	771.53	-	771.53
Surviving/Unsubsidized Spouse + Child(ren)	1,113.90	-	1,113.90

- The State Retiree Participant Premiums above are subsidized rates for those who retired *before* January 1, 1994.
- For those who retired *on or after* January 1,1994, refer to the State Retiree Years of Service Subsidy Table on page 27, then *add or subtract* the appropriate subsidy based on your years of service to/from the Participant Premium shown above to determine your final premium.

To determine your final premium, turn to page 27.

Note: Survivors and unsubsidized dependents are not eligible for a subsidy.

State Retiree with Domestic Partner Rates

Effective July 1, 2017 - June 30, 2018

Consumer Driven Health Plan State Retiree with Domestic Partner Rates	Statewide PPO			
	Consumer Driven High Deductible Health Plan			
	Unsubsidized Rate	Base Subsidy	Taxable Subsidy	Participant Premium
Retiree + DP	1,067.37	372.70	216.81	477.86
Retiree + DP's Child(ren)	771.82	372.70	86.52	312.60
Retiree + Children of both	771.82	459.22	-	312.60
Retiree + DP + Ret's Child(ren)	1,258.81	459.22	216.81	582.78
Retiree + DP + DP's Child(ren)	1,258.81	372.70	303.33	582.78
Retiree + DP + Children of both	1,258.81	459.22	216.81	582.78

Standard HMO State Retiree with Domestic Partner Rates	Standard HMO Plan			
	Hometown Health & Health Plan of Nevada			
	Unsubsidized Rate	Base Subsidy	Taxable Subsidy	Participant Premium
Retiree + DP	1,585.19	404.76	238.03	942.40
Retiree + DP's Child(ren)	1,175.77	404.76	113.48	657.53
Retiree + Children of both	1,175.77	518.24	-	657.53
Retiree + DP + Ret's Child(ren)	1,958.21	518.24	238.03	1,201.94
Retiree + DP + DP's Child(ren)	1,958.21	404.76	351.51	1,201.94
Retiree + DP + Children of both	1,958.21	518.24	238.03	1,201.94

Alternate HMO State Retiree with Domestic Partner Rates	Alternate HMO Plan			
	Hometown Health Plan & Health Plan of Nevada			
	Unsubsidized Rate	Base Subsidy	Taxable Subsidy	Participant Premium
Retiree + DP	1,483.81	391.01	224.28	868.52
Retiree + DP's Child(ren)	1,113.90	391.01	105.43	617.46
Retiree + Children of both	1,113.90	496.44	-	617.46
Retiree + DP + Ret's Child(ren)	1,848.13	496.44	224.28	1,127.41
Retiree + DP + DP's Child(ren)	1,848.13	391.01	329.71	1,127.41
Retiree + DP + Children of both	1,848.13	496.44	224.28	1,127.41

- The State Retiree Participant Premiums above are subsidized rates for those who retired *before* January 1, 1994.
- For those who retired *on or after* January 1,1994, refer to the State Retiree Years of Service Subsidy Table on page 27, then add or subtract the appropriate subsidy based on your years of service to/ from the Participant Premium shown above to determine your final premium.

To determine your final premium, turn to page 27.

Note: Survivors and unsubsidized dependents are not eligible for a subsidy.

State Retiree Years of Service Subsidy

State Retiree Years of Service Subsidy for Retirees Enrolled in the CDHP/HMO Plan	
Years of Service	**Subsidy**
5	+333.77
6	+300.39
7	+267.02
8	+233.64
9	+200.26
10	+166.89
11	+133.51
12	+100.13
13	+66.75
14	+33.38
15	—
16	-33.38
17	-66.75
18	-100.13
19	-133.51
20	-166.89

- For participants who retired before January 1, 1994, the participant premium is shown on pages 25-26.
- For participants who retired *on or after* January 1, 1994, *add or subtract* the appropriate subsidy based on the number of years of service *to or from* the Participant Premium for the selected plan and tier shown on pages 25-26.
- Those retirees with less than 15 Years of Service, who were hired by their last employer on or after January 1, 2010 and who are not disabled do not receive a Years of Service Subsidy or Base Subsidy.
- Those retirees who were hired on or after January 1, 2012 do not receive a Years of Service Subsidy.
- If you are a retiree (or survivor) enrolled in the CDHP or HMO plan and you have submitted proof of your Medicare Part B enrollment to the PEBP office, deduct $134 from your premium cost.

Non-State Employee Rates

Effective July 1, 2017 - June 30, 2018

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

Non-State Employee rates are unsubsidized rates. Employees working for a non-state agency should contact their agency to inquire about any premium subsidies.

Non-State Retiree and Survivor Rates

Effective July 1, 2017 - June 30, 2018

Consumer Driven Health Plan Non-State Retiree and Survivor Rates	Statewide PPO		
	Consumer Driven High Deductible Health Plan		
	Unsubsidized Rate	Base Subsidy	Participant Premium
Retiree only	1,100.86	709.19	391.67
Retiree + Spouse/DP	2,111.26	1,158.03	953.23
Retiree + Child(ren)	1,976.42	1,098.13	878.29
Retiree + Family	2,986.82	1,546.96	1,439.86
Surviving/Unsubsidized Dependent	1,100.86	-	1,100.86
Surviving/Unsubsidized Spouse/DP + Child(ren)	1,976.42	-	1,976.42

Standard HMO Non-State Retiree and Survivor Rates	Standard HMO Plan		
	Hometown Health Plan & Health Plan of Nevada		
	Unsubsidized Rate	Base Subsidy	Participant Premium
Retiree only	868.57	429.26	439.31
Retiree + Spouse/DP	1,716.83	678.83	1,038.00
Retiree + Child(ren)	1,304.99	557.66	747.33
Retiree + Family	2,153.25	807.23	1,346.02
Surviving/Unsubsidized Dependent	868.57	-	868.57
Surviving/Unsubsidized Spouse/DP + Child(ren)	1,304.99	-	1,304.99

Alternate HMO Non-State Retiree and Survivor Rates	Alternate HMO Plan		
	Hometown Health Plan & Health Plan of Nevada		
	Unsubsidized Rate	Base Subsidy	Participant Premium
Retiree only	816.27	412.43	403.84
Retiree + Spouse/DP	1,591.44	645.18	946.26
Retiree + Child(ren)	1,219.45	530.78	688.67
Retiree + Family	1,994.61	763.52	1,231.09
Surviving/Unsubsidized Dependent	816.27	-	816.27
Surviving/Unsubsidized Spouse/DP + Child(ren)	1,219.45	-	1,219.45

- The Non-State Retiree Participant Premiums above are subsidized rates for those who retired prior to January 1, 1994.
- For those who retired on or after January 1, 1994, refer to the Non-State Retiree Years of Service Subsidy Table on page 30, *add or subtract* the appropriate subsidy based on your years of service to/from the Participant Premium shown above to determine your final premium.

To determine your final premium, turn to page 31.

Non-State Retiree Years of Service Subsidy

Non-State Retiree Years of Service Subsidy for Retirees Enrolled in the CDHP/HMO Plan	
Years of Service	**Subsidy***
5	+333.77
6	+300.39
7	+267.02
8	+233.64
9	+200.26
10	+166.89
11	+133.51
12	+100.13
13	+66.75
14	+33.38
15	—
16	-33.38
17	-66.75
18	-100.13
19	-133.51
20	-166.89

- For participants who retired *before* January 1, 1994, the Participant Premium for the selected plan and tier is shown on page 29.
- For participants who retired *on or after* January 1, 1994, *add or subtract* the appropriate subsidy based on the number of years of service *to or from* the Participant Premium for the selected plan and tier shown on page 29.
- Those retirees with less than 15 Years of Service, who were initially hired by their last employer *on or after* January 1, 2010 and who are not disabled do not receive a Years of Service Subsidy or Base Subsidy.
- Those retirees who were hired *on or after* January 1, 2012 do not receive a Years of Service Subsidy or Base Subsidy.
- If you are a retiree (or survivor) enrolled in the CDHP or HMO plan and you have submitted proof of your Medicare Part B enrollment to the PEBP office, deduct $134 from your premium cost.

Exchange-HRA Years of Service Contribution

Retirees Enrolled in OneExchange

Exchange-HRA Contribution for Medicare Retirees Enrolled in OneExchange	
Years of Service	**Contribution**
5	+60.00
6	+72.00
7	+84.00
8	+96.00
9	+108.00
10	+120.00
11	+132.00
12	+144.00
13	+156.00
14	+168.00
15 (Base)	+180.00
16	+192.00
17	+204.00
18	+216.00
19	+228.00
20	+240.00

- For participants who retired before January 1, 1994 receive the 15 year ($180) base contribution.
- For participants who retired on or after January 1, 1994, the contribution is $12 per month, per year of service, beginning with 5 years ($60) and a maximum of 20 years ($240).
- Retirees with less than 15 years of service, who were hired by their last employer on or after January 1, 2010, and who are not disabled, do not receive a Years of Service HRA contribution.
- Retirees who were hired by their last employer on or after January 1, 2012, do not receive a Years of Service HRA contribution.

Health Reimbursement Arrangement timely filing

Plan provisions allow for a 12 month, 365 day, timely filing period for eligible medical claims submission. The 365 days is measured from the date the services were incurred. No plan benefits will be paid for any claim submitted after this period.

Optional Dental Coverage Medicare Exchange Retirees

Retirees and Covered Dependents Enrolled in OneExchange

Voluntary PEBP Dental Coverage Optional dental coverage for retirees enrolled in a OneExchange Medical Plan		
Voluntary Dental Coverage	**State Retiree Rate**	**Non-State Retiree Rate**
Retiree only	$38.89	$38.21
Retiree + Spouse/DP	$77.78	$76.42
Surviving/Unsubsidized Spouse/DP	$38.89	$38.21

Retirees and their spouses or domestic partners enrolled in a medical plan through OneExchange may enroll or decline PEBP dental coverage during Open Enrollment.

To enroll in PEBP dental or to decline PEBP dental coverage, contact PEBP at (775) 684-7000 or (800) 326-5496 to request the Open Enrollment Form.

COBRA Rates

State and Non-State Employee and Retiree

	Statewide PPO	Standard HMO Plan	Alternate HMO Plan
	PPO Consumer Driven High Deductible Health Plan	Hometown Health Plan & Health Plan of Nevada	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 COBRA do not receive a subsidy

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.

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 You or 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 You or 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. If you are a State or non-State Retiree, special enrollment does not apply to you but it does apply to your Dependents if you are covered under the Plan. If you are a Surviving Spouse or Surviving Domestic Partner special enrollment does not apply to you or your Dependents.

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.

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 PEBP 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, Attn: 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

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 ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-326-5496 (መስማት ለተሳናቸው፡1-800-545-8279).

เรียน: ถ้าคณุพดู ภาษา ไทยคณุสามารถ ใช้บริการชว่ ยเหลือทางภาษา 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 1-800-623-6945 (رقم هاتف الصم والبكم: 1-800-545-9728).

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: 1-800-545-8279) 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 kenyam. Awagan ti 1-800-326-5496 (TTY: 1-800-545-8279).

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Vendor Contact List

CDHP Medical and PPO Dental Claims Administrator • Claim status inquiries • Diabetes Care Management • Obesity Care Management • Plan benefit information • HSA/PPO-HRA Administration • Network Providers • ID cards	**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
CDHP National Provider Network For participants who reside outside of Nevada or travel outside of Nevada for their Health Care.	**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
Dental PPO Network • Statewide dental PPO providers • Dental provider directory	**Diversified Dental Services** Northern Nevada: (866) 270-8326 Southern Nevada: (800) 249-3538 www.ddsppo.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 • Preventive Drug benefit	**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 May 1 - 31, 2016)** **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

Vendor Contact List

Northern HMO Plan • Standard and Alternate HMO • 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 • Standard and Alternate HMO • Provider network • Provider directories • Benefit Information/Appeals • Additions/deletions of providers	**Health Plan of Nevada** Customer Service: (702) 242-7300 (800) 777-1840 www.stateofnvhpnbenefits.com
Life and Long Term Disability Insurance • Life insurance benefits information • Claim filing • MEDEX travel assistance • Beneficiary designation forms	**Standard Insurance Company** Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html
Medicare Exchange Medicare plans Exchange-HRA administrator	**Towers Watson's OneExchange** 10975 Sterling View Drive, Suite A1 South Jordan, UT 84095 Customer Service: (888) 598-7545 www.medicare.oneexchange.com/PEBP
PayFlex—Health Reimbursement Arrangement	**PayFlex** Customer Service: (888) 598-7545 General Fax: (402) 231-4300 Claims Fax: (402) 231-4310

Voluntary Product Contacts

Life Insurance • Voluntary Life Insurance • Voluntary Short-Term Disability Insurance	**Standard Insurance Company** Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html or www.pebp.state.nv.us
Long-Term Care Insurance	**UNUM** Customer Service: (800) 227-4165 www.pebp.state.nv.us
Home and Auto Insurance	**Liberty Mutual** Customer Service: (800) 637-7026 gary.bishop@libertymutual.com

Open Enrollment Meetings

MEETING DATES AND LOCATIONS		
Tuesday, May 2, 2017	9:00 am – 11:00 am	**Great Basin College, Elko** Leonard Center for Student Life Solarium and Theatre 1500 College Parkway Elko, NV 89801
Wednesday, May 3, 2017	9:00 am – 11:00 am 1:00 pm – 3:00 pm	**National Guard Armory** Auditorium and Solarium 2460 Fairview Drive Carson City, NV 89701 ***Be prepared to show I.D. at the gate***
Thursday, May 4, 2017	10:00 am – 12:00 pm 1:00 pm – 3:00 pm	**University of Nevada, Reno** Joe Crowley Student Union Theatre 1664 North Virginia Street Reno, NV 89557 **** **UNR PARTICIPANTS ONLY***
Friday, May 5, 2017	9:00 am – 11:00 am 1:00 pm – 3:00 pm	**Truckee Meadows Community College** Red Mountain Building, Room 255/256 7000 Dandini Blvd Reno, NV 89512
Monday, May 8, 2017	2:00 pm – 4:00 pm	**University of Nevada, Las Vegas** Student Union, Room 208B and 208C 4505 South Maryland Parkway Las Vegas, NV 89154 ****UNLV PARTICIPANTS ONLY***
Tuesday, May 9, 2017	9:00 am – 11:00 am 1:00 pm – 3:00 pm	**College of Southern Nevada, Charleston Campus** Ralph and Betty Engelstad School of Health Sciences Building K, Room 101 6375 W. Charleston Blvd Las Vegas, NV 89146
Wednesday, May 10, 2017	9:00 am – 11:00 am 1:00 pm – 3:00 pm	**College of Southern Nevada,** **North Las Vegas Campus** Horn Theatre 3200 East Cheyenne Ave North Las Vegas, NV 89030

Administrative Leave

Administrative leave is authorized per NAC 284.589.6(b) for active employees attending a PEBP coordinated event. Open Enrollment meetings are scheduled in 2 hour increments. PEBP recommends employees work with their supervisor to request approval to attend an Open Enrollment meeting.