STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
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BRIAN SANDOVAL
Governor

JAMES R. WELLS, CPA
Executive Officer

LEO M. DROZDOFF, P.E.
Board Chairman

Memorandum

DATE: January 16, 2013

TO: Public Employees' Benefits Program Board
Richard S. Combs, Director, Legislative Counsel Bureau
Jeff Mohlenkamp, Director, Department of Administration

CC: Laura Freed, Fiscal Analyst, LCB Fiscal Division
Julie Strandberg, Budget Analyst, Budget Office

FROM: James R. Wells, Executive Officer

SUBJECT: NRS 287.0425 Report

Summary

In accordance with NRS 287.0425, this report provides to the Public Employees' Benefits Program Board, the Department of Administration and the Director of the Legislative Counsel Bureau for transmission to various committees of the Legislature the status on several matters pertaining to the Public Employees Benefits Program (PEBP). The report is being provided to the PEBP Board without attachments (only Attachment D-5 is provided to the Board) since most of the attachments were provided to the Board at previous Board meetings (Attachment F will be provided to the Board at the January 31, 2013 Board meeting). The Board meeting dates at which the items were presented and a link to the reports on the PEBP website are included in this report where applicable. Topics included are as follows:

A. Section 1(a) – An audited financial statement of the Program Fund for the immediately preceding fiscal year.
B. Section 1(b) – An audited financial statement of the Retirees' Fund for the immediately preceding fiscal year.
C. Section 1(c) – A report of the utilization of the Program by participants during the immediately preceding plan year, segregated by benefit, administrative cost, active employees and retirees, including, without limitation, an assessment of the actuarial accuracy of reserves.
D. Section 1(d) – Material provided generally to participants or prospective participants in connection with enrollment in the Program for the current plan year.
E. Section 2(a) – An independent biennial certified actuarial valuation and report of the State's health and welfare benefits for current and future state retirees, which are

provided for the purpose of developing the annual required contribution pursuant to the statements issued by the Governmental Accounting Standards Board.

F. Section 2(b) – A biennial review of the Program to determine whether the Program complies with federal and state laws relating to taxes and employee benefits.

Report

A. Section 1(a) – An audited financial statement of the Program Fund for the immediately preceding fiscal year.

The annual audit of the Program Fund conducted by an independent certified public accountant can be found in the following attachment:

Attachment A
Audited financial statements for the Self-Insurance Trust Fund (Fund 625) for the year ending June 30, 2012

The financial statements were presented to the Board at its December 10, 2012 meeting. They are available on the following web page:

http://www.pebp.state.nv.us/fiscalutilization.htm

B. Section 1(b) – An audited financial statement of the Retirees' Fund for the immediately preceding fiscal year.

The annual audit of the Retirees' Fund conducted by an independent certified public accountant can be found in the following attachment:

Attachment B
Audited financial statements for the State Retirees' Health and Welfare Benefits Fund (Fund 680) for the year ending June 30, 2012

The financial statements were presented to the Board at its December 10, 2012 meeting. They are available on the following web page:

http://www.pebp.state.nv.us/fiscalutilization.htm

C. Section 1(c) – A report of the utilization of the Program by participants during the immediately preceding plan year, segregated by benefit, administrative cost, active employees and retirees, including, without limitation, an assessment of the actuarial accuracy of reserves.

Attachment C
Self-Funded Plan Utilization Report for the year ending June 30, 2012

The annual utilization report was presented to the Board at its September 13, 2012 meeting. It is available on the following web page:

http://www.pebp.state.nv.us/fiscalutilization.htm

A summary of all PEBP reserves is provided below. The Health Reimbursement Arrangement (HRA) Reserve is the liability created by the estimated balances in each HRA account as of June 30, 2013. PEBP's actuary provides the estimates for the Reserve for Incurred But Not Reported (IBNR) claims and a Catastrophic Reserve (to provide a 95% probability the plan will maintain fiscal solvency) each year. The $29.7 million in estimated excess reserves for FY 2013 decreased from the FY 2012 amount due to the Board utilizing the excess reserves in FY 2013 to increase Health Savings Account and HRA contributions and to partially mitigate premium increases for participants in FY 2013. With the usage of excess reserves approved by the Board, it was projected the excess reserves as of June 30, 2013 would be approximately $10.2 million. The additional estimated excess reserve of approximately $19.5 million is due to better than expected claims experience year to date in FY 2013. Any projected excess reserves as of June 30, 2013 are included in the PEBP budget to be spent down during the FY 2014/2015 biennium.

Reserves (estimated as of December 24, 2012)		
	FY 2012 Actual	FY 2013 Estimated (as of 12/24/2012)
HRA Reserve	8,097,038	15,478,878
IBNR Reserve	34,891,000	37,898,000
Catastrophic Reserve	26,800,000	27,800,000
"Excess" Reserve	59,063,535	29,702,258
Total Reserves	128,851,573	110,879.136

D. Section)(d) – Material provided generally to participants or prospective participants in connection with enrollment in the Program for the current plan year, including, without limitation:

(1) Information regarding rates and the costs for participation in the Program paid by participants on a monthly basis; and

(2) A summary of the changes in the plan design for the current plan year from the plan design for the immediately preceding plan year.

The following documents were provided generally to participants or prospective participants in connection with enrollment in the Program for the current plan year

Attachment D-1
Open Enrollment Guide, Plan Year 2013

Attachment D-2
Introduction to Employee Benefits, Plan Year 2013

Attachment D-3
Retiree Enrollment Guide, Plan Year 2013

The Open Enrollment Guides and Introduction to Employee Benefits, Plan Year 2013 are available on the following web page:

http://www.pebp.state.nv.us/forms_pub.htm

A summary of the plan design changes and monthly rates for Plan Year 2013 can be found in the following Board report. The Board ultimately approved rates not included in the original scenarios found in Attachment A of the Board report. Therefore, that attachment has been excluded. The final approved rates are included.

Attachment D-4
Plan Year 2013 Plan Design and Rates

The Plan Year 2013 Plan Design and Rates were presented to and approved by the Board at its March 29, 2012 meeting. The report is available as Agenda Item VII of the March 29, 2012 Board Packet and the approved rates are available as Supporting Material for the March 29, 2012 Board meeting on the following web page:

http://www.pebp.state.nv.us/board.htm

A summary of Plan Year 2012 communications can be found in the following attachment.

Attachment D-5
Plan Year 2012 Communication Activities

E. Section 2(a) – An independent biennial certified actuarial valuation and report of the State's health and welfare benefits for current and future state retirees, which are provided for the purpose of developing the annual required contribution pursuant to the statements issued by the Governmental Accounting Standards Board.

The independent certified actuarial valuation and report of the State's health and welfare benefits for current and future state retirees can be found in the following attachment:

Attachment E
Nevada Public Employees' Benefits Program's Retiree Health and Life Insurance Plans Actuarial Report for GASB OPEB Valuation – FINAL, Fiscal Year Ending June 30, 2011

The GASB OPEB Valuation report was presented to the Board at its September 22, 2011 meeting. It is available on the following web page:

http://www.pebp.state.nv.us/fiscalutilization.htm

F. Section 2(b) – A biennial review of the Program to determine whether the Program complies with federal and state laws relating to taxes and employee benefits.

The biennial review of the Program to determine whether the Program complies with federal and state laws relating to taxes and employee benefits can be found in the following attachment:

Attachment F
The Biennial Legal Compliance Review will be presented to the Board at its January 31, 2013 meeting. The report will be available as Agenda Item VII of the January 31, 2013 Board Packet on the following web page: (Pending Posting)

http://www.pebp.state.nv.us/board.htm

A.

NRS 287.0425 Sec 1 (a)

An audited financial statement of the Program Fund for the immediately preceding fiscal year.

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM

JUNE 30, 2012 AND 2011

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
JUNE 30, 2012 AND 2011

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Casey, Neilon & Associates, LLC
Accountants and Advisors

INDEPENDENT AUDITOR'S REPORT

To the Board of the
Public Employees' Benefits Program

We have audited the accompanying financial statements of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada as of and for the years ended June 30, 2012 and 2011 as listed in the table of contents. These financial statements are the responsibility of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America and in accordance with the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinions.

As discussed in Note 1, the financial statements present only the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada and do not purport to, and do not, present fairly the financial position of the State of Nevada, as of June 30, 2012 and 2011, and the changes in its financial position, or, where applicable, its cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada as of June 30, 2012 and 2011, and the changes in financial position and cash flows thereof for the years then ended in conformity with accounting principles generally accepted in the United States of America.

In accordance with *Government Auditing Standards*, we have also issued our report dated November 30, 2012 on our consideration of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's internal control over financial reporting and on compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and the results of that testing, and not to provide an opinion on internal control over financial reporting. That report is an integral part of an audit performed in accordance with Government Auditing Standards and should be considered in assessing the results of our audit.

Casey, Neilon & Associates, LLC

Carson City, Nevada
November 30, 2012

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
STATEMENTS OF NET ASSETS
JUNE 30, 2012 AND 2011

	2012	2011
ASSETS		
Current assets:		
Cash and cash equivalents	$ 125,987,872	$ 111,556,212
Receivables:		
Accounts receivable, net	582,194	1,770,825
Intergovernmental receivable	3,148,590	5,700,415
Due from other funds	3,051,713	616,770
Due from component units, net	42,583	1,339,528
Total Current Assets	132,812,952	120,983,750
Capital assets:		
Property and equipment	327,909	361,572
Less: Accumulated depreciation	(252,696)	(292,635)
Total Capital Assets (net of accumulated depreciation)	75,213	68,937
Total Assets	132,888,165	121,052,687
LIABILITIES		
Current liabilities:		
Bank overdraft	5,545,826	2,516,747
Accounts payable	1,287,359	7,632,611
Accrued payroll and related liabilities	101,942	98,960
Due to other funds	11,383	19,720
Unearned revenue	75,658	97,226
Compensated absences	117,694	124,423
Reserve for losses	42,988,038	33,849,000
Total Current Liabilities	50,127,900	44,338,687
Noncurrent liabilities:		
Compensated absences	78,289	69,863
Total Noncurrent Liabilities	78,289	69,863
Total Liabilities	50,206,189	44,408,550
NET ASSETS		
Invested in capital assets	75,213	68,937
Restricted for losses	82,606,763	76,575,200
Total Net Assets	$ 82,681,976	$ 76,644,137

See accompanying notes.

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
STATEMENTS OF REVENUES, EXPENSES AND CHANGES
IN FUND NET ASSETS
FOR THE YEARS ENDED JUNE 30, 2012 AND 2011

	2012	2011
OPERATING REVENUES:		
Insurance premiums	$ 312,173,658	$ 370,543,399
Other	(223,789)	4,031,677
Total Operating Revenues	311,949,869	374,575,076
OPERATING EXPENSES:		
Salaries and benefits	2,033,462	2,158,411
Operating	2,740,405	3,230,764
Claims expense	185,704,927	237,323,825
Depreciation	35,124	34,097
Insurance premiums and contractual obligations	114,837,228	109,586,367
Total Operating Expenses	305,351,146	352,333,464
Operating Income (Loss)	6,598,723	22,241,612
NONOPERATING REVENUES (EXPENSES):		
Investment loss	(1,143,968)	(763,892)
Interest income	583,084	476,518
Total Nonoperating Revenues (Expenses)	(560,884)	(287,374)
Change in Net Assets	6,037,839	21,954,238
Net Assets, July 1	76,644,137	54,689,899
Net Assets, June 30	$ 82,681,976	$ 76,644,137

See accompanying notes.

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED JUNE 30, 2012 AND 2011

	2012	2011
CASH FLOWS FROM OPERATING ACTIVITIES:		
Receipts from customers and users	$ 66,179,488	$ 96,869,568
Receipts for interfund services provided	175,613,356	202,038,695
Receipts from component units	72,382,243	81,030,127
Payments to suppliers, other governments and beneficiaries	(295,836,663)	(349,986,937)
Payments to employees	(2,028,783)	(2,105,269)
Payments for interfund services used	(1,019,736)	(1,052,976)
Net Cash Provided by Operating Activities	15,289,905	26,793,208
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Purchase of capital assets	(41,400)	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest on investments	327,123	327,365
Investment Loss	(1,143,968)	(763,892)
Net Cash Used by Operating Activities	(816,845)	(436,527)
Net Increase in Cash and Cash Equivalents	14,431,660	26,356,681
Cash and cash equivalents, July 1	111,556,212	85,199,531
Cash and cash equivalents, June 30	$ 125,987,872	$ 111,556,212
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES:		
Operating income	$ 6,598,723	$ 22,241,612
Adjustments to reconcile operating income to net cash provided by operating activities:		
Depreciation	35,124	34,097
Allowance for doubtful accounts	177,744	170,837
Changes in assets and liabilities:		
(Increase) decrease in receivables	2,424,714	5,203,511
Increase (decrease) in payables and accruals	6,053,600	(856,849)
Total Adjustments	8,691,182	4,551,596
Net Cash Provided by Operating Activities	$ 15,289,905	$ 26,793,208

See accompanying notes.

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
NOTES TO FINANCIAL STATEMENTS
JUNE 30, 2012 AND 2011

NOTE 1 - Summary of Significant Accounting Policies:

The financial statements of the Self Insurance Trust Fund, Public Employees' Benefits Program ("PEBP") of the State of Nevada ("Self Insurance Trust Fund") have been prepared in conformity with accounting principles generally accepted in the United States of America (USGAAP) as applied to governmental units. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. A summary of the Self Insurance Trust Fund's significant accounting policies applied in the preparation of the accompanying financial statements is presented below.

Plan Description:

The Self Insurance Trust Fund was created in 1983 by the Nevada Legislature to administer group health, life and disability insurance for covered employees, both active and retired, of the State, and certain other participating public employers within the State of Nevada. All public employers in the State are eligible to participate in the activities of the Self Insurance Trust Fund and currently, in addition to the State, there are eleven public employers whose employees are covered under the plan. Additionally, all retirees of public employers contracted with PEBP to provide coverage to their employees are eligible to join the program subsequent to their retirement. Public employers are required to subsidize their retirees who participate in the plan in the same manner the State subsidizes its retirees. Currently, the State, the Nevada System of Higher Education and 122 public employers within the State of Nevada are billed for retiree subsidies. The Self Insurance Trust Fund provides medical, dental, vision, long-term disability, mental health, substance abuse, and life insurance benefits. The Self Insurance Trust Fund is overseen by the Public Employees' Benefits Program Board. The Board is composed of nine members, eight members appointed by the Governor, and the Director of the Department of Administration or his designee.

The Self Insurance Trust Fund is self-insured for medical, dental, vision, mental health and substance abuse benefits and also offers fully insured HMO products. Long-term disability and life insurance benefits are fully insured by outside carriers. For the self-insured benefits, rate-setting policies have been established after consultation with an actuary. The participating public employers, with the exception of the State, are not subject to supplemental assessment in the event of deficiencies.

For the 2012 plan year PEBP instituted a Consumer Driven Health Plan (CDHP) with a Health Savings Account (HSA) component and a Health Reimbursement Account (HRA) component. The HSA component is designed for eligible active employee's where the HRA component is for retirees and surviving spouses, domestic partners and certain employees enrolled in the CDHP.

For the 2012 plan year PEBP also implemented an individual market Medicare exchange where retirees eligible for Medicare purchase individual coverage on the private market with an HRA component to reimburse retirees for insurance premiums and other out of pocket expenses.

Reporting Entity:

Governmental accounting and financial reporting principles require that basic financial statements be presented for governmental entities which present financial statements in accordance with generally accepted accounting principles. The accompanying financial statements are not intended to present the combined financial activities of the State of Nevada taken as a whole, but are intended only to present the financial position, results of operations, and cash flows of the Self Insurance Trust Fund.

NOTE 1 - Summary of Significant Accounting Policies (continued):

Fund Accounting:

The operations of the Self Insurance Trust Fund, a proprietary fund (internal service fund), are accounted for by a separate set of self-balancing accounts that comprise its assets, liabilities, net assets, revenues, and expenses. The Self Insurance Trust Fund is used to account for the services provided to the employees and retirees of the State of Nevada and other governmental units under the programs administered by management.

Basis of Accounting:

The Self Insurance Trust Fund maintains its accounting records on the accrual basis of accounting as defined by the Governmental Accounting Standards Board ("GASB"). Under this method, revenues are recognized at the time they are earned and expenses are recognized when the related liabilities are incurred regardless of the timing of cash flows. The Self Insurance Trust Fund applies all applicable GASB pronouncements as well as Financial Accounting Standards Board ("FASB") statements and interpretations, APB opinions, and ARB's (unless those pronouncements conflict with or contradict GASB pronouncements) issued on or before November 30, 1989, in accounting and reporting for its proprietary operations. As permitted by GASB Statement No. 20 the State has elected not to apply FASB pronouncements issued after that date.

The Self Insurance Trust Fund is reported using the economic resources measurement focus. The revenues derived from current operations are generally intended to provide those resources necessary to maintain continued delivery of such services in the future. Net assets greater or lesser than those required to support ongoing operations are moderated by adjustments of future charge rates appropriate to accomplish the long-term cost recovery objectives of the Self Insurance Trust Fund.

Internal Service Funds distinguish operating revenues and expenses from nonoperating items. Operating revenues and expenses result from providing services in connection with providing group health, life and disability insurance. Operating expenses include the cost of services, administrative expenses and depreciation on capital assets. All revenues and expenses not meeting this definition are reported as nonoperating revenues and expenses.

Cash Equivalents:

For the purpose of presentation in the Self Insurance Trust Fund's financial statements, cash equivalents are short-term, highly liquid investments that are both (a) readily convertible to known amounts of cash and (b) so near to maturity that they present insignificant risk of changes in value due to changing interest rates.

Receivables:

Insurance premiums due through June 30 but remitted after that date are recorded as receivables or due from other funds, component units or governments in the financial statements.

The third party administrator that processes claims payments on behalf of the Self Insurance Trust Fund has identified overpayments in the amount of $837,670 and $1,880,495 as of June 30, 2012 and 2011, respectively. Overpayments are followed up on every 30 days until recovery is made. These amounts have not been accrued as a receivable on the statement of net assets, but are recorded as a reduction to claims expense in the period in which recovery is received. Collection attempts cease when the overpayment is greater than 4 years old.

NOTE 1 - Summary of Significant Accounting Policies (continued):

Receivables (continued):

The Self Insurance Trust Fund administered an additional pass-through budget account, the Active Employee Group Insurance Subsidy (AEGIS) budget account through June 30, 2011. It was utilized for recording the payments made by the state and received by the Self Insurance Trust Fund on behalf of active employees. Agencies contributed a fixed dollar amount per employee into this budget account. However, insurance premiums were earned by the main operating budget account in accordance with the PEBP approved rate for insurance coverage for the plan and tier to which each employee belonged. The difference between cash contributions and revenue recognition resulted in a surplus (shortfall) of contributions over premium allocation of $(363,819) for the year ended June 30, 2011. These amounts were allocated among all state entities that paid the AEGIS subsidy proportionate to their size and were included in the subsequent year's budget. Effective July 1, 2011, the Active Employee Group Insurance Subsidy budget account was reported under the State of Nevada Agency Fund for the Payroll of the State.

The Self Insurance Trust Fund considers $177,744 and $170,837 in participant premiums as uncollectible as of June 30, 2012 and 2011 respectively. Pursuant to NRS 353C.220, only accounts that have been approved by the State of Nevada Board of Examiners may be written off. Of the uncollectible premiums listed above, $0 and $5,576 were approved for write-off by the State of Nevada Board of Examiners as of June 30, 2012 and 2011, respectively. The State has a policy in which all uncollectible amounts are remitted to the State Controller's Office for continued collection attempts and eventual write-off. In accordance with this policy, the Self Insurance Trust Fund created an allowance of $177,744 and $170,837 at June 30, 2012 and 2011, respectively, to account for the remaining uncollectible amounts that have been remitted to the State Controller's Office, but not yet been approved by the State of Nevada Board of Examiners for write off.

Property and Equipment:

Fixed assets are capitalized and depreciated using the straight line method of depreciation over the assets' estimated useful lives ranging from three to ten years. Capital acquisitions for the years ended June 30, 2012 and 2011 were $41,400 and $0, respectively; Capital dispositions for the years ended June 30, 2012 and 2011 were $75,063 and $0, respectively.

Estimated Claims:

The Self Insurance Trust Fund contracted with Aon , a provider of consulting and actuarial services, to estimate its liability for incurred but not reported claims, claims reported but not yet paid and administrative expenses expected to be incurred in conjunction with processing incurred but not reported claims as of June 30, 2012 and 2011, respectively. This liability is estimated by the actuary based on industry trends and claims lag information reported by the third party administrator. Such liabilities are necessarily based on estimates, and, while management believes the amount is adequate, the ultimate liability may be in excess of, or less than the amounts provided. The methods for making such estimates and for establishing the resulting liability are reviewed on an annual basis and any adjustments are currently reflected in net income from operations.

Aon Consulting, the prior year actuary, purchased Hewitt Associates in October 2010. Hewitt Associates operations were merged with elements of Aon Consulting to form a new subsidiary of the Aon Group called Aon Hewitt.

Included in the estimated claims is the liability for the unused portion of the HRA component of the CDHP and the Medicare exchange. The Fund contracted with HealthSCOPE and Extend Health, respectively, to administer these programs and the liabilities are provided by each.

NOTE 1 - Summary of Significant Accounting Policies (continued):

Compensated Absences:

Compensated absences are accounted for in accordance with GASB Statement No. 16, Accounting for Compensated Absences, which requires that a liability for compensated absences relating to services already rendered and that are not contingent on a specified event be accrued as employees earn the rights to the benefits. Compensated absences relating to future services or that are contingent on a specified event will be accounted for in the period those services are rendered or those events take place. Annual and sick leave benefits not used as earned accumulate to be carried over to the next year, except that annual leave in excess of 240 hours (30 days) per employee is forfeited each December 31.

Accumulated annual leave and compensatory time are payable upon termination, retirement, or death. Unused sick leave may be partially compensated at that time according to formulas established by the Department of Administration. The Self Insurance Trust Fund reports accrued compensated absences as a liability.

Net Assets:

Net assets present the difference between assets and liabilities in the statement of net assets. Net assets invested in capital assets are net of accumulated depreciation and reduced by the outstanding balances of any borrowings used for the acquisition, construction or improvements of those assets. Restricted net assets result when constraints placed on net asset use are either externally imposed by creditors, grantors, contributors and the like, or imposed by law through constitutional provisions or enabling legislation. Management determined that all of the net assets at year end should be restricted for future claims payments due to legal restrictions on the use of the funds.

Reinsurance:

The Self Insurance Trust Fund does not carry any reinsurance policies.

Use of Estimates:

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and the liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Prior Year Reclassifications:

The prior year's financial statements have been reclassified where applicable to conform to the current year's presentation.

NOTE 2 - Compliance with Nevada Revised Statutes and the Nevada Administrative Code:

The Self Insurance Trust Fund conformed to all significant statutory constraints on its financial administration during the year.

NOTE 3 - Cash and Deposits with the State Treasurer as of June 30:

	2012	2011
Cash:		
Operating checking account:		
Bank of America	$ (5,545,826)	$ (2,516,747)
Deposits with State Treasurer:		
State Treasurer's Investment Pool	129,412,409	113,836,781
GASB 31 adjustment	(3,424,537)	(2,280,569)
	125,987,872	111,556,212
Total Cash and Deposits	$ 120,442,046	$ 109,039,465

The Self Insurance Trust Fund has three checking accounts with Bank of America. The zero balance account ending in 6003 was closed on April 30, 2006 and contains $71.49 in stale outstanding checks; the zero balance account ending in 4161 was closed during fiscal year 2012 and contains $826,030 in stale outstanding checks. Checks presented for payment from these accounts are rejected by the bank, voided, and reissued by the Self Insurance Trust Fund using the controlled disbursement account. The controlled disbursement account is funded only when checks are presented for payment. The negative balance represents outstanding checks issued that have not been presented for payment. In accordance with NRS 353.140, the Self Insurance Trust Fund honors outstanding stale warrants presented for payment within six years from the date of origination. For insurance and collateral purposes, the account is commingled with all of the cash accounts of the State of Nevada. All cash and deposits are recorded at fair value.

Nevada Revised Statutes direct the Office of the State Treasurer to deposit funds into any state, or national bank, credit union or savings and loan association covered by federal depository insurance. For those deposits over and above the federal depository insurance maximum balance, sufficient collateral must be held by the financial institution to protect the State of Nevada against loss. The pooled collateral for the deposits program maintains a 102% pledge collateral for all public deposits.

NRS 355.140 details the types of securities in which the State may invest. In general, authorized investments include: certificates of deposit, asset-backed securities, bankers' acceptances and commercial paper, collateralized mortgage obligations, corporate notes, money market funds whose policies meet the criteria set forth in the statute, United States treasury securities and specific securities implicitly guaranteed by the federal government. Additionally, the State may invest in limited types of repurchase agreements; however, statutes generally prohibit the State from entering into reverse-repurchase agreements.

A copy of the State of Nevada Comprehensive Annual Financial Report can be obtained online at http://controller.nv.gov/FinancialReports/CAFR_Download_Page.html.

NOTE 4 - Pension Plan:

Plan Description. The Self Insurance Trust Fund contributes to the Public Employees' Retirement System of the State of Nevada (PERS), a cost sharing, multiple employer, defined benefit plan administered by the Public Employees' Retirement System of the State of Nevada. PERS provides retirement benefits, disability benefits, and death benefits, including annual cost of living adjustments, to plan members and their beneficiaries. Chapter 286 of the Nevada Revised Statutes establishes the benefit provisions provided to the participants of PERS. These benefit provisions may only be amended through legislation. A publicly available financial report that includes financial statements and required supplementary information for PERS may be obtained by writing to the Public Employees' Retirement System of the State of Nevada, 693 West Nye Lane, Carson City, NV 89703-1599 or by calling (775) 687-4200.

NOTE 4 - Pension Plan (continued):

Funding Policy. Plan members' benefits are funded under one of two methods. Under the employer paid contribution plan, the Self Insurance Trust Fund is required to contribute all amounts due under the plan. The rate for those contributions was 23.75%, 21.50% and 21.50% for regular members on all covered payroll for the years ended June 30, 2012, 2011 and 2010, respectively. The second funding mechanism for providing benefits is the employer/employee paid contribution plan. Under this method, employees are required to contribute a percentage of their compensation to the plan, while the Self Insurance Trust Fund is required to match that contribution. The rate for regular employees under this plan was 12.25%, 11.25% and 11.25% for the years ended June 30, 2012, 2011 and 2010, respectively. The contribution requirements of plan members and the Self Insurance Trust Fund are established by NRS Chapter 286. The funding mechanism may only be amended through legislation. The Self Insurance Trust Fund's contributions to PERS for the years ended June 30, 2012, 2011 and 2010 were $260,815, $247,593 and $249,985, respectively, equal to the required contributions for the year.

NOTE 5 - Post-Retirement Insurance Benefits:

Employees of the State, who meet the eligibility requirements for retirement, have the option upon retirement to continue group insurance pursuant to NAC 287.530. NRS 287.046 requires the State to pay an amount toward the cost of the premiums for most persons retired from state service. Retirees assume any portion of the premium not covered by the State. The State allocates funds for payment of post retirement insurance benefits as a percentage of budgeted payroll to all State agencies. The cost of the employer contribution is recognized in the year the costs are charged. No unused funds are carried forward to the next fiscal year.

NOTE 6 - Commitments:

The Self Insurance Trust Fund is committed to the following contracts or policies after June 30, 2012:

Contractor	Contract Rate	Expiration Date
Aon Consulting	Hourly Rate	6/30/16
APS Healthcare	$2.59 per PPO participant per month	6/30/15
Capital Reporters	Hourly Rate	5/31/13
Casey, Neilon & Associates, LLC	Hourly Rate	12/31/15
Catalyst RX	$3.10 per PPO participant per month	6/30/15
Diversified Dental Services	$0.67 per participant per month	6/30/13
Extend Health	No fee through 12/31/11 $3.50 per HRA Account per month beginning 1/1/12	6/30/15
First Data Government Solutions	Varies	11/30/13
Health Claim Auditors	Hourly Rate	9/30/17
Health Plan of Nevada (HMO)	Varies	6/30/12
HealthSCOPE Benefits	15.95 per PPO participant per month 1.50 per HMO/dental only participant per month	6/30/16
HealthSCOPE Benefits Network	$2.50 per in-state PPO participant per month $5.50 per out-of-state PPO participant per month	6/30/16
Hometown Health Plan (HMO)	Varies	6/30/15
Hometown Health Providers	$3.13 per PPO in-state participant per month	6/30/14
Hughes-Calihan Konica Minolta, Inc.	$0.0045 per copy $921.00 monthly fee	11/20/12
Morneau Shepell	$2.21 per participant per month	12/31/14
The Standard Insurance	$16.58 per employee $2.83 per retiree	6/30/13
US Preventive Medicine	Varies	6/30/14

NOTE 6 – Commitments (continued):

The above contracts include varying termination provisions that allow termination without cause with notice required between 30 and 180 days prior to the date of termination.

NOTE 7 - Risk Management:

Estimated Claims Liabilities:

The management of the Self Insurance Trust Fund establishes claims liabilities based on estimates of the ultimate cost of claims (including future claim adjustment expenses) that have been reported but not settled, and of claims that have been incurred but not reported and the unused portion of the HRA liability. Because actual claims costs depend on such complex factors as inflation, changes in doctrines of legal liability and damage awards, the process used in computing claims liabilities does not necessarily result in an exact amount. Typically, after consultation with an actuary, claims liabilities are recomputed annually using a variety of actuarial and statistical techniques to produce current estimates that reflect recent settlements, claim frequency and other economic and social factors. A provision for inflation in the calculation of estimated future claims costs is implicit in the calculation, because reliance is placed both on actual historical data that reflect past inflation and on other factors that are considered to be appropriate modifiers of past experience. Adjustments to claims liabilities are charged or credited to expense in the periods in which claims are made.

Unpaid Claims Liabilities:

As discussed above, management established a liability for both reported and unreported insured events, which includes estimates of both future payments of losses and related claim adjustment expenses. The following presents changes in those aggregate liabilities for the Self Insurance Trust Fund during the past two years.

	2012	2011
Beginning balance	$ 33,849,000	$ 34,473,000
Reserve for claims balance		
Claims and changes in estimates	152,025,641	241,356,569
Claim payments	(150,983,641)	(241,980,569)
Ending balance reserve for claims balance	$ 34,891,000	$ 33,849,000
HRA liability		
Incurred	25,379,626	--
Paid	(17,282,588)	--
Ending balance HRA liability	8,097,038	--
Ending Balance	$ 42,988,038	$ 33,849,000

These unpaid claims liabilities are all for the self-funded medical, dental, vision and prescription drug benefits and the CDHP and Medicare exchange HRAs.

NOTE 8 - Contingent Liabilities:

In accordance with NRS 353.140, the Self Insurance Trust Fund honors outstanding stale warrants presented for payment within six years from the date of origination. Management has estimated the total amount of outstanding stale warrants less than six years old to be $826,101 and $901,889 as of June 30, 2012 and June 30, 2011, respectively. Management has assessed that it is not probable that these warrants will be presented for payment during the statutory time frame. However these warrants will continue to be recorded as a liability.

NOTE 9 - Subsequent Events:

Management has evaluated subsequent events through November 30, 2012, the date which the financial statements were available to be issued.

REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

To the Board of the
Public Employees' Benefits Program

We have audited the accompanying financial statements of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada, as of and for the year ended June 30, 2012, and have issued our report thereon dated November 30, 2012. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Internal Control Over Financial Reporting

Public Employees' Benefits Program of the State of Nevada is responsible for establishing an maintaining effective internal control over financial reporting. In planning and performing our audit, we considered Public Employees' Benefits Program's internal control over financial reporting as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of Public Employees' Benefits Program of the State of Nevada's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Public Employees' Benefits Program of the State of Nevada's internal control over financial reporting.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over financial reporting that might be deficiencies, significant deficiencies, or material weaknesses. We did not identify any deficiencies in internal control over financial reporting that we consider to be material weaknesses, as defined above.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether Public Employees' Benefits Program of the State of Nevada's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*

This report is intended solely for the information and use of management, members of the Board, and others within the entity and is not intended to be and should not be used by anyone other than these specified parties.

Casey Neilon & Associates, LLC

Carson City, Nevada
November 30, 2012

B.

NRS 287.0425 1(b)

An audited financial statement of the Retirees' Fund for the immediately preceding fiscal year.

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM

JUNE 30, 2012 AND 2011

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
JUNE 30, 2012 AND 2011

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Casey, Neilon & Associates, LLC
Accountants and Advisors

INDEPENDENT AUDITOR'S REPORT

To the Board of the
Public Employees' Benefits Program

We have audited the accompanying financial statements of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada for the years ended June 30, 2012 and 2011 as listed in the table of contents. These financial statements are the responsibility of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America and in accordance with the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinions.

As discussed in Note 1, the financial statements present only the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada and do not purport to, and do not, present fairly the financial position of the State of Nevada, as of June 30, 2012 and 2011, and the changes in its plan net assets, where applicable, for the years then ended, in conformity with accounting principles generally accepted in the United States of America.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada as of June 30, 2012 and 2011, and the changes in plan net assets thereof for the years then ended in conformity with accounting principles generally accepted in the United States of America.

In accordance with *Government Auditing Standards*, we have also issued our report dated November 30, 2012 on our consideration of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada's internal control over financial reporting and on compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and the results of that testing, and not to provide an opinion on internal control over financial reporting. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

Accounting principles generally accepted in the Untied States of America require that the Schedule of Funding Progress and the Schedule of Employer Contributions on page 10, be presented to supplement the financial statements. Such information, although not part of the financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted principally of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's response to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Casey, Neilon & Associates, LLC

Carson City, Nevada
November 30, 2012

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
STATEMENTS OF PLAN NET ASSETS
JUNE 30, 2012 AND 2011

	2012	2011
ASSETS		
Cash with treasurer	$ 1,528,963	$ 3,671,497
Intergovernmental receivable	15,025	25,881
Due from other funds	10,214	138,632
Due from component unit	1,185,918	366,680
Investments at fair value	940,236	918,432
Total Assets	3,680,356	5,121,122
LIABILITIES		
Due to other funds	2,402,664	-
Deferred revenues	-	1,537
Total Liabilities	2,402,664	1,537
NET ASSETS HELD IN TRUST FOR OTHER POSTEMPLOYMENT BENEFITS	$ 1,277,692	$ 5,119,585

See accompanying notes.

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
STATEMENTS OF CHANGES IN PLAN NET ASSETS
FOR THE YEARS ENDED JUNE 30, 2012 AND 2011

	2012	2011
ADDITIONS		
Contributions		
Employer contributions	$ 27,881,834	$ 9,649,348
Investment income		
Interest and dividends	16,156	28,823
Net appreciation (depreciation) in fair value of investments	29,092	705,883
Investment expense	(404)	(610)
Net investment income	44,844	734,096
Total additions	27,926,678	10,383,444
DEDUCTIONS		
Benefit payments	31,768,571	35,159,114
Total deductions	31,768,571	35,159,114
Net increase (decrease)	(3,841,893)	(24,775,670)
NET ASSETS HELD IN TRUST FOR OTHER POSTEMPLOYMENT BENEFITS		
Beginning of year, July 1	5,119,585	29,895,255
End of year, June 30	$ 1,277,692	$ 5,119,585

See accompanying notes.

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE
BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
NOTES TO FINANCIAL STATEMENTS
JUNE 30, 2012 AND 2011

NOTE 1 - Summary of Significant Accounting Policies:

The financial statements of the State Retirees' Health and Welfare Benefits Fund, Public Employees' Benefits Program ("PEBP") of the State of Nevada ("Retirees' Fund") have been prepared in conformity with accounting principles generally accepted in the United States of America (USGAAP) as applied to governmental units. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. A summary of the Retirees' Fund's significant accounting policies applied in the preparation of the accompanying financial statements is presented below.

Basis of Accounting:

The financial statements of the Retirees' Fund have been prepared using the accrual basis of accounting. Employer contributions are recognized when due and the employer has made a formal commitment to provide the contributions. Benefits and refunds are recognized when due and payable in accordance with the terms of the plan. The Retirees' Fund does not receive member contributions.

Method Used to Value Investments:

Investments are reported at fair value, which for the Retirees' Fund is determined by the Retirement Benefits Investment Fund.

Plan Description and Contribution Information:

The State Retirees' Health and Welfare Benefits Fund was created in 2007 by the Nevada Legislature to account for the financial assets designated to offset the portion of current and future costs of health and welfare benefits paid on behalf of state retirees. The Retirees' Fund is a multiple employer cost sharing defined postemployment benefit plan run by the PEBP Board. The Retirees' Fund provides benefits other than pensions to eligible retirees and their dependents through the payment of subsidies to PEBP which administers a group health and life insurance program.

Pursuant to NRS 287.023 and NRS 287.046, the following individuals and their dependents are eligible to receive benefits from the Retirees' Fund:

Any PEBP covered retiree with state service whose last employer was the state or a participating local government entity and who:

- Has at least five years of public service and who was initially hired by the state prior to January 1, 2010; or
- Has at least fifteen years of public service and who was initially hired by the state on or after January 1, 2010, but before January 1, 2012; or
- Has at least five years of public service, who has a disability and who was initially hired by the state on or after January 1, 2010, but before January 1, 2012; or

Any PEBP covered retiree with state service whose last employer was not the state or a participating local government entity and who has been continuously covered under PEBP as a retiree since November 30, 2008.

NOTE I - Summary of Significant Accounting Policies (continued):

Plan Description and Contribution Information (continued):

State service is defined as employment with any Nevada State agency, the Nevada System of Higher Education and any State Board or Commission. Participating local government entity is defined as a county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency that has an agreement in effect with PEBP to provide health coverage for its active employees.

The money in the Retirees' Fund belongs to the officers, employees and retirees of the State of Nevada in aggregate; neither the State nor the governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State, nor any single officer, employee or retiree of any such entity has any right to the money in the Retirees' Fund. Pursuant to NRS 287.0425, the Executive Officer reports information regarding the Retirees' Fund annually to the Department of Administration and the Nevada Legislature. The Retirees' Fund is governed by NRS 287.0436 through NRS 287.04364.

Contributions to the fund are paid by the State of Nevada through an assessment of actual payroll paid by each State entity. The assessment is set by the Department of Administration based on an amount provided by the Legislature each biennium in session law. The assessment was 2.134% and 0.658% of actual payroll for the years ending June 30, 2012 and 2011, respectively. Benefits are paid to the Public Employees' Benefits Program Self Insurance Trust Fund as necessary to offset retiree premiums pursuant to NRS 287.046. Funds not required to pay benefits are invested in the Retiree Benefits Investment Fund established pursuant to NRS 355.220 or are held in the State of Nevada General Portfolio pursuant to NRS 226.110 as approved in the Legislatively Approved Budget. Administrative costs of the Retirees' Fund are absorbed by the Self Insurance Trust Fund.

State active employee and retiree enrollment consisted of the following June 30, 2012 and 2011 respectively:

	2012	2011
Active Employees	23,608	25,187
Retirees	8,541	8,489
Total Enrollment	32,149	33,676
Number of pay centers	19	19

NOTE 2 - Funding Status:

For financial reporting purposes, an actuarial valuation is required at least biennially for OPEB plans with a total membership of 200 or more as provided in GASB statement 45. The last valuation was for fiscal year ended June 30, 2011. The funded status as of the most recent actuarial valuation date is as follows (dollar amounts in thousands):

Actuarial Valuation Date	Actuarial Value of Assets (a)	Actuarial Accrued Liability (AAL) (b)	Unfunded AAL (UAAL) (b - a)	Funded Ratio (a / b)	Covered Payroll (c)	UAAL as a Percentage of Covered Payroll ([b – a] / c)
7/1/2010	$29,895	$977,045	$947,150	3.1%	$1,398,963	67.7%

Actuarial valuations of an ongoing plan involve estimates of the value of reported amounts and assumptions about the probability of occurrence of events far into the future. Examples include assumptions about future employment, mortality and the healthcare cost trend. Actuarially determined amounts are subject to continual revision as actual results are compared with past expectations and new estimates are made about the future. The schedules of funding progress, presented as required supplementary information following the notes to the financial statements, present multiyear trend information about whether the actuarial value of plan assets are increasing or decreasing over time relative to the actuarial accrued liabilities for benefits.

The accompanying schedules of employer contributions present trend information about the amounts contributed to the plan by employers in comparison to the Annual Required Contribution (ARC), an amount that is actuarially determined in accordance with the parameters of the GASB Statement 43. The ARC represents a level of funding that, if paid on an ongoing basis, is projected to cover normal costs for each year and amortize the unfunded actuarial liabilities over a period of thirty years.

Projections of benefits for financial reporting purposes are based on the substantive plan (the plan as understood by the employer and plan members) and include the types of benefits provided at the time of each valuation and the historical pattern of sharing of benefit costs between the employer and plan members to that point. The actuarial methods and assumptions used include techniques that are designed to reduce the effects of short-term volatility in actuarial accrued liabilities and the actuarial value of assets, consistent with the long-term perspective of the calculations. Additional information as of the latest actuarial valuation follows:

Valuation date	July 1, 2010
For year ending	June 30, 2011
Actuarial cost method	Projected Unit Credit
Amortization method	Level dollar
Remaining amortization period	30 years
Asset valuation method	5-year smoothed market
Investment rate of return*	4%

NOTE 2 - Funding Status (continued):

Assumed Trends							
Year	Self-Funded				Admin	HRA	State
Beginning	Medical	Pharmacy	HMOs	Dental	Costs	Account	Subsidy
7/1/2010	9.75%	11.0%	9.75%	4.5%	3.0%	0.0%	9.75%
7/1/2011	9.5%	10.0%	9.5%	4.5%	3.0%	0.0%	9.5%
7/1/2012	9.0%	9.0%	9.0%	4.5%	3.0%	0.0%	9.0%
7/1/2013	8.5%	8.5%	8.5%	4.5%	3.0%	0.0%	8.5%
7/1/2014	8.0%	8.0%	8.0%	4.5%	3.0%	0.0%	8.0%
7/1/2015	7.5%	7.5%	7.5%	4.5%	3.0%	0.0%	7.5%
7/1/2016	7.0%	7.0%	7.0%	4.5%	3.0%	0.0%	7.0%
7/1/2017	6.5%	6.5%	6.5%	4.5%	3.0%	0.0%	6.5%
7/1/2018	6.0%	6.0%	6.0%	4.5%	3.0%	0.0%	6.0%
7/1/2019	5.5%	5.5%	5.5%	4.5%	3.0%	0.0%	5.5%
7/1/2020 and beyond	5.0%	5.0%	5.0%	4.5%	3.0%	0.0%	5.0%

* The investment rate of return is based on the historical rate of return for State of Nevada General Fund money held by the State Treasurer. Due to statewide revenue shortfalls, in February 2010, the 26th Special Session of the Nevada Legislature directed $24,700,000 be withdrawn from the Retirees' Benefits Investment Fund to be used to pay for retiree healthcare during the year ending June 30, 2011, thereby reducing the amount paid by state agencies to the Retirees' Fund. No additional investments or withdrawals from the Retirees' Benefits Investment Fund occurred during the years ending June 30, 2012 or June 30, 2011.

NOTE 3 - Cash and Deposits with the State Treasurer as of June 30:

	2012	2011
Cash:		
Deposits with State Treasurer:		
State Treasurer's Investment Pool	$ 1,570,560	$ 3,746,595
GASB 31 adjustment	(41,597)	(75,098)
Total Cash and Deposits	$ 1,528,963	$ 3,671,497

The Nevada Revised Statutes direct the Office of the State Treasurer to deposit funds into any state, or national bank, credit union or savings and loan association covered by federal depository insurance. For those deposits over and above the federal depository insurance maximum balance, sufficient collateral must be held by the financial institution to protect the State of Nevada against loss. The pooled collateral for deposits program maintains a 102% pledge collateral for all public deposits.

NOTE 3 - Cash and Deposits with the State Treasurer as of June 30 (continued):

NRS 355.140 details the types of securities in which the State may invest. In general, authorized investments include: certificates of deposit, asset-backed securities, bankers' acceptances and commercial paper, collateralized mortgage obligations, corporate notes, money market funds whose policies meet the criteria set forth in the statute, United States treasury securities and specific securities implicitly guaranteed by the federal government. Additionally, the State may invest in limited types of repurchase agreements; however, statutes generally prohibit the State from entering into reverse-repurchase agreements.

A copy of the State of Nevada Comprehensive Annual Financial Report can be obtained online at http://controller.nv.gov/FinancialReports/CAFR_Download_Page.html.

NOTE 4 - Retirement Benefits Investment Fund:

The Nevada Legislature established the Retirement Benefits Investment Fund (RBIF) with an effective date of July 1, 2007. The purpose of the Fund is to invest contributions made by participating public entities, as defined NRS 355.220 to enable such entities to support financing of other post employment benefits at some time in the future. Per NRS 355.220(2) monies received by the RBIF from participating entities are held for investment purposes only and not in any fiduciary capacity. Each participating entity acts as fiduciary for its particular share of the Fund. NRS 3550.220(2) requires that any money in the Fund must be invested in the same manner as money in the Public Employees' Retirement System of Nevada (PERS) Investment Fund is invested. The PERS Investment Fund is governed primarily by the "prudent person" standard as set forth in NRS 286.682, which authorizes the Retirement Board to invest PERS' funds in "every kind of investment which persons of prudence, discretion and intelligence acquire or retain for their own account." PERS has established limits on the concentration of investments in any single issuer or class of issuer or managed by a single investment firm. In general, the authorized investments include: fixed income, both US comingled and non-US comingled; domestic, international and comingled equity; money market funds; and short-term investments.

The RBIF is designed to value participants' shares in the Fund according to the contributions of each entity, and accordingly, earnings (including realized and unrealized gains and losses, interest, and other income) and expenses are allocated to each entity in proportion to the participant's share in the Fund. The financial statements of the RBIF were audited in accordance with auditing standards generally accepted in the United States of America and can be obtained from the Public Employees' Retirement System, 693 West Nye Lane, Carson City, Nevada 89703.

NOTE 5 – Subsequent Events:

Management has evaluated subsequent events through November 30, 2012, the date which the financial statements were available to be issued.

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE
BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
REQUIRED SUPPLEMENTARY INFORMATION
JUNE 30, 2012

Schedule of Funding Progress
(Dollar amounts in thousands)

Actuarial Valuation Date	Actuarial Value of Assets (a)	Actuarial Accrued Liability (AAL) (b)	Unfunded AAL (UAAL) (b - a)	Funded Ratio (a / b)	Covered Payroll (c)	UAAL as a Percentage of Covered Payroll ([b – a] / c)
7/1/2008	$25,665	$1,815,501	$1,789,836	1.4%	$1,488,847	120.2%
7/1/2009	$24,209	$1,874,005	$1,849,796	1.3%	$1,556,892	118.8%
7/1/2010	$29,895	$977,045	$947,150	3.1%	$1,398,963	67.7%

Schedule of Employer Contributions
(Dollar amounts in thousands)

Year Ended June 30	Annual Required Contribution	Annual OPEB Cost (d)	Claims Paid (e)	Funds Invested (f)	Percentage Contributed ([e + f] / d)
2009	$239,147	$235,264	$50,809	$0	21.6%
2010	$220,709	$213,537	$46,104	$0	21.6%
2011	$119,959	$109,802	$47,209	$0	43.0%

A copy of the actuarial valuation for the year ended June 30. 2011 may be obtained online at http://www.pebp.state.nv.us/fiscalutilization.htm.

Casey, Neilon & Associates, LLC
Accountants and Advisors

REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

To the Board of the
Public Employees' Benefits Program

We have audited the accompanying financial statements of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada for the year ended June 30, 2012 and have issued our report thereon dated November 30, 2012. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Internal Control Over Financial Reporting

Public Employees' Benefits Program of the State of Nevada is responsible for establishing an maintaining effective internal control over financial reporting. In planning and performing our audit, we considered Public Employees' Benefits Program's internal control over financial reporting as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of Public Employees' Benefits Program of the State of Nevada's internal control over financial reporting. Accordingly, we do not express an opinion on the effectiveness of the Public Employees' Benefits Program of the State of Nevada's internal control over financial reporting.

A *deficiency* in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or combination of deficiencies, in internal control such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis.

Our consideration of internal control over financial reporting was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over financial reporting that might be deficiencies, significant deficiencies, or material weaknesses. We did not identify any deficiencies in internal control over financial reporting that we consider to be material weaknesses, as defined above.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on such compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

This report is intended solely for the information and use of management, the Board of the Public Employees' Benefits Program and others within the entity and is not intended to be and should not be used by anyone other than these specified parties.

Casey, Neilon & Associates, LLC

Carson City, Nevada
November 30, 2012

C.

NRS 287.0245(1)(c)

A report of the utilization of the Program by participants during the immediately preceding plan year, segregated by benefit, administrative cost, active employees and retirees, including, without limitation, an assessment of the actuarial accuracy of reserves.

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Governor

JAMES R. WELLS, CPA
Executive Officer

LEO M. DROZDOFF, P.E.
Board Chairman

AGENDA ITEM

☐ Action Item
☒ Information Only

Date: September 13, 2012

Item Number: XII

Title: Self-Funded Plan Utilization Report for the year ending June 30, 2012

Summary

This report addresses medical, dental, prescription drug and HSA/HRA utilization for the year ending June 30, 2012.

Report

Notes Regarding the Data

The medical and dental data provided in this utilization report was prepared by HealthSCOPE Benefits using Benefit Informatics and the HealthSCOPE Benefits claims data system. Detailed drug utilization information was prepared by Catalyst Rx.

Please note the following:

1. Comparisons to claims data paid prior to June 30, 2011, use information from prior utilization reports. Information for previous utilization reports was provided by UMR through Medstat, a secure on-line eligibility based claims system. Medstat data typically varied from actual claims data by about 1%. This may result in a slight overstatement (approximately 1%) of increases in claims costs and a slight understatement (approximately 1%) of decreases in claims costs, when current period claims are compared to prior period claims.
2. This report reflects only self-funded plan activity and does not include any fully insured benefit cost (e.g. HMOs) information.
3. Dollar amounts categorized into various demographic groups (tiers, division, etc.) are reported on a paid basis for the twelve months ending June 30, 2012, compared to the year ending June 30, 2011.
4. A "Participant" is defined as the primary insured. Per participant per month costs are labeled "PPPM". "Member" includes both the primary insured and all dependents. Per member per month costs are labeled "PMPM".

5. Enrollment figures will vary slightly (generally less than 1%) from other financial reports because the information provided in this utilization report includes retroactive enrollment transactions. Other reports provided by PEBP staff use "snap-shots" of enrollment on the first of each month.
6. Unless otherwise noted, state and non-state claims are reported in aggregate.

Key Observations

During the year ending June 30, 2012:

- Total medical spent was $117.8M (25% below PY11 at $157M), of which 57.1% was spent by the State Active population. However, the average plan cost was $486 PPPM, 7% higher than the PY11 average cost of $454.

- $28.2M of $117.8M, or 23.9%, of paid medical claims, was attributable to run-in claims from the prior plan year, ending June 30, 2011, down from 32.5%, reported in the first nine months of PY12.

- The plan paid 157 claimants in excess of $100,000, compared to 100 high cost claimants reported in the first nine months of PY12. Although representing 0.4% of the total membership, this segment accounted for 31.2% of dollars spent by the plan.

- Approximately two-thirds of all PPO HDHP participants (65.8%) claimed medical expenses of less than $2,500, and nearly a quarter of all PPO HDHP participants (21.3%) had no claims filed.

- 92% of all paid dollars were to in-network providers with an average discount of 54% of retail cost.

- Drug utilization (number of members utilizing the PEBP pharmacy benefit as a percent of all PPO self-funded members) decreased from 49.0% to 36.3% from the year ending June 30, 2011, to the year ending June 30, 2012.

- Employees continue to fund their HSA, with an average employee contribution of $540 during PY12.

Executive Summary

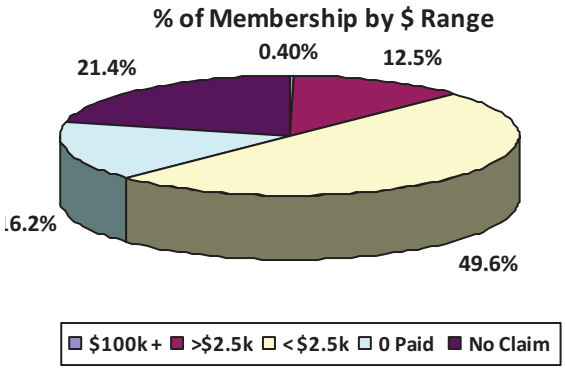
Financial Summary

Total medical claims spending was $117.8 million, 25% below PY11 at $157 million.

- The average PPPM plan cost was higher than PY11 ($486 vs. $454).
- The plan paid on average $3,398 per member (up 42% from the previous quarter).
- PPPM inpatient claims were higher compared to PY11 ($164 vs. $159).

Medical–Cost Distribution

During the year ending June 30th, the largest group (66%) of members had claims paid in the amount of less than $2,500. Notably, 157 claimants with catastrophic claims (.40% of the total membership) account for 31.2% of all dollars paid by the plan.

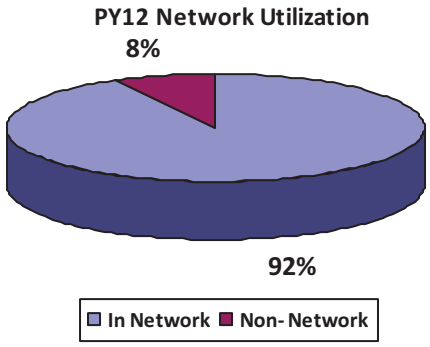


- The average payment per claimant for a catastrophic claim was $234,220.

The average medical claim for this period was $290, or 3% below PY11 ($298).

Network Utilization

Most participants utilized medical service within the Network resulting in a 54% discount; however, the in-network utilization rate of 92.3% was slightly below that noted in PY11 (94.6%).



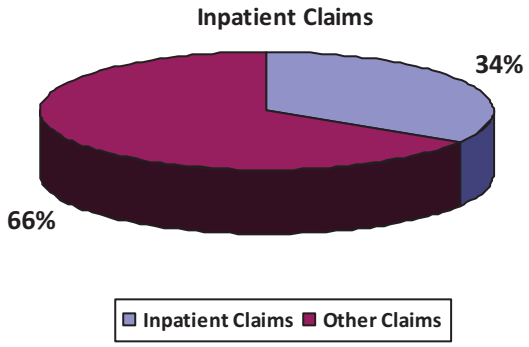
Major Diagnostic

Musculoskeletal, Factors Affecting Health and Neoplasms are the most expensive three diagnostic categories, together accounting for 40.8% of total costs by the plan. The costs associated with these three categories are:

- Musculoskeletal at $17.2 million
- Factors Affecting Health at $15.0 million
- Neoplasms at $14.9 million

Inpatient Summary

Total inpatient claims paid account, for 33.8% of the total amount of claims paid by the plan.

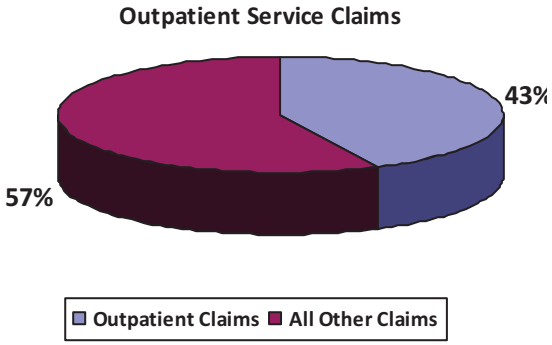


- The top 25 hospitals that receive more money from PEBP for acute visits than any other hospital make up 74.9% of all acute costs.
- The top three healthcare providers (Renown Regional Medical Center, Carson Tahoe Regional Healthcare and St. Rose Dominican Siena) together account for 29.3% of all acute costs.

Outpatient Services

Total outpatient services account for 42.9% of total plan costs.

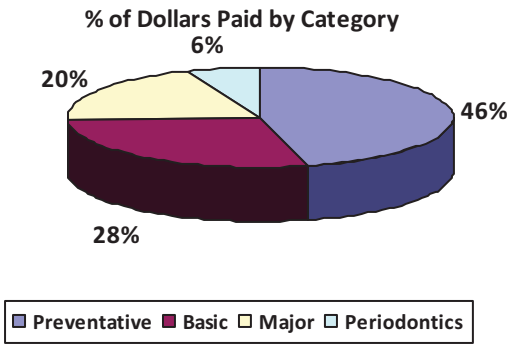
- The top 25 outpatient services account for 98.2% of all outpatient costs.
- The top three services by service code (Hospital Ancillary, Radiology, and Surgery) together account for 61.2% of the total outpatient services.



Dental

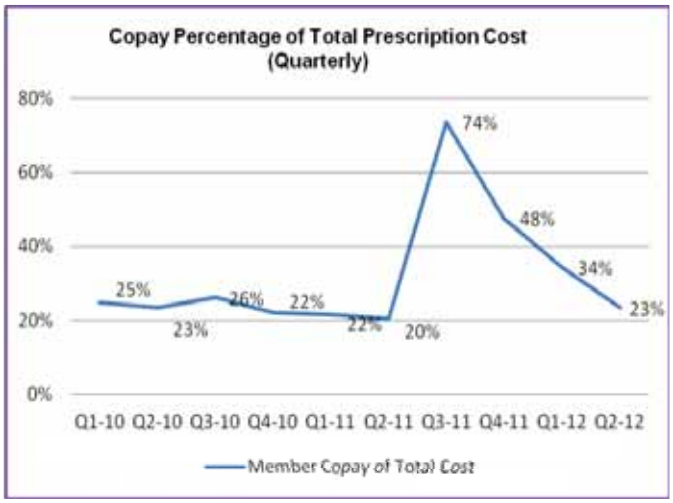
The average dental claim for the year ending June 30, 2012, was $117. This represents a 36.7% decrease from the $185 average dental claim for the year ending June 30, 2011.

Of the $17.9 million in paid dental claims, during the year ending June 30, 2012, $8.3 million (46%) was for preventive services.



Drug Utilization

Drug utilization (number of members utilizing the PEBP pharmacy benefit as a percentage of all PPO self-funded members) has decreased from 49.0% to 36.3% from the year ending June 30, 2011, to year ending June 30, 2012.



The participant's share of costs has decreased throughout the year as more participants met their deductible and out-of-pocket maximums.

Generic drug utilization (generic scripts filled as a percent of all scripts) increased from 74.6% to 78.0% from the year ending June 30, 2011, to the year ending June 30, 2012. This generic utilization rate is among the highest in the nation.

Wellness

In addition to the 23,500 patients receiving wellness screenings and/or vaccinations, paid through HealthSCOPE, USPM administered 15,457 biometric screenings and 3,697 PSA tests in the year ending June 30, 2012.

Diabetes Compliance

212 of 1,651, or 12.4%, of active PPO HDHP diabetics, with nine months of service, have received the minimum number of recommended services. This is up from 9.2% noted in the previous quarterly report.

PPO HDHP HSA/HRA

The amount of HRA claims paid was nearly half of $8.4 million in PEBP contributions leaving a liability of $4.2 million in unused HRA funds for fiscal year 2012.

Employees continue to contribute to their HSA account with an average employee contribution of $540 during the year ending June 30th.

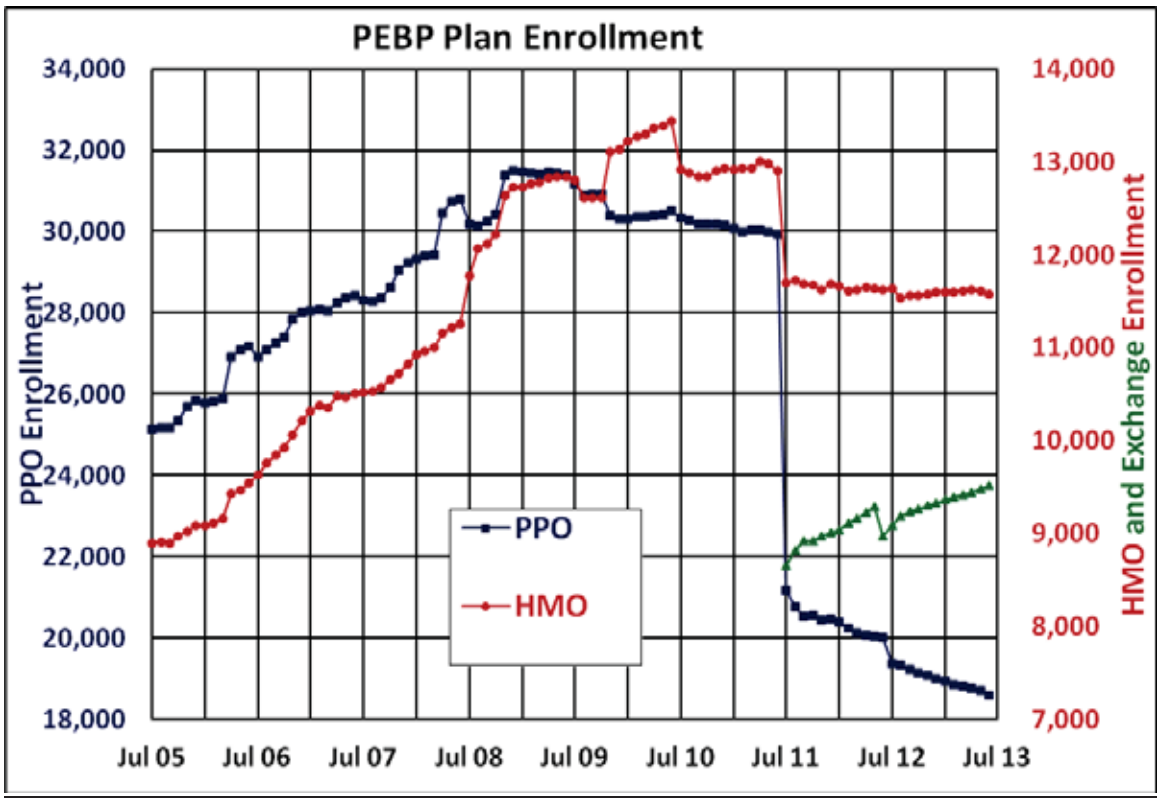
Detailed Findings

Medical Section

Monthly Enrollment Summary

Average enrollment in the self-funded PPO medical plan decreased 32.3% from the year ending June 30, 2011, to the year ending June 30, 2012, with dental plan enrollment decreasing by 16.80% during the same period. The average age of all self-funded members decreased 11.5% to 40.2 years. These changes were largely a result of the migration of most Medicare retirees to the Medicare Exchange.

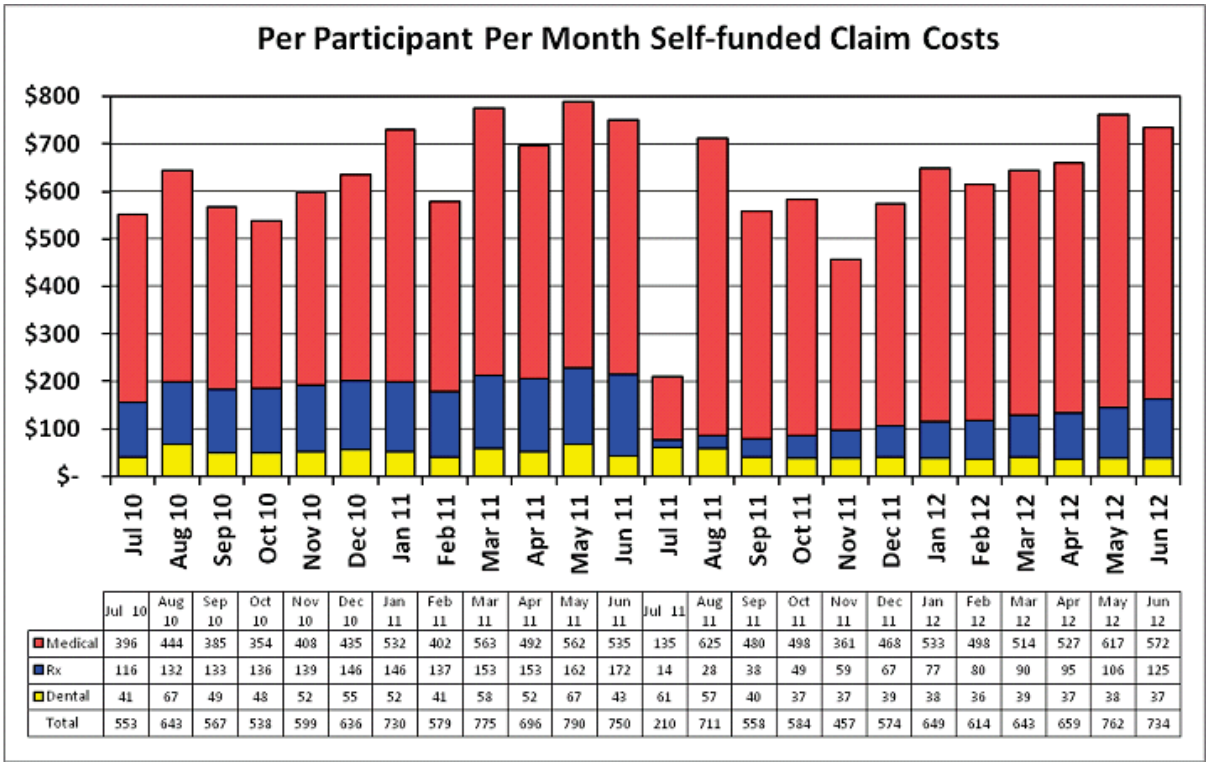
Enrollment in the Northern HMO increased by 14.4% while it decreased by 20.5% in the Southern HMO during the same periods. These changes were largely a result of the policy to blend HMO rates, effective July 1, 2011, combined with the migration of most Medicare retirees to the Medicare Exchange. Total enrollment in the HMOs decreased 9.7%.



Monthly Cost Summary

From the year ending June 30, 2011, to the year ending June 30, 2012, the number of medical claims paid per participant increased 9.4%. Total dollars paid for medical claims increased 7.0% on a per participant basis while paid dental claims decreased 19.2%.

The following graph shows PPPM self-funded claim costs for the 24 months ending June 30, 2012. Data for the graph was compiled directly from the daily check register sent to PEBP by UMR/HealthSCOPE Benefits and the monthly claim costs reported by Catalyst, rather than from the Medstat/Benefit Informatics reporting tools.



	Jul 10	Aug 10	Sep 10	Oct 10	Nov 10	Dec 10	Jan 11	Feb 11	Mar 11	Apr 11	May 11	Jun 11	Jul 11	Aug 11	Sep 11	Oct 11	Nov 11	Dec 11	Jan 12	Feb 12	Mar 12	Apr 12	May 12	Jun 12
Medical	396	444	385	354	408	435	532	402	563	492	562	535	135	625	480	498	361	468	533	498	514	527	617	572
Rx	116	132	133	136	139	146	146	137	153	153	162	172	14	28	38	49	59	67	77	80	90	95	106	125
Dental	41	67	49	48	52	55	52	41	58	52	67	43	61	57	40	37	37	39	38	36	39	37	38	37
Total	553	643	567	538	599	636	730	579	775	696	790	750	210	711	558	584	457	574	649	614	643	659	762	734

Utilization

From the year ending June 30, 2011, to the year ending June 30, 2012:

- Admits Acute per 1,000 decreased 25.6%
- Days per 1,000 decreased 14.3%
- ER visits per 1,000 remained flat at 170

Despite these decreases, all utilization measures, except ER visits per 1,000, are higher than those of HealthSCOPE Benefits' other clients during 2010.

Utilization (Annualized)			
	Jun-12	PY12	HSB 2010 Index
Admits per 1,000	87	67	61
Days per 1,000	479	365	261
Avg Length of Stay	5.5	5.4	4.3
Office Visits per 1,000	3800	3600	3000
ER Visits per 1,000	170	170	210

Claims paid by Division

Extremely low medical claims paid in July are a result of the transition of third party administrator services from UMR to HealthSCOPE Benefits. The high amount in August reflects HealthSCOPE Benefits' efforts to reduce the backlog created by the transition and pay any run-out claims not paid in July from the plan year ending June 30, 2011.

Paid by Division - Medical Claims						
Month	State Active	Non-State Active	State Retirees	Non-State Retirees	Cobra	Total
July	$1,728,509	$16,486	$588,070	$511,461	$8,578	$2,853,104
August	$7,231,664	$44,344	$2,794,512	$2,756,453	$89,104	$12,916,078
September	$6,231,039	$26,604	$1,887,031	$1,583,464	$47,827	$9,775,964
October	$6,356,102	$41,012	$1,992,368	$1,747,596	$38,215	$10,175,293
November	$4,042,039	$77,655	$2,009,536	$1,025,144	$129,305	$7,283,680
December	$5,340,624	$86,492	$2,501,538	$1,490,144	$64,135	$9,482,933
January	$5,714,009	$48,928	$2,744,153	$2,142,712	$49,087	$10,698,889
February	$5,445,391	$13,677	$2,275,509	$2,172,714	$60,693	$9,967,984
March	$5,929,860	$36,599	$2,306,300	$1,945,972	$78,939	$10,297,670
April	$6,402,369	$21,500	$2,087,047	$1,882,928	$93,157	$10,487,001
May	$6,251,813	$20,753	$3,186,182	$2,771,469	$107,346	$12,337,563
June	$6,646,738	$21,388	$2,594,978	$2,215,405	$53,006	$11,531,515
Year To Date	**$67,320,157**	**$455,438**	**$26,967,224**	**$22,245,462**	**$819,392**	**$117,807,672**

Medical Claims by Plan / Relationship

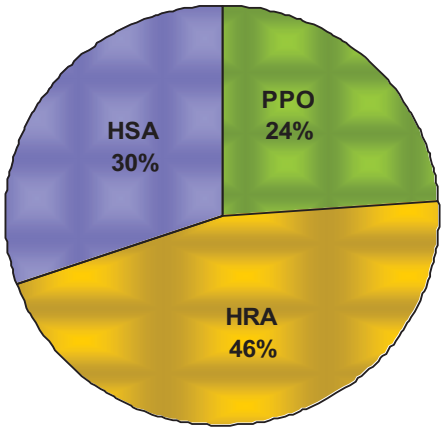
Medical Claims by Plan - 4Q YTD			
	PPO	HRA	HSA
Total Costs	$28,159,327	$53,906,814	$35,741,530
PMPM (Per Member per Month)	$0**	$420	$193

**PPO Plan was for PY2011; this reflects run-in claims paid by HSB

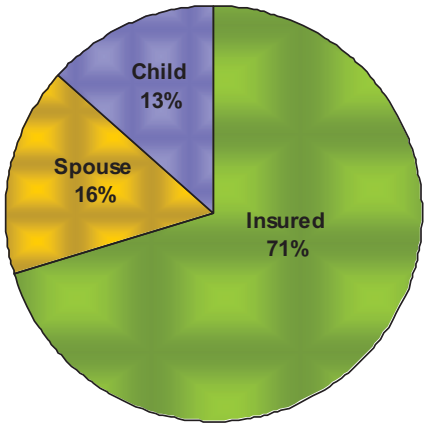
Total Medical Claims Paid / Relationship						
	1Q	2Q	3Q	4Q	YTD	PMPM
Insured	$17,671,205	$19,088,659	$21,791,135	$24,285,677	$82,836,676	$346
Spouse	$4,677,597	$5,128,628	$4,860,752	$4,511,560	$19,178,538	$377
Child	$3,196,343	$2,724,618	$4,312,655	$5,558,843	$15,792,458	$131
Total	**$25,545,145**	**$26,941,905**	**$30,964,542**	**$34,356,080**	**$117,807,672**	**$287**

It is important to note that 23.9% of the claims paid in the year ending June 30, 2012, were run-out claims for the $800 deductible PPO plan that ended on June 30, 2011.

Medical Claims by Plan



Medical Claims by Relationship



Financial Summary

During the year ending June 30, 2011, participants paid 26.8% of total medical costs owed by the plan and participants combined, after deducting ineligible amounts, network discounts and third party payments from billed charges. During the year ending June 31, 2012, participants' share of costs decreased to 24.9% of the total medical costs paid by the plan and participants.

Summary	All Combined Groups	State Active	Non-State Active	State Retirees	Non-State Retirees	PY11	HSB 2010 Index
# Participants	20,211	14,416	124	2,999	2,672	30,120	
# Members	34,671	27,143	193	4,120	3,215	49,525	
Mem / Part Ratio	1.72	1.88	1.56	1.37	1.20	1.64	
Gross Cost	$156,823,450	$93,198,413	$692,933	$34,585,146	$28,346,958		
Gross Plan Cost	$117,807,672	$67,933,528	$455,438	$27,005,200	$22,413,506	$163,949,107	
Gross Participant Cost	$39,015,778	$25,264,885	$237,495	$7,579,946	$5,933,452		
PPPM Gross Cost	$647	$539	$466	$961	$884		
PPPM Gross Plan Cost	$486	$393	$306	$750	$699	$454	$533
PPPM Gross Participant Cost	$161	$146	$160	$211	$185		
Catastrophic Summary							
Catastrophic Cases	157	78	0	40	39	213	
Catastrophic Cases / 1,000	4.5	2.9	0.0	9.7	12.1	4.3	9.2
Avg. Catastrophic Paid / Case	$234,220	$227,308	$0	$257,680	$223,981	----	$115,079
Catastrophic % of Gross Dollars	31.2%	26.1%	0.0%	38.2%	39.0%	25.0%	
Cost Distribution -Paid Per Member							
Hospital Inpatient	$1,160	$789	$459	$2,601	$2,490	$1,164	$443
Facility Outpatient	$1,651	$1,249	$1,547	$3,022	$3,301	$2,112	$839
Physician Office	$586	$465	$356	$936	$1,188	----	$273
Total:	$3,397	$2,503	$2,362	$6,559	$6,979	$3,276	$1,554

Cost Distribution

During the year ending June 30, 2012, the plan paid 157 claimants in excess of $100,000 (0.40% of total members; 31.2% of total claim dollars paid) for an average of 138 members. This is 57% higher than the level noted during the first nine months of the year at 100 claimants.

Out of the total PPO HDHP membership:

- 12.9% had total medical claims paid by the plan of $2,500 or more
- 49.6% had total medical claims paid by the plan of less than $2,500
- 16.2% had submitted claims that were not paid by the plan (member had not met deductible)
- 21.3% had no claims filed.

The average medical claim for the year ending June 30, 2012, was $290.34. This represents a 2.6% decrease from the $297.96 average medical claim for the year ending June 30, 2011.

COST DISTRIBUTION - MEDICAL CLAIMS						
Paid Dollar Range	Avg Members	% of Members	# of Claims	% of Claims	Total Paid	% of Paid
$100,000.01 Plus	138	0.40%	21,182	5.22%	$36,772,529	31.21%
$50,000.01 - $100,000.00	220	0.63%	17,389	4.29%	$17,757,799	15.07%
$25,000.01 - $50,000.00	410	1.18%	25,240	6.22%	$16,608,430	14.10%
$10,000.01 - $25,000.00	920	2.65%	38,944	9.60%	$16,888,546	14.34%
$5,000.01 - $10,000.00	1,145	3.30%	39,603	9.76%	$9,871,717	8.38%
$2,500.01 - $5,000.00	1,658	4.78%	45,015	11.09%	$7,374,255	6.26%
$0.01 - $2,500.00	17,201	49.61%	198,325	48.88%	$12,534,396	10.64%
$0.00	5,598	16.15%	20,061	4.94%	$0	0.00%
No Claims Filed	7,381	21.29%	0	0.00%	$0	0.00%
	34,671	**100.00%**	**405,759**	**100.00%**	**$117,807,672**	**100.00%**

*Member count is an average over the 12 month period

Plan Summary Grid

Cost Distribution – Paid Per Member

The plan paid medical claims in the amount of $3,398 per member for the reporting period ending June 30, 2012, a 3.0% increase from the year ending June 30, 2011, and ($283 vs. $275 PMPM).

Physician Office

The plan paid an average of $30 per physician office visit compared to $55 per visit using the HealthSCOPE Benefits' Index. The $30 average represents payments made by PEBP to providers where participants had met their deductible and/or out-of-pocket maximum offset by office visits paid entirely by the participant prior to meeting the deductible.

Emergency Room

ER visits remained flat at a rate of 170 per 1,000 during the year ending June 30, 2012, vs. the year ending June 30, 2011.

Inpatient

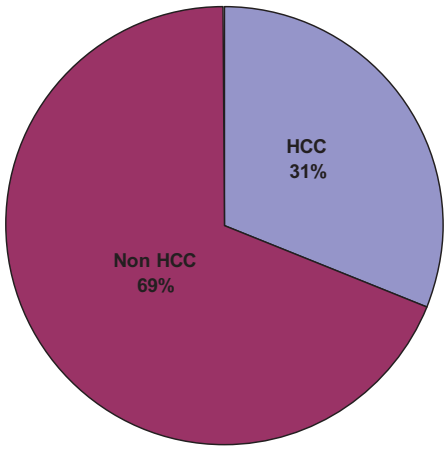
Inpatient claims paid PPPM increased 3.3% during the year ending June 30, 2012, vs. the year ending June 30, 2011, increasing from $159.06 to $164.30. Net inpatient claims paid decreased 30.7%, while admits per 1,000 decreased 25.6% during the same period.

	All Combined Groups	State Active (incl Cobra)	Non-State Active (incl Cobra)	State Retirees (incl Cobra)	Non-State Retirees (incl Cobra)	PY11	HSB 2010 Index
Inpatient:							
# of Admits	2,307	1,371	8	557	371		
# of Patient Days	12,638	6,078	19	3,836	2,705		
Paid per Admit	$17,273	$15,910	$11,818	$17,888	$21,509	$12,922	$14,303
Paid per Day	$3,153	$3,589	$4,976	$2,597	$2,950	$2,775	$3,360
Admits / 1,000	67	51	41	135	115	90	61
Days / 1,000	365	224	99	931	841	426	261
Average LOS	5.5	4.4	2.4	6.9	7.3	4.7	4.3
Physician Office:							
Physician OV Utilization	3.6	2.9	2.7	5.9	6.4		1.5
Physician OV Avg Paid per Visit	$30	$29	$31	$32	$32		$55
OV Avg Paid per Member	$108	$84	$84	$189	$205		$83
Physician DX&L Utilization	9.8	7.9	5.3	15.5	18.6		4.5
Physician DX&L Avg Paid per Visit	$60	$56	$91	$67	$65		$78
DX&L Avg Paid per Member	$588	$442	$482	$1,039	$1,209		$347
*DX&L=Diagnostic, Xray, & Lab							
Emergency Room:							
Number of Patients	4,264	2,867	32	803	565		
Number of Visits	5,722	3,780	41	1,074	827	8,269	
Number of Admits	1,090	553	3	328	206	1,105	
Visits/Member*	0.17	0.14	0.21	0.26	0.26	0.17	0.21
Avg Paid per Visit	$1,394	$1,425	$1,227	$1,314	$1,367	$2,313	$1,180
Admits per Visit	0.19	0.15	0.07	0.31	0.25	0.13	0.13

Catastrophic Summary

The plan paid an average of $234,220 per member for those (157 members) with catastrophic "High Cost Claims" (HCC) in excess of $100,000. This represents 31.2% of total allowable claims (claims paid by the participant and the plan). The number of catastrophic cases per 1,000 (4.5) compares favorably to HealthSCOPE Benefits' book of business for 2010 (9.2); however, the average payment per case ($234,220) far exceeds the average for HealthSCOPE Benefits' other customers ($115,079) the largest of which cost the plan $1,611,864 with a primary diagnosis of Acute and Chronic Respiratory Failure**.**

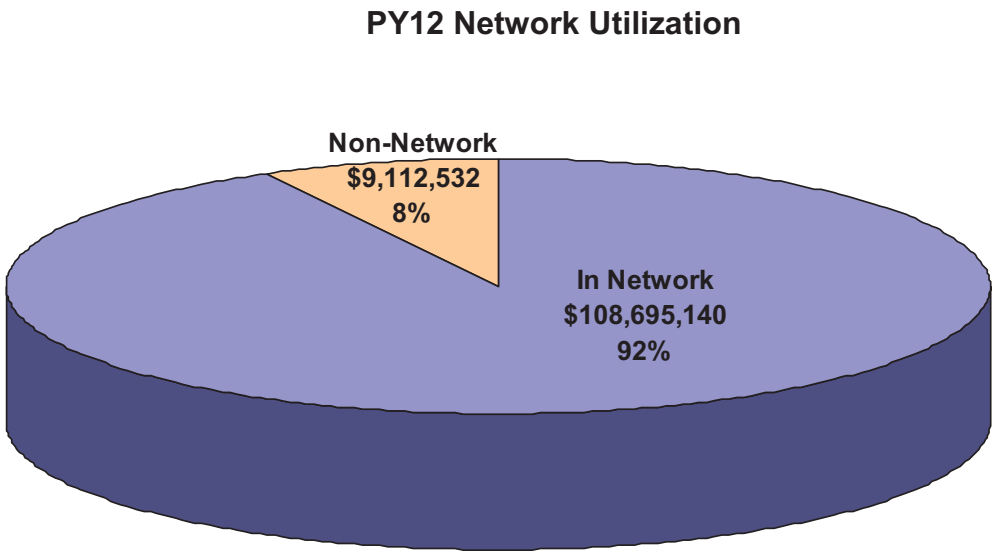
Distribution of HCC Medical Paid Claims Amount



Catastrophic Summary	
HCC Groups	***Total Paid***
Disease of Respiratory System	$3,586,182
Chemotherapy Treatment	$3,486,023
Musculoskeletal Disorders	$3,285,749
Other Diseases	$3,150,794
Complications Med/Surg	$3,012,725
Cardiovascular Disease	$2,738,587
Renal Function Failure	$2,218,543
Accident	$1,778,282
Complications of Pregnancy	$1,722,914
Disease of Digestive System	$1,635,706
Cancer - Other	$1,593,768
Metabolic & Immunity Disorders	$1,564,088
Nervous System Disorders	$1,357,009
Cancer - Breast	$1,280,792
Cancer - Reproductive	$1,121,970
Cancer - Stomach	$997,327
Cancer - Brain/Lymph/Organ	$658,031
Cancer - Lung	$599,059
Leukemia	$535,521
Cancer - Colorectal	$449,459
Total	***$36,772,528***

In-Network Medical Discounts

The in-network utilization rate decreased from 94.6% to 92.3% from the year ending June 30, 2011, to year ending June 30, 2012.



Major Diagnostic Category

Total claims decreased 24.8% from $156.6 million from the year ending June 30, 2011.

Description	# Patients	# Claims	Total Paid	% of Paid
(MDC 18) DISORDER OF MUSCULOSKELETAL SYSTEM	12,058	66,698	$17,204,008	14.60%
(MDC 25) FACTORS AFFECTING HEALTH	20,088	61,601	$15,072,933	12.80%
(MDC 02) NEOPLASMS	4,995	24,040	$14,942,583	12.68%
(MDC 10) DISORDER OF CIRCULATORY SYSTEM	7,798	25,966	$10,293,615	8.74%
(MDC 23) FRACTURES AND OTHER INJURIES	5,747	18,994	$9,040,157	7.67%
(MDC 22) ILLDEFINED CONDITIONS	13,288	43,984	$8,108,610	6.88%
(MDC 11) DISORDER OF RESPIRATORY SYSTEM	10,072	29,106	$5,803,089	4.93%
(MDC 12) DISORDER OF DIGESTIVE SYSTEM	3,428	9,110	$4,752,787	4.03%
(MDC 14) NEPHRITIS / NEPHROSIS	2,955	10,398	$4,142,200	3.51%
(MDC 03) ENDOCRINE, NUTRITIONAL, METABOLIC, IMMUNITY, DISORDERS	9,497	28,392	$4,030,542	3.42%
(MDC 01) INFECTIOUS / PARASITIC DISEASE	2,906	5,214	$3,978,116	3.38%
(MDC 07) DISORDER OF NERVOUS SYSTEM	3,174	11,991	$3,878,280	3.29%
(MDC 19) DISORDER OF BREAST OR SKIN	6,906	13,883	$2,597,038	2.20%
(MDC 13) OTHER DIGESTIVE DISORDERS	984	3,446	$2,477,213	2.10%
(MDC 05) PSYCHOTIC CONDITIONS	3,270	14,308	$2,356,804	2.00%
(MDC 08) DISORDER OF EYE / ADNEXA	9,972	17,323	$2,140,433	1.81%
(MDC 17) PREGNANCY / CHILDBIRTH	401	2,408	$1,739,028	1.48%
(MDC 04) DISORDER OF BLOOD	1,094	3,739	$1,587,600	1.35%
(MDC 16) FEMALE DISORDERS	2,599	6,124	$1,395,717	1.18%
(MDC 09) DISORDER OF EAR	2,574	4,364	$802,500	0.68%
(MDC 21) PERINATAL PERIOD CONDITIONS	144	1,041	$579,841	0.49%
(MDC 20) CONGENITAL ANOMALIES	519	1,274	$460,504	0.39%
(MDC 15) DISORDER OF MALE GENITAL ORGANS	1,005	2,139	$243,580	0.21%
(MDC 06) ALCOHOL / DRUG PSYCHOTROPIC DEPENDENCY	36	110	$174,857	0.15%
(MDC 24) BURNS / ACCIDENTS BY FIRE	53	106	$5,637	0.00%
TOTAL	**125,563**	**405,759**	**$117,807,672**	**100.00%**

Musculoskeletal, Factors Affecting Health and Neoplasms are the most expensive three diagnostic categories, together accounting for 40.8 % of total costs.

MDC (18) DISORDER OF MUSCULOSKELETAL SYSTEM

MDC	Diag Code	Diagnosis Description	# Patients	# Claims	Total Paid
18	71536	OSTEOARTHROSIS, LOCALIZED, NOT SPECIFIED WHETHER PRIMARY OR SECONDARY, LOWER LEG	113	228	$1,143,973
18	72252	DEGENERATION OF LUMBAR OR LUMBOSACRAL INTERVERTEBRAL DISC	646	1591	$1,066,765
18	72210	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY	389	1322	$768,828
18	7213	LUMBOSACRAL SPONDYLOSIS WITHOUT MYELOPATHY	450	1025	$618,727
18	71596	OSTEOARTHROSIS UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED INVOLVING LOWER LEG	367	839	$612,073

MDC (25) FACTORS AFFECTING HEALTH

MDC	Diag Code	Diagnosis Description	# Patients	# Claims	Total Paid
25	V5811	ENCOUNTER FOR ANTINEOPLASTIC CHEMOTHERAPY	79	640	$1,997,299
25	V7651	SPECIAL SCREENING FOR MALIGNANT NEOPLASMS OF COLON	1332	3161	$1,453,710
25	V5789	CARE INVOLVING OTHER SPECIFIED REHABILITATION PROCEDURE	125	264	$1,417,239
25	V202	ROUTINE INFANT OR CHILD HEALTH CHECK	2874	5055	$944,917
25	V700	ROUTINE GENERAL MEDICAL EXAMINATION AT A HEALTH CARE FACILITY	4548	7102	$944,153

MDC (02) NEOPLASMS

MDC	Diag Code	Diagnosis Description	# Patients	# Claims	Total Paid
2	185	MALIGNANT NEOPLASM OF PROSTATE	252	2096	$1,511,934
2	1749	MALIGNANT NEOPLASM OF BREAST (FEMALE) UNSPECIFIED SITE	312	2049	$1,391,540
2	23875	MYELODYSPLASTIC SYNDROME, UNSPECIFIED	12	244	$642,287
2	1830	MALIGNANT NEOPLASM OF OVARY	37	513	$632,848
2	20280	OTHER MALIGNANT LYMPHOMAS UNSPECIFIED SITE	52	524	$481,546

Inpatient Summary

Claims by the top 25 most utilized hospitals make up 74.9% of all acute costs paid by PEBP on behalf of its members. The top three hospitals (Renown Regional Medical Center, Carson Tahoe Regional Healthcare and St. Rose Dominican Siena) together account for 29.3% of all acute costs. Total inpatient claims paid account for 33.8% of total plan costs.

Cedars Sinai Medical Center, Stanford University Hospital, and UCSF Medical Center were paid the most on a per-day acute basis. This data should be used only to demonstrate to which hospitals large dollar amounts are going. Determining which hospitals cost more can only be determined via an in-depth study of costs per diagnosis code.

Tax ID	Hospital	Admits	Bed Days	Avg LOS	Total Paid	Paid per Admit	Paid per Day	% of Admits	% of Paid
88-0213754	RENOWN BEHAVIORAL HEALTH	489	2,399	4.9	$5,852,614	$11,969	$2,440	21.20%	14.71%
88-0502320	CARSON TAHOE REGIONAL MEDICAL CENTER	255	1,007	3.9	$2,986,669	$11,712	$2,966	11.05%	7.51%
88-0455713	ST ROSE DOMINICAN SIENA	124	771	6.2	$2,826,325	$22,793	$3,666	5.37%	7.10%
62-1762537	SUNRISE HOSPTIAL AND MED CTR LLC	95	806	8.5	$2,107,879	$22,188	$2,615	4.12%	5.30%
94-3281657	UCSF MEDICAL CENTER	11	95	8.6	$1,611,487	$146,499	$16,963	0.48%	4.05%
38-3667923	SIERRA SURGERY & IMAGING LLC	45	143	3.2	$1,205,619	$26,792	$8,431	1.95%	3.03%
23-2939047	SUMMERLIN MEDICAL CENTER	103	496	4.8	$995,270	$9,663	$2,007	4.46%	2.50%
94-2854057	MCKAY DEE HOSPITAL CENTER	50	216	4.3	$986,693	$19,734	$4,568	2.17%	2.48%
30-0291277	VISTA RANCHO SPECIALITY HOSPITAL	2	125	62.5	$985,370	$492,685	$7,883	0.09%	2.48%
62-1600397	MOUNTAIN VIEW HOSPITAL	74	293	4.0	$977,904	$13,215	$3,338	3.21%	2.46%
94-6036494	U.C. DAVIS MEDICAL CENTER	8	70	8.8	$966,868	$120,859	$13,812	0.35%	2.43%
77-0465765	STANFORD UNIVERSITY HOSPITAL	9	44	4.9	$961,558	$106,840	$21,854	0.39%	2.42%
88-6000436	UNIVERSITY MEDICAL CENTER	50	247	4.9	$671,083	$13,422	$2,717	2.17%	1.69%
23-2973511	VALLEY HOSPITAL MEDICAL CENTER	60	347	5.8	$624,725	$10,412	$1,800	2.60%	1.57%
95-1644600	CEDARS SINAI MEDICAL CENTER	3	15	5.0	$601,256	$200,419	$40,084	0.13%	1.51%
74-3048428	SO HILLS HOSPITAL MEDICAL CTR LLC	36	109	3.0	$600,783	$16,688	$5,512	1.56%	1.51%
46-0517825	RENOWN REHAB HOSPITAL	81	277	3.4	$600,132	$7,409	$2,167	3.51%	1.51%
20-4993360	CENTENNIAL HILLS HOSPITAL MED CENTE	48	180	3.8	$598,065	$12,460	$3,323	2.08%	1.50%
94-0562680	CALIFORNIA PACIFIC MEDICAL CENTER	2	35	17.5	$593,408	$296,704	$16,955	0.09%	1.49%
95-3522679	LOMA LINDA UNIVERSITY MED CENTER	1	39	39.0	$562,871	$562,871	$14,433	0.04%	1.41%
72-1549752	SPRING VALLEY HOSPITAL MEDICAL CENTER	54	225	4.2	$561,064	$10,390	$2,494	2.34%	1.41%
38-3730230	ST ROSE DOMINICAN HOSP DBA DIGNITY HEALTH	50	200	4.0	$519,551	$10,391	$2,598	2.17%	1.31%
62-1740235	NORTHEASTERN NEVADA REG HOSP	35	94	2.7	$477,526	$13,644	$5,080	1.52%	1.20%
87-6000525	UNIVERSITY OF UTAH	25	130	5.2	$468,984	$18,759	$3,608	1.08%	1.18%
94-6050274	BARTON MEMORIAL HOSPITAL	16	53	3.3	$453,585	$28,349	$8,558	0.69%	1.14%
	Top 25	**1,726**	**8,416**	**4.9**	**$29,797,287**	**$17,264**	**$3,541**	**74.82%**	**74.88%**
	Total All Other	**581**	**4,190**	**7.2**	**$9,995,427**	**$17,204**	**$2,386**	**25.18%**	**25.12%**
	Grand Total	**2,307**	**12,638**	**5.5**	**$39,792,715**	**$17,249**	**$3,149**	**100.00%**	**100.00%**

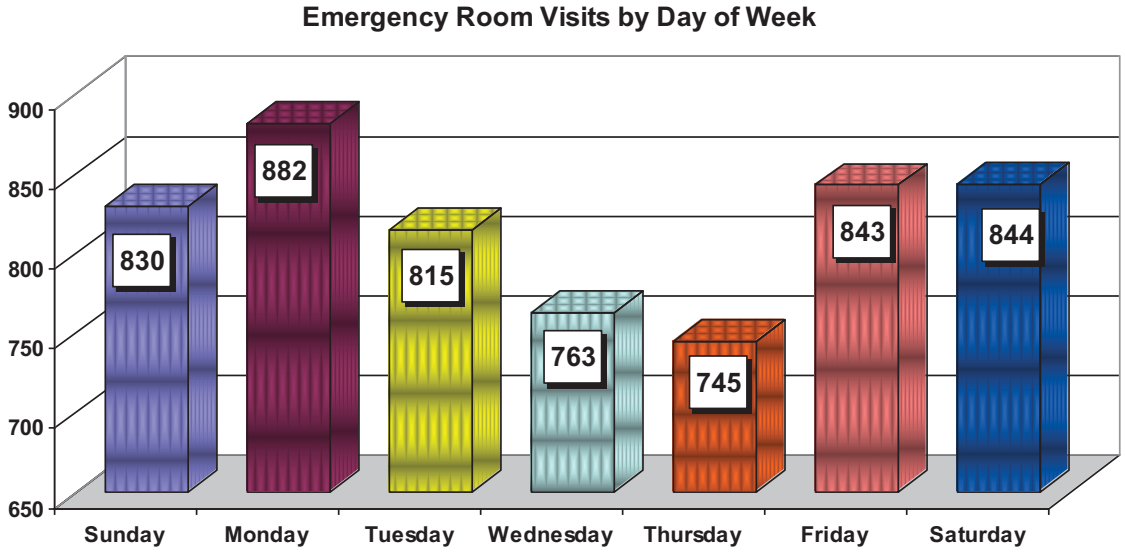
Top 25 Outpatient Type of Service

The top 25 outpatient services account for 98.2% of all outpatient costs. Outpatient services account for 42.9% of plan costs.

Service Code	# Patients	% of Patients	Paid	% of Paid
Hospital Ancillary	7,906	9.12%	$18,510,955	36.66%
Radiology	8,939	10.32%	$7,126,127	14.11%
Surgery	5,652	6.52%	$5,284,042	10.46%
Laboratory	17,899	20.66%	$3,874,119	7.67%
Anesthesia	4,290	4.95%	$2,217,886	4.39%
Injection	723	0.83%	$1,867,994	3.70%
Emergency Room	4,017	4.64%	$1,820,469	3.60%
Ambulance	822	0.95%	$1,398,436	2.77%
Radiation Therapy	56	0.06%	$1,091,914	2.16%
ER Professional Fee	4,090	4.72%	$964,985	1.91%
Pathology	3,155	3.64%	$895,423	1.77%
Medical Equipment	1,905	2.20%	$717,699	1.42%
Miscellaneous	2,658	3.07%	$671,077	1.33%
Infusion Therapy	178	0.21%	$435,721	0.86%
Physical Therapy	645	0.74%	$411,220	0.81%
Mammogram	2,057	2.37%	$400,202	0.79%
Pap Smear	4,611	5.32%	$340,788	0.67%
Psychotherapy	238	0.27%	$312,670	0.62%
Office Visit	6,027	6.96%	$299,711	0.59%
Assistant Surgery	424	0.49%	$194,610	0.39%
Chemotherapy	93	0.11%	$189,942	0.38%
Clinic	1,429	1.65%	$189,271	0.37%
Hospice Care	33	0.04%	$127,341	0.25%
Dialysis	61	0.07%	$118,497	0.23%
Home Health Care	111	0.13%	$113,807	0.23%
Total Top 25	**78,019**	**90.04%**	**$49,574,908**	**98.17%**
Total All Other	**8,633**	**9.96%**	**$924,447**	**1.83%**
Grand Total	**86,652**	**100.00%**	**$50,499,355**	**100.00%**

Emergency Room Summary

From the year ending June 30, 2011, to the year ending June 30, 2012, ER visits remained flat at 170 per 1,000 members. Emergency rooms are utilized more than average on Friday through Monday. Further analysis of the use of emergency rooms may provide potential areas for cost savings and reducing spikes in weekend utilization, including amending network contracts to incentivize family practice doctors to keep their offices open over the weekend.



Savings Summary

During the year ending June 30, 2011, direct out-of-pocket costs (deductible, co-payment and co-insurance) by participants accounted for 26.4% of total medical costs owed by the plan and participants after deducting ineligible amounts, network discounts and third party payments from billed charges. During the year ending June 30, 2012, direct out-of-pocket costs by participants decreased to 24.8% of the total medical costs paid by the plan and participants. This decrease is due to the implementation of the Consumer Driven High Deductible Health Plan effective July 1, 2011, offset by claims run-out from Plan Year 2011 and the impact of high cost claims.

Category	Dollars	PPPM	% of Eligible
Eligible Charges	$428,855,448	$1,768	100.00%
COB	$31,018,330	$128	7.23%
Medicare	$20,839,568	$86	4.86%
Excess/Maximums	$3,039,940	$13	0.71%
PPO Discount	$217,134,160	$895	50.63%
Deductible	$23,959,212	$99	5.59%
Coinsurance	$14,249,095	$59	3.32%
Copay	$807,471	$3	0.19%
Total Participant Cost	**$39,015,778**	**$161**	**9.10%**
Total Plan Paid	**$117,807,672**	**$486**	**27.47%**

Plan Year 2011	**$454**

Patient Demographics

During the year ending June 30, 2012, the plan paid $283 PMPM. The average cost per adult was $347 PMPM. The average cost per child was $129 PMPM.

Patient Type	Patient Relationship	# Members	Inpatient Paid	Outpatient Paid	PCP Paid	Specialist Paid	Other Paid	Total Paid	PMPM
Child	Child	10,111	$5,194,313	$3,622,233	$1,620,885	$3,435,239	$513,178	$14,385,847	$119
	Disabled Dependent	55	$1,087,570	$118,898	$64,591	$105,646	$29,906	$1,406,612	$2,131
		10,166	***$6,281,883***	***$3,741,132***	***$1,685,476***	***$3,540,885***	***$543,084***	***$15,792,459***	***$129***
Self	Insured	20,210	$27,191,486	$24,685,535	$5,527,597	$23,973,408	$1,458,649	$82,836,676	$342
		20,210	***$27,191,486***	***$24,685,535***	***$5,527,597***	***$23,973,408***	***$1,458,649***	***$82,836,676***	***$342***
Spouse	Domestic Partner	9	$0	$11,162	$1,902	$8,631	$402	$22,097	$205
	Husband	1,414	$2,314,878	$2,268,802	$485,275	$1,514,066	$102,379	$6,685,400	$394
	Wife	2,873	$4,434,594	$3,452,596	$692,845	$3,663,698	$227,307	$12,471,040	$362
		4,296	***$6,749,473***	***$5,732,559***	***$1,180,023***	***$5,186,395***	***$330,088***	***$19,178,537***	***$372***
Female		18,029	$21,371,390	$19,138,280	$5,094,824	$19,503,424	$1,154,835	$66,262,752	$306
Male		16,642	**$18,851,452**	**$15,020,946**	**$3,298,272**	**$13,197,263**	**$1,176,987**	**$51,544,920**	**$258**
Total:		***34,671***	***$40,222,842***	***$34,159,227***	***$8,393,096***	***$32,700,687***	***$2,331,821***	***$117,807,672***	***$283***

Age Range Summary

The column on the right of the table shows per patient per month costs in each age category. Children under 1 and Adults 65 and older had the highest PMPM at $825 and $579, respectively. The average cost per adult between the ages of 55 and 64 was $502 PMPM, compared to the average cost of all members of $283 PMPM.

Age Range	# Members	# Patients	% of Patients	Inpatient Paid	Outpatient Paid	ER Paid	Physician Paid	Other Paid	Total Paid	% of Paid	PMPM
<1	313	547	0.87%	$2,061,214	$27,730	$28,764	$955,207	$27,469	$3,100,384	2.63%	$825
1	94	580	0.92%	$62,670	$83,618	$44,339	$274,024	$12,603	$477,254	0.41%	$423
2 - 4	933	1,442	2.29%	$127,893	$140,195	$189,326	$379,075	$101,078	$937,567	0.80%	$84
5 - 9	1888	2,260	3.59%	$304,716	$107,753	$169,679	$410,990	$66,452	$1,059,591	0.90%	$47
10 - 14	2163	2,645	4.20%	$235,417	$176,956	$261,624	$574,893	$46,551	$1,295,441	1.10%	$50
15 - 19	2504	3,163	5.02%	$1,459,501	$908,298	$474,699	$1,125,478	$132,206	$4,100,182	3.48%	$136
20 - 24	2268	2,405	3.82%	$2,225,971	$481,302	$593,406	$1,578,875	$128,592	$5,008,146	4.25%	$184
25 - 29	1352	1,731	2.75%	$465,819	$285,300	$180,473	$601,036	$37,958	$1,570,586	1.33%	$97
30 - 34	1689	2,332	3.70%	$455,029	$410,057	$320,503	$795,184	$64,899	$2,045,672	1.74%	$101
35 - 39	1911	2,811	4.46%	$1,258,494	$906,997	$309,813	$1,343,422	$71,880	$3,890,606	3.30%	$170
40 - 44	2360	3,627	5.76%	$2,051,246	$1,092,992	$453,057	$1,923,197	$83,530	$5,604,022	4.76%	$198
45 - 49	2753	4,425	7.02%	$2,543,187	$2,092,924	$669,215	$3,011,744	$108,850	$8,425,920	7.15%	$255
50 - 54	3263	5,634	8.94%	$2,989,688	$2,911,477	$807,148	$4,277,396	$199,024	$11,184,733	9.49%	$286
55 - 59	4144	7,586	12.04%	$6,057,748	$4,868,069	$1,264,901	$7,786,410	$457,243	$20,434,371	17.35%	$411
60 - 64	5118	9,560	15.17%	$13,170,439	$8,755,901	$1,682,918	$11,198,681	$543,294	$35,351,234	30.01%	$576
65 +	1918	12,261	19.46%	$4,753,810	$2,846,405	$613,386	$4,858,170	$250,194	$13,321,965	11.31%	$579
	34,671	***63,009***	***100.00%***	***$40,222,842***	***$26,095,976***	***$8,063,251***	***$41,093,783***	***$2,331,821***	***$117,807,672***	***100.00%***	***$283***

Participants by Tier

During the year ending June 30, 2012, the plan paid $283 PMPM.

Coverage Tier	Members
Single	12,766
Employee + Spouse	3,778
Employee + Children	8,633
Family	9,494
Total	***34,671***

Member Type	# Members	Total Paid	PMPM
Children	10,166	$15,792,459	$129
Adults	24,505	$102,015,213	$347
Total	***34,671***	***$117,807,672***	***$283***

Dental Section

Cost Distribution

The maximum per member dental benefit for Plan Year 2012 is $1,000. However, claims paid during the year included run-out claims for Plan Year 2011. This accounts for the plan paying in excess of $1,000 on behalf of 1,493 members.

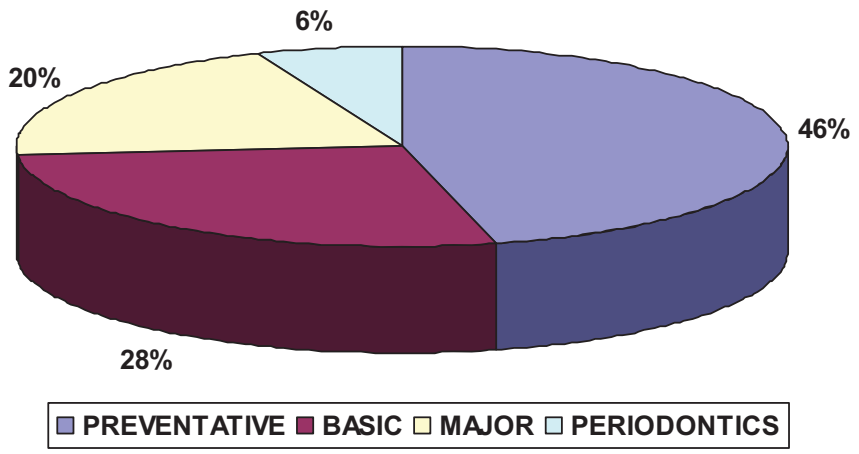
The average dental claim for the year ending June 30, 2012, was $117.20. This represents a 36.7% decrease from the $185.02 average dental claim for the year ending June 30, 2011.

Paid Dollar Range	*Avg Members*	*% of Members*	*# of Claims*	*% of Claims*	*Total Paid*	*% of Paid*
$1,000.01 Plus	1,493	2.48%	11,333	7.39%	$2,195,889	12.21%
$750.01 - $1,000.00	5,363	8.93%	32,992	21.50%	$5,463,779	30.38%
$500.01 - $750.00	4,262	7.09%	21,661	14.12%	$2,883,881	16.04%
$250.01 - $500.00	12,543	20.88%	47,846	31.18%	$4,688,222	26.07%
$0.01 - $250.00	15,034	25.02%	38,905	25.35%	$2,750,957	15.30%
$0.00	488	0.81%	705	0.46%	$0	0.00%
No Claims Filed	20,898	34.78%	0	0.00%	$0	0.00%
	60,081	**100.00%**	**153,442**	**100.00%**	**$17,982,727**	**100.00%**

* Member count is an average over the 12 month period

Dental Paid by Type of Service

Of the $17.9 million in paid dental claims during the year ending June 30, 2012, $8.3 million (46%) was for preventive services.



Savings Summary

During the year ending June 30, 2011, participants paid 30.5% of total dental costs owed by the plan and participants combined, after deducting ineligible amounts, network discounts and third party payments from billed charges. During the year ending June 30, 2012, participants' share of costs increased to 34.0% of total dental costs paid by the plan and participants. This increase is due to patients meeting their benefit maximum for the plan year ending June 30, 2011, (claims paid after June 30, 2011), the higher deductible reset on July 1, 2011, and the higher coinsurance effective July 1, 2011.

Category	Dollars	PPPM	% of Eligible
Eligible Charges	$37,520,400	$87	100.00%
COB	$169,209	$0	0.45%
PPO Discount	$5,468,461	$13	14.57%
Excess/Maximums	$4,628,109	$11	12.33%
Deductible	$2,428,333	$6	6.47%
Coinsurance	$6,843,560	$16	18.24%
Total Participant Paid	**$9,271,894**	**$22**	**24.71%**
Total Plan Paid	**$17,982,727**	**$42**	**47.93%**

Plan Year 2011	**$52**

Patient Demographics

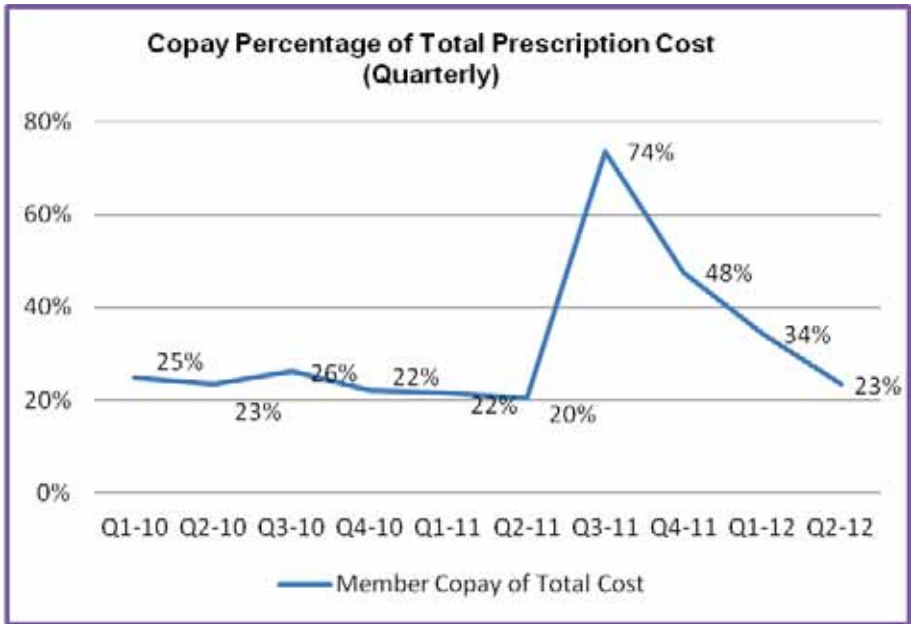
During the year ending June 30, 2012, the plan paid $25 PMPM. The average cost per adult was $27 PMPM. The average cost per child was $20 PMPM.

Member Type	# Members	Total Paid	PMPM
Children	16,772	$3,975,707	$19.75
Adults	43,309	$14,007,020	$26.95
Total	***60,081***	***$17,982,727***	***$24.94***

Drug Utilization

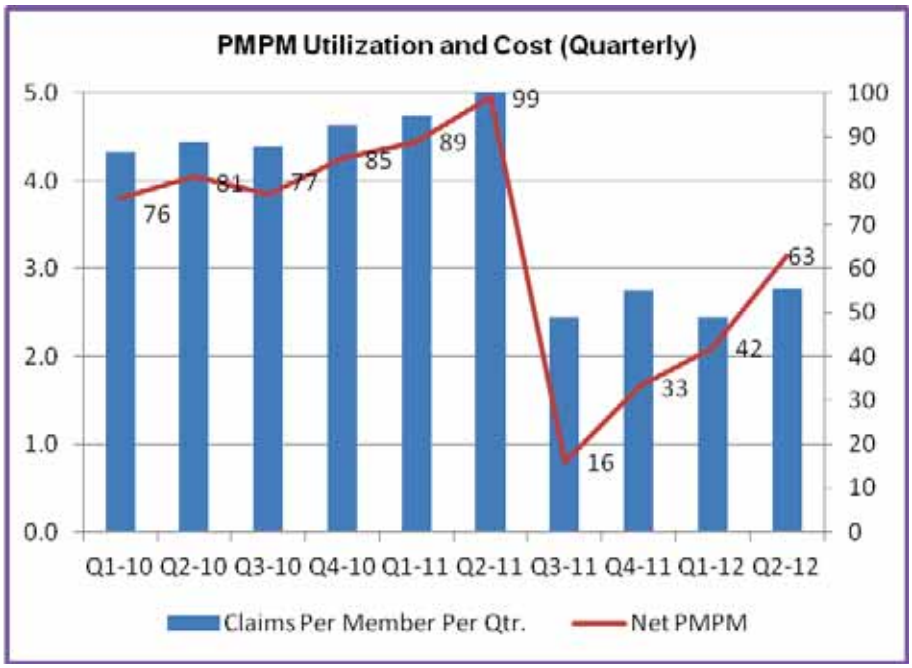
Drug utilization (number of members utilizing the PEBP pharmacy benefit as a percent of all PPO self-funded members) has decreased from 49.0% to 36.3% from the year ending June 30, 2011, to the year ending June 30, 2012. Total prescription drug net costs decreased 56.2% (38.4% PMPM) from $67.0 million to $29.3 million. A large share of the reduction in prescription drug costs is attributable to the Medicare retirees being moved to the Medicare Exchange.

Total prescription drug net costs paid by the plan decreased 67.5% (54.4% PMPM) from $51.9 million to $16.8 million while prescription drug costs paid by participants decreased (17.0%) from $15.1 million to $12.5 million, PMPM costs increased 16.6%. Participants paid 22.5% of total drug costs for the year ending June 30, 2011, and 42.6% of total drug costs for the year ending June 30, 2012. However, it should be noted much of this can be attributed to the introduction of the Consumer Driven High Deductible Health Plan effective July 1, 2011. Participants are now responsible for the full price of their prescription drugs until they meet their deductible. After a participant meets the deductible they will be responsible for 25% of the cost of their drugs until they meet the out-of-pocket maximum. The participant share of costs will decrease through the year as more participants meet their deductible and out-of-pocket maximums. Additionally, the higher prescription drug cost sharing reduces the amount of medical claim cost sharing due to the combined deductibles.



The chart shows the percent of total prescription costs paid by participants for the ten quarters ending June 30, 2012.

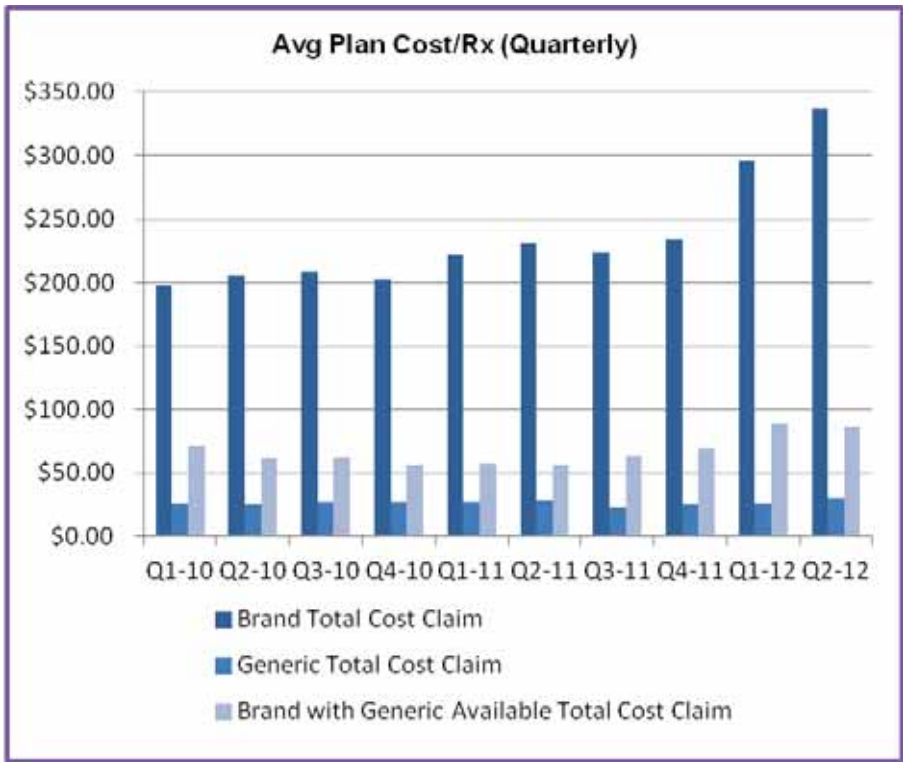
The chart below shows a relatively steady increase in the number of claims per eligible member until June 30, 2011. The decreases in the net PMPM plan costs in the 3rd quarter of calendar years 2010 and 2011 are due to the prescription drug deductible reset on July 1, 2010 and the implementation of the Consumer Driven High Deductible Health Plan effective July 1, 2011.



Generic drug utilization (generic scripts filled as a percent of all scripts) increased from 74.6% in the year ending June 30, 2011, to 78.0% in the year ending June 30, 2012. This generic utilization rate is among the highest in the nation and is a result of the plan's mandatory generic program. Due to the unavailability of generic equivalents for certain brand drugs, the maximum generic utilization rate the plan could achieve for the year ending June 30, 2012, is 91.5%.

From the year ending June 30, 2011, to the year ending June 30, 2012, the net total number of generic prescriptions filled decreased 55.8%, (37.8% PMPM) while the net total cost of generic drugs to the plan and its participants decreased 57.5% (40.2% PMPM). During the year ending June 30, 2012, generic drugs cost $8.0 million out of $29.3 million in total prescription drug costs paid by the plan and participants. Again, a large share of the reduction in generic prescription drug costs is attributable to the migration of Medicare retirees to the Medicare Exchange.

The following table shows the average plan cost per prescription for brand drugs, generic drugs and brand drugs with generic equivalents for the year ending June 30, 2012.



The net cost of specialty drugs decreased 35.8% (9.8% PMPM) from $11.5 million during the year ending June 30, 2011, to $7.4 million in the year ending June 30, 2012. The average number of patients with 7 or more prescription claims per month decreased 74.5% from 3,281 as of June 30, 2011, to 834 as of June 30, 2012. As with the other aspects of prescription drugs, a large share of these reductions is attributable to the migration of Medicare retirees to the Medicare Exchange.

During the year ending June 30, 2012, the five most expensive drugs for the plan and participants (total) were Copaxone, Lipitor, Rebif, Enbrel (includes Endrel Sureclick), and Avonex. Lipitor was scheduled to have a generic equivalent in May 2012, and fell from the list of the five most expensive drugs in June. A list of brand drugs that are scheduled to have a generic equivalent can be found in the Catalyst Rx quarterly report.

Staff is working with Catalyst Rx to add information regarding possible therapeutic equivalents to their website and mobile applications so that members have more information and can better compare prescribed drugs and potential generic alternatives in order to provide additional cost savings to participants and the plan.

	Rolling Total for 12 Months
Membership Summary	
Member Count	**35,162**
Utilizing Member Count	**12,777**
Percent Utilizing	**36.3%**
Claim Summary	
Net Claims (Mail/Retail)	**392,067**
Claims per Elig Member per Month	**0.93**
Total Claims for Brand	**76,209**
Total Claims for Generic	**305,668**
Total Claims for Brand w/Gen Equiv	**10,190**
Generic % of Total Claims	**78.0%**
Mail Order Claims	**17,682**
Mail Order % of Total Claims	**4.5%**
Claims Cost Summary	
Total Prescription Cost	**$29,339,073.51**
Total Ingredient Cost	**$28,730,535.16**
Total Dispensing Fee	**$524,457.22**
Total Other (e.g. tax)	**$5,231.07**
Total Incentive Fee	**$78,850.06**
Avg Total Cost per Claim	**$74.83**
Avg Total Cost for Brand	**$269.54**
Avg Total Cost for Generic	**$26.15**
Avg Total Cost for Brand w/Gen Equiv	**$78.97**

	Rolling Total for 12 Months (cont.)
Member Cost Summary	
Total Copay	**$12,485,712.93**
Avg Copay per Claim	**$31.85**
Avg Copay for Brand	**$91.91**
Avg Copay for Generic	**$16.25**
Avg Copay for Brand w/Gen Equiv	**$50.39**
Copay % of Total Prescription Cost	**42.6%**
Other Plan Paid Cost Summary	
Total Other Plan Paid Cost	**$0.00**
Plan Cost Summary	
Total Plan Cost	**$16,853,360.58**
Total Specialty Drug Cost	**$7,350,004.50**
Increase % Total Cost over Last 3 Mos.	
Avg Plan Cost per Claim	**$42.99**
Avg Plan Cost for Brand	**$177.63**
Avg Plan Cost for Generic	**$9.90**
Avg Plan Cost for Brand w/Gen Equiv	**$28.59**
Net PMPM	**$39.94**
PMPM for Specialty Only	**$17.42**
PMPM without Specialty	**$22.52**

Wellness Summary

In addition to the wellness screenings paid through HealthSCOPE, USPM administered 15,457 biometric screenings and 3,697 PSA tests in the year ending June 30, 2012. Note, many of the USPM labs (7,344) and PSA tests (1,753) conducted in the fourth quarter were needed by participants to qualify for premium incentives in the next plan year.

Well Child	# Eligible	# Patients	Per 1,000	HSB Index per 1,000	Total Paid	Paid Per Pt
Routine Infant or Child Health Check	7,292	2,797	384	494	$377,175	$135
Prophylactic Vaccinations and Inoculations	7,292	1,592	218	N/A	$105,560	$66

Well Woman	# Eligible	# Patients	Per 1,000	HSB Index per 1,000	Total Paid	Paid Per Pt
Mammogram	10,362	5,229	505	410	$955,807	$183
Colonoscopy	7,703	1,413	183	126	$804,030	$569
Cervical Screening	13,748	5,177	377	402	$532,296	$103
Routine General Medical Exam	14,225	1,674	118	637	$218,578	$131
Prophylactic Vaccinations and Inoculations	14,225	749	53	N/A	$18,524	$25

Well Man	# Eligible	# Patients	Per 1,000	HSB Index per 1,000	Total Paid	Paid Per Pt
Colonoscopy	6,564	792	121	110	$740,453	$935
Routine General Medical Exam	12,717	1,692	133	333	$231,502	$137
Prostate Screening	6,564	1,834	279	408	$54,353	$30
Prophylactic Vaccinations and Inoculations	12,717	554	44	N/A	$14,873	$27

Diabetes Compliance

212 of 1,651 active PPO HDHP diabetics with nine months of service (12.4%) have received the minimum number of recommended services (semiannual visit, semiannual glycohemoglobin determination, annual urinalysis or microalbuminuria test, annual ophthalmologic evaluation, annual lipid profile) in the 12 months ending June 30, 2012. 517 members (31%) have received all of the recommended services when the ophthalmologic exams are excluded. With the exception of the annual urinalysis test, the compliance rates for all other tests were below those noted in PY11.

Diabetes Compliance Requirements

- **Semiannual visit**

  The American Diabetes Association recommends at least semiannual visits to monitor metabolic control and review laboratory results. Patients who require adjustment of their medical regimen will require more frequent follow-ups.

- **Semiannual glycohemoglobin determination**

  Glycohemoglobin determination is a method for assessing long term glycemic control in patients and is recommended at least semiannually by the American Diabetes Association

- **Annual urinalysis or microalbuminuria test**

  Diabetes is associated with multiple renal complications, the most serious being renal insufficiency (diabetic nephropathy). One of the earliest manifestations of diabetic nephropathy is microalbuminuria. The American Diabetes Association recommends a urinalysis annually for all patients with diabetes mellitus. Patients with long standing diabetes may benefit from a 24-hour urine albumin determination.

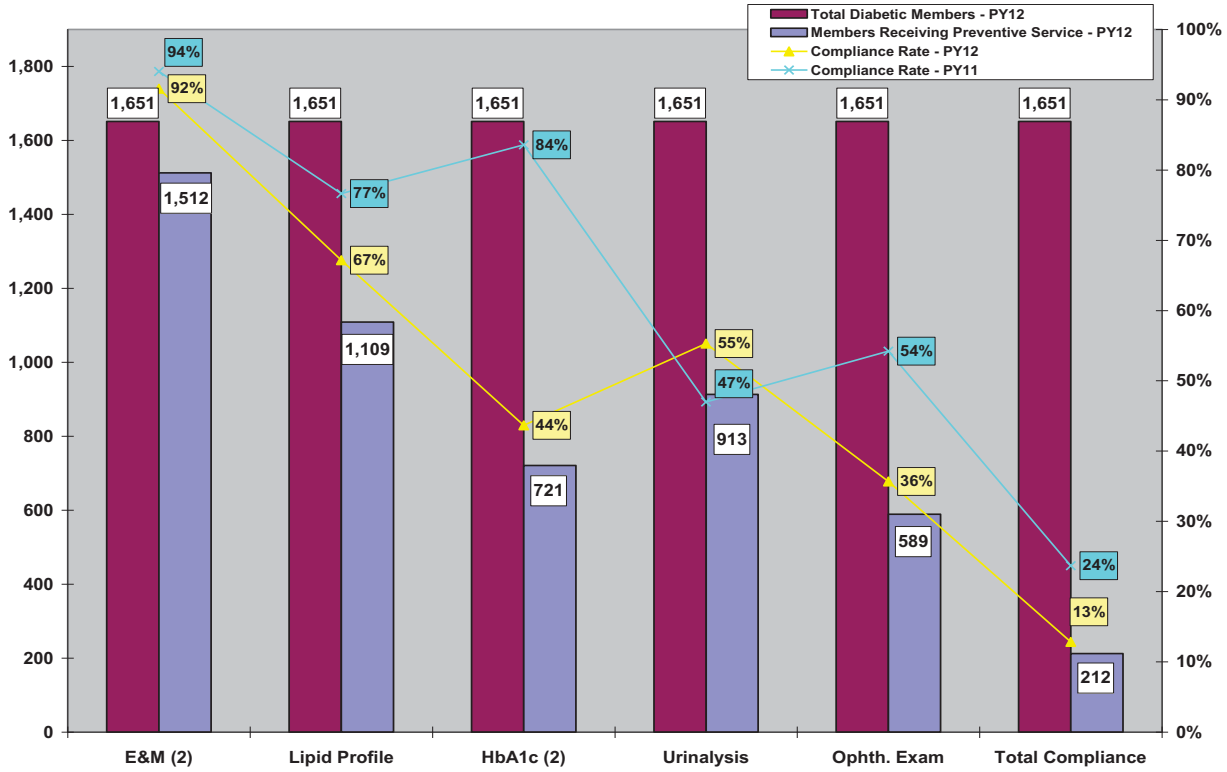
- **Annual ophthalmologic evaluation**

  Diabetic ocular complications are the leading cause of blindness among adults 20 to 74 years of age. Early detection and treatment of proliferative retinopathy can prevent or delay progressive vision loss. Yearly dilated ophthalmologic examination by an experienced physician (usually an ophthalmologist) is a proven screening strategy recommended by the American Diabetes Association, American College of Physicians, and the American Academy of Ophthalmology.

- **Annual lipid profile**

  One of the complications of diabetes is an increased risk for cardiovascular disease. If a person has diabetes and has an elevated cholesterol, the American Diabetes Association recommends a lipid profile every year.

Semiannual blood glucose monitoring: almost all patients will monitor blood glucose at home. Periodic laboratory testing serves to verify the accuracy of the home glucose meter and, in some patients, correlates with metabolic control. This type of test is recommended, but not required for compliance.



*** Based on active members with 9 months of service; 12 months of utilization data.**

- **PY12 -- 517 members (1,651 total) received all services other than ophth exam (31%)**
- **PY11 – 679 members (1,656 total) received all services other than ophth exam (41%)**

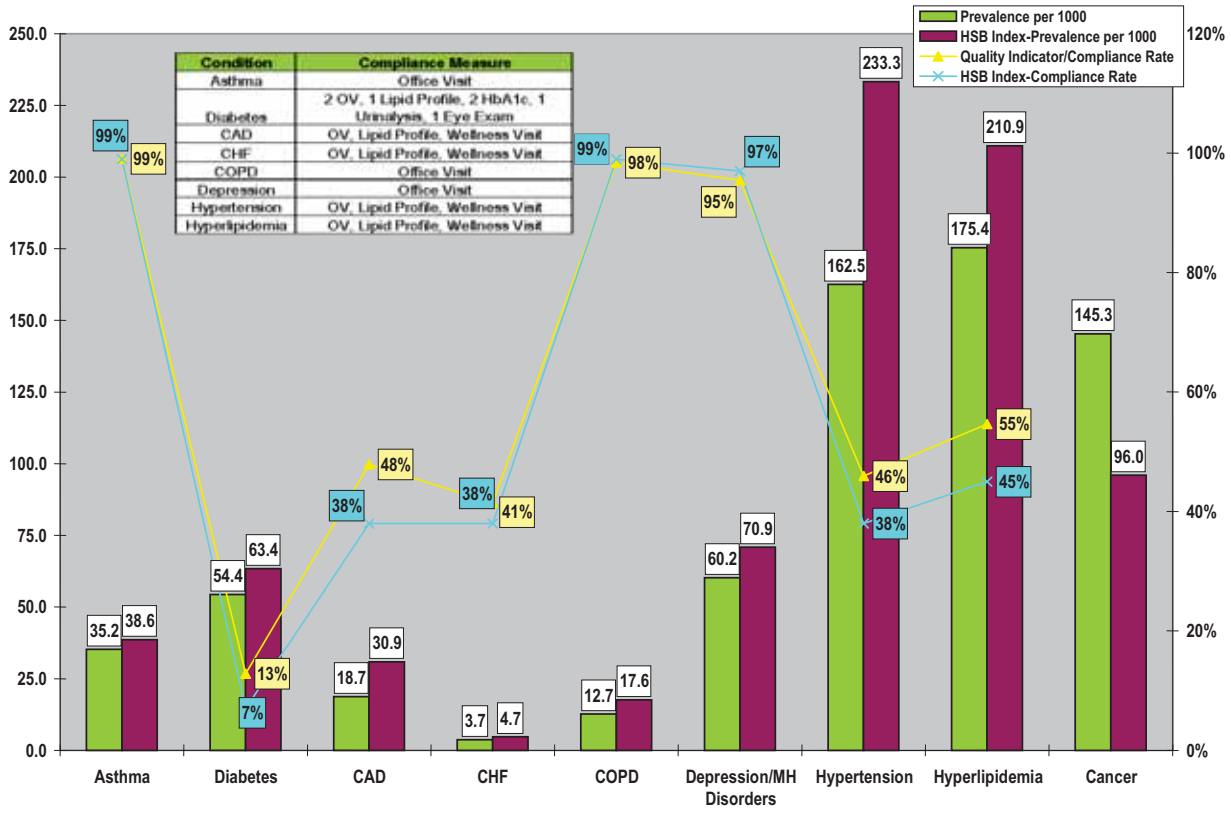
Chronic Conditions

The Chronic Conditions Overview shows the total paid by the plan for chronic conditions for the period ending June 30, 2012, for members with nine continuous months of service. Congestive heart failure was the most expensive chronic condition with an average annual cost per patient of $47,416, while Hyperlipidemia was the most frequent condition. Occurrences of cancer (14.5%) within the PEBP population, as a percentage, were considerably higher than the level noted in HealthSCOPE Benefits' Index (9.6%).

Chronic Condition	*# Members*	*% of Population*	*HSB Index % of Population*	*Average Age*	*Total Paid*	*Avg Cost / Member (Annualized)*
Asthma	1,068	3.5%	3.9%	41.6	$7,940,717	$7,435
Cancer	4,408	14.5%	9.6%	53.8	$41,371,155	$9,385
Chronic Obstructive Pulmonary Disease (COPD)	384	1.3%	1.0%	59.7	$6,999,458	$18,228
Congestive Heart Failure (CHF)	111	0.4%	0.3%	63.8	$5,263,199	$47,416
Coronary Artery Disease (CAD)	568	1.9%	2.1%	61.0	$9,703,060	$17,083
Depression / Mental Health Disorders	1,827	6.0%	7.1%	45.4	$18,463,278	$10,106
Diabetes	1,651	5.4%	6.3%	57.7	$16,808,354	$10,181
Hyperlipidemia	5,321	17.5%	14.5%	56.8	$27,114,672	$5,096
Hypertension	4,932	16.3%	16.1%	57.4	$38,293,299	$7,764

Chronic Condition	*# of Employees*	*# of Spouses*	*# of Dependents*	*Total # Members*
Asthma	635	129	304	1,068
Cancer	3,508	658	242	4,408
Chronic Obstructive Pulmonary Disease (COPD)	297	77	10	384
Congestive Heart Failure (CHF)	93	18	0	111
Coronary Artery Disease (CAD)	487	78	3	568
Depression / Mental Health Disorders	1,191	296	340	1,827
Diabetes	1,391	226	34	1,651
Hyperlipidemia	4,486	781	54	5,321
Hypertension	4,174	718	40	4,932

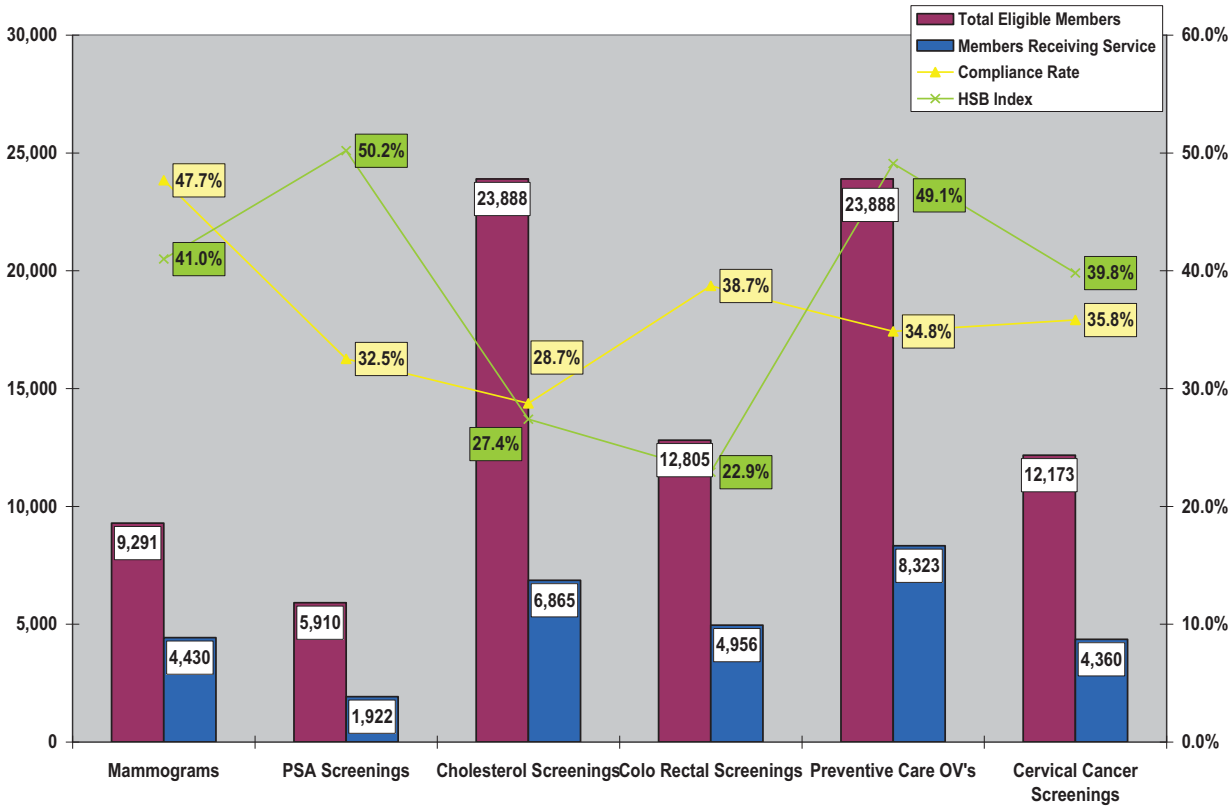
Chronic conditions that require only office visits (Asthma, COPD, and Depression) have compliance rates of approximately 97%. When recommendations for chronic conditions include labs (Diabetes, CAD, CHF, Hypertension, and Hyperlipidemia) compliance rates drop to between 13%-55%; however, the compliance levels are generally higher than the compliance rates associated with HealthSCOPE Benefit's Index for the same conditions.



*** Based on active members with 9 months of service; 15 months of utilization data.**

Preventive Services

PPO HDHP preventive service compliance rates were nearly split with Mammograms, Cholesterol Screenings and Colon Cancer Screenings being above the HealthSCOPE Benefits' Index while PSA Screenings, Preventive Care OV's and Cervical Cancer Screenings were well below the compliance index.



*** Based on active members with 9 months of service; 15 months of utilization data – Colo Rectal based on 35 months.**

PPO HDHP HSA/HRA Account Balances

HealthSCOPE Benefits administers approximately 11,694 PO HDHP HRA accounts with approximately $8.4 million in PEBP contributions. The average contribution is $724. In the year ending June 30, 2012, PEBP paid approximately $4.2 million in HRA claims, leaving a liability of $4.2 million in unused HRA funds, or $363 per account, at the end of Fiscal Year 2012.

HealthSCOPE Benefits administers approximately 11,342 PPO HDHP HSA accounts with approximately $9.7 million in PEBP contributions and $6.1 million in employee contributions. The average PEBP contribution is $855. The average employee contribution is $540. During the year ending June 30, 2012, HealthSCOPE Benefits administered the reimbursement of approximately $7.9 million in HSA claims leaving $7.9 million in unused HSA funds, or $699 per account, at the end of Fiscal Year 2012.

HRA Account Balance Details					
Total Accounts	Employer Contribution	Paid*	Employer Deposits	Available Balance	Avg Acct Balance
11,694	$8,471,238	($4,199,196)	$8,428,388	$4,245,785	$363

* Paid amounts are based on the date the payment is generated not the effective date of the payment.

HSA Savers Plan Year 2012						
Category	TotalAccounts	PctTotal	AvgEEContr	AvgERContr	AvgBalance	AvgAcctAge
Very Low	425	3.75%	$7.21	$247.78	202.69	4.5
Low	5,222	46.04%	$16.19	$739.44	$515.84	11.6
Medium	4,323	38.11%	$422.05	$1,015.24	$747.73	12.3
High	1,372	12.10%	$3,073.32	$977.45	$1,399.06	12.7

HSA Spenders Plan Year 2012						
Category	TotalAccounts	PctTotal	AvgContr	AvgDistr	SaveSpend	AvgBal
Low Activity	6,400	56.43%	$68.63	$36.97	$31.65	$532.97
Spender - High	2,481	21.87%	$195.62	$181.45	$14.17	$556.46
Spender - Mid	1,457	12.85%	$214.40	$113.13	$101.27	$1,109.99
Saver - Mid	532	4.69%	$221.11	$29.95	$191.16	$1,612.16
Saver - Aggressive	472	4.16%	$182.56	$0.00	$182.56	$1,409.51

Exchange HRA Account Balances

Extend Health administers approximately 9,210 Medicare Exchange HRA accounts, with an annual contribution of $16.9 million. In the year ending June 30, 2012, PEBP paid $13.1 million in Medicare Exchange HRA claims ($119 per retiree per month) leaving a liability of $3.8 million (22.7%) in unused Medicare Exchange HRA funds, or $417 per account, at the end of Fiscal Year 2012.

Recommendations

None

D-1

NRS 287.0425 (2) (d) 1

Open Enrollment Guide,

Plan Year 2013

Open Enrollment Guide
Plan Year 2013

State of Nevada

Public Employees' Benefits Program

Public Employees' Benefits Program
901 S. Stewart St., Suite 1001
Carson City, NV 89701

www.pebp.state.nv.us
(775) 684-7000
(800) 326-5496
Fax: (775) 684-7028

mservices@peb.state.nv.us

What's Inside:

Effective July 1, 2012 - June 30, 2013

Plan Year 2013 Open Enrollment

DEADLINE FOR OPEN ENROLLMENT SUBMISSIONS
MAY 31, 2012

Supporting documents to add dependents must be received in the PEBP office by June 30, 2012

PEBP Member Services
(775) 684-7000 or (800) 326-5496
Monday - Friday (except holidays) 8:00 a.m. to 5:00 p.m.
Email: mservices@peb.state.nv.us

Introduction to

Open Enrollment

May 1 - May 31, 2012

Dear PEBP Participant:

During last year's open enrollment period, we provided information regarding several changes to PEBP's health plans. For Plan Year 2013, there are no significant changes in plan design; however, on the next few pages you will find a summary of the changes you can expect on July 1, 2012. For the new premium rates, please turn to pages 26 - 32.

Open enrollment will be held May 1 through May 31, 2012 and provides you the opportunity to evaluate your benefits and review plan design changes that will occur for the next plan year. This is also a good time to update your contact information with PEBP and review the voluntary benefit options available to you.

We encourage you to review and consider the information provided in this 2013 Open Enrollment Guide carefully. Should you have any questions or would like to request clarification on any of the plan options, PEBP's member service representatives can assist you. Please call 775-684-7000, 800-326-5496 or email mservices@peb.state.nv.us.

PEBP's Commitment to you:

- Provide you and your family with affordable and comprehensive health plan choices such as the Consumer Driven PPO High Deductible Health Plan, Health Plan of Nevada and Hometown Health HMO Plan.

- Evaluate future plan offerings and continually look for ways to enhance our benefit offerings.

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

Allowable Changes

Important note: If you have a spouse or domestic partner covered on your plan who is eligible for coverage through their own employer, you must remove them from your PEBP coverage.

Changes you can make using the e-PEBP Online Enrollment tool at www.pebp.state.nv.us

- ☐ Change health plan options
- ☐ Add or drop a dependent (not a domestic partner)
- ☐ Change your Health Savings Account (HSA) beneficiary designation
- ☐ Elect or change contributions to your HSA
- ☐ Establish a HSA (new CD PPO HDHP employees effective July 1, 2012, or eligible employees who defaulted to the PPO Health Reimbursement Arrangement in July 2011).
- ☐ Establish a PPO HRA
- ☐ Update contact information

Changes you cannot make using the e-PEBP Online Enrollment tool

- ☐ Enroll in Medical Flexible Spending
- ☐ Enroll in Dependent Care Flexible Spending Account
- ☐ Enroll in voluntary products
- ☐ Cancel voluntary products
- ☐ Initial enrollment in retiree coverage
- ☐ COBRA enrollment
- ☐ Domestic Partner Enrollment
- ☐ Participant name change
- ☐ Moving outside coverage area

Your Responsibilities

- Understand that if you do not make any changes during Open Enrollment, your current plan option, dependent coverage and HSA contribution (if any) will remain in effect July 1, 2012, and you will pay the designated premium for your coverage.
- If you are making changes during Open Enrollment, be sure your election is submitted online, or if completing the paper form, that it is received by the PEBP office, or postmarked by May 31, 2012.
- If you are adding dependent(s) to your coverage, you must provide required supporting eligibility documentation to the PEBP office by June 30, 2012.
- You must notify PEBP within 30 days of a change to your address.
- Notify PEBP about any family status changes during the year that affects your benefits, such as birth, divorce, or marriage within 60 days of the event.
- Understand that family status changes not received within 60 days of the date of the event will be denied.
- If you *decline* coverage for yourself and/or your dependents, you will NOT be eligible to enroll in a medical plan until the next Open Enrollment period unless you have a qualifying family status change as defined in the Plan Year 2013 Master Plan Document available at www.pebp.state.nv.us.
- If you are currently paying for a voluntary Life Insurance policy or Short-Term Disability policy through The Standard and you decline your PEBP coverage during open enrollment, or any other time, these voluntary policies will also terminate.

How to Enroll

Complete your enrollment by doing one of the following:

1. Complete your enrollment online

Log on to the PEBP website at www.pebp.state.nv.us and click on Enroll Now. Follow the instructions to complete your enrollment.

All participants are encouraged to enroll online. Enrolling online will simplify your enrollment process and you will not have to complete the Open Enrollment Form. If you are enrolling in the CD PPO HDHP, you can also amend or elect your HSA contribution. If you are making changes you must enroll by May 31, 2012.

Or

2. Complete the Open Enrollment Form

- If you did not receive a form with your Open Enrollment letter, you may contact the PEBP office to request the Open Enrollment Form at 775-684-7000 or 800-326-5496.
- If you are completing the paper version of the form, you must return the completed form to the PEBP office by May 31, 2012 or postmarked by May 31, 2012.

Enrolling Dependent(s)

To add new dependents effective July 1, 2012, you must add them to your Open Enrollment election through online enrollment or include their information on the Open Enrollment form. Note: If you wish to add a domestic partner, you must complete the paper form available by calling 775-684-7000 or 800-326-5496.

Documentation to Add Dependent(s)

To *add* a spouse or domestic partner, submit a copy of your marriage certificate or a copy of your domestic partner certificate issued from the Nevada Secretary of State's office. To cover children from birth to age 26, submit a copy of the child's birth certificate. If the dependent is your stepchild or the child of your domestic partner, you must also provide a copy of your marriage certificate or domestic partner certificate. Supporting documentation to determine a dependent's eligibility for coverage must be received in the PEBP office by June 30, 2012.

For more information regarding supporting document requirements, please visit www.pebp.state.nv.us or call 775-684-7000, 800-326-5496 or email mservices@peb.state.nv.us.

Health Savings Account (HSA)

Employees who are currently self-contributing to their HSA through payroll deductions will continue making these same deductions (if continuing coverage under the CD PPO HDHP) after July 1, 2012. **Exception**: **Employees who complete an online enrollment change will automatically reset their election on July 1, 2012 to $0.00, unless a new contribution amount is elected when completing the online open enrollment event**.

Overview of Changes for Plan Year 2013

Consumer Driven PPO High Deductible Health Plan (CD PPO HDHP)

PPO Diabetes Care Management Program

The *Diabetes Care Management Program* is a disease management program open to all primary CD PPO HDHP participants, their covered spouses/domestic partners, and beginning July 1, 2012, their dependent children diagnosed with diabetes. The program provides you with a nurse health coach who will work with you on things such as your medications, health questions, blood glucose monitoring, foot and eye care, and other ways you can effectively manage your health.

Adults over age 18 who are participating in the Diabetes Care Management Program and who are considered "actively engaged" by HealthSCOPE Benefits and U.S. Preventive Medicine (USPM) will receive expanded benefits by adhering to the following:

- Performing daily monitoring/journaling of blood glucose levels; reporting results to your physician and USPM health coach
- Carrying a diabetes alert identifier in the event of an emergency
- Taking medications and/or daily aspirin therapy as prescribed by your physician

Children ages 1 - 18 will be considered "actively engaged" when adhering to the following:

- Completing at least 2 visits with their primary care physician or endocrinologist each plan year
- Completing appropriate lab testing each plan year
- Routinely taking medications as prescribed by their physician

Qualifying benefit enhancements for being actively engaged:

- Annually, receive two physician's office visits (with a primary diagnosis of diabetes) and two routine laboratory blood tests (e.g. hemoglobin (A1c) test) paid at 100%.
- Pay flat copayments for diabetes-related medications such as insulin or Metformin.
- Retail Prescription Drugs - 30 Day Supply/90 Day Supply
  - Generic: $5 copay -30 day supply or $15 copay - 90 day supply
  - Preferred Brand: $25 copay - 30 day supply or $75 copay 90 day supply

* Benefit enhancement will not apply to non-Preferred Brand medications.

- Diabetic Supplies
  - Receive valuable savings on diabetic supplies such as alcohol pads, test strips, syringes, lancets, etc. Purchase each 90-day supply item for a $50 copayment (or less if the actual cost is less). Supplies must be coordinated through Catalyst Rx and their vendor partner Liberty.

Overview of Changes for Plan Year 2013, Continued

CD PPO HDHP

Obesity Care Management

Effective July 1, 2012, the CD PPO HDHP will offer an Obesity Care Management Program to participants and their covered dependents who meet specific health-related eligibility criteria. Participants who are deemed actively engaged in the program by USPM and HealthSCOPE Benefits will receive expanded weight loss benefits paid at 100%; eligible expenses will not be subject to deductible or coinsurance (exceptions will apply to pharmacotherapy and meal replacements).

Active engagement in the program requires participation in the Live Well, Be Well Prevention Plan, regular office visits with a weight loss medical provider, adherence to the provider's treatment plan and a demonstrated consistent commitment to weight loss, including, but not limited to, routine exercise, proper nutrition and diet, and pharmacotherapy (if prescribed). For a detailed description of the Obesity Care Management Program, refer to the Plan Year 2013 Master Plan Document available at www. pebp.state.nv.us.

Weight Loss Surgeries and Plan Restrictions effective July 1, 2012

Weight loss surgeries (e.g. lap band and gastric bypass) must be performed at an in-network (PPO) outpatient or inpatient *Center of Excellence* facility, this restriction also applies to surgeons and other ancillary providers. The plan restricts one obesity related surgical procedure of any type in an individual's lifetime. For more information, refer to the Plan Year 2013 Master Plan Document at www. pebp.state.nv.us.

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

Provide reimbursement of certain travel and hotel accommodation expenses for the patient and one additional individual person (spouse/domestic partner, family member or friend) when associated with medical treatment for organ and tissue transplants, and obesity surgery services are performed at a Center of Excellence. Limitations apply to this benefit, for detailed information regarding these plan restrictions, refer to the PlanYear 2013 Master Plan Document at www. pebp.state.nv.us.

National Preferred Provider Network

Effective July 1, 2012, the current national preferred provider network (Beech Street) will be replaced by GWH-CIGNA for participants residing *outside* of Nevada. Participants residing outside Nevada to travel to Nevada for healthcare will access healthcare using the Statewide PPO Network. Participants residing in Nevada who wish to access healthcare outside Nevada will use the First Health Network

Refer to page 34 for contact information.

Plan Year 2013 Dental Plan Benefits (for CD PPO HDHP and HMO participants)

The PPO Dental Plan's Preventive care benefit (e.g. four teeth cleanings, bitewing X-rays) will be paid at 100% when using in-network dental providers. This is in addition to the $1,000 annual maximum for Basic and Major services.

Overview of Changes for Plan Year 2013, continued

CD PPO HDHP Medical ID Cards

CD PPO HDHP participants will receive a new medical ID on or about July 1, 2012. Current participants continuing coverage under the CD PPO HDHP on July 1, 2012 may continue to use their current medical ID card pending receipt of the new card. Participants who are accessing healthcare outside Nevada will need to confirm whether or not their provider is contracted with the new CD PPO HDHP national network by calling HealthSCOPE Benefits at 888-763-8232.

One-time Supplemental HSA and HRA Contribution

Primary participants and their covered dependents enrolled in the CD PPO HDHP on July 1, 2012 will receive a one-time increase to their HSA and HRA funding. For details about the contribution amounts and eligibility, refer to page 17.

Live Well, Be Well (LWBW) Prevention Plan

This program provides an online portal that you can use 24/7 to get healthy or stay healthy. It features a broad range of educational materials, such as health and wellness webinars, a comprehensive medical library with reliable resources where you can learn about nutrition, healthy living, medical tests and procedures, health and wellness activities, various disease states, illness, and more. Participants have access to a confidential health journal to track physician office visits, lab results, medications, and more. The program offers a Health Assessment Questionnaire (HAQ) that will identify a person's five highest health risks. Any information you entered into the personal profile is completely confidential.

The program is offered to primary participants, their covered spouses/domestic partners and children enrolled in the CD PPO HDHP beginning July 1, 2012.

- Returning LWBW primary participants (who enrolled in the program last fall by October 31, 2011) had until February 29, 2012 to build their Intervention Score. Premium reductions effective July 1, 2012 are based on the total Prevention Score and may be found on page 7. The registration period for those who wish to continue the LWBW Prevention Plan and new participants who wish to enroll for Plan Year 2013 will have until May 15, 2012 to register, complete the biometric screening and the HAQ. Completing these three steps will allow primary participants to earn an additional $5 premium reduction effective July 1, 2012 and the opportunity to start building their Prevention Score to earn premium credits for Plan Year 2014, effective July 1, 2013. Premium reductions will not apply to dependents of primary participants.
- Participants who change from an HMO plan to the CD PPO HDHP during the open enrollment period will be eligible to enroll in the LWBW Prevention Plan in late June after their open enrollment election has been processed. The enrollment period for these participants will end August 15, 2012. Primary participants who complete registration, lab work and the HAQ during this period will be eligible to receive a $5 premium credit beginning October 1, 2012. This will allow them to start building their Prevention Score toward a premium incentive for Plan Year 2014, effective July 1, 2013.

Overview of Changes for Plan Year 2013, continued

Live Well, Be Well (LWBW) Prevention Plan

- New hires whose coverage becomes effective June 1 through August 1, 2012, and who enroll in the CD PPO HDHP will be eligible to enroll in the LWBW Prevention Plan in late June after their new hire paperwork has been processed. The enrollment period for these participants will end August 15, 2012. Primary participants who complete registration, lab work and the HAQ during this period will be eligible to receive a $5 premium credit beginning October 1, 2012.

To learn more about the LWBW Prevention Plan, visit:
http://nevadapebp.thepreventionplan.com/

The following table provides the point range of the LWBW Prevention Plan and related premium reduction incentives for primary CD PPO HDHP participants who completed the *Intervention* phase (through February 29, 2012) and the spring *Assessment* phase ending May 15, 2012.

If final Prevention Score falls in this range:	Receive this monthly premium reduction:	Bonus monthly premium reduction earned by completing HRA & biometric screening in Spring 2012	Total monthly premium reduction earned July 1, 2012
0-400	$0	$5	$5
401-500	$5	$5	$10
501-600	$10	$5	$15
601-700	$20	$5	$25
701-800	$30	$5	$35
801-1,000	$40	$5	$45

Health Plan of Nevada (HPN)

HPN's emergency room visit copayment will change to $75 copayment per visit.

Hometown Health Plan (HHP)

Hometown Health Plan will not have any plan design changes for Plan Year 2013

Health Plan Options

Consumer Driven PPO High Deductible Health Plan (CD PPO HDHP)

The CD PPO HDHP includes a $1,900 individual and $3,800 family deductible. This plan is coupled with a HSA or a PPO-HRA to help offset out-of-pocket healthcare expenses. The plan is designed so all eligible medical and pharmacy expenses are subject to the annual deductible. The CD PPO HDHP offers wellness benefits (only when services are accessed through in-network providers) based upon guidelines published by the Centers for Disease Control and Prevention (CDC).

The plan year out-of-pocket maximum (in-network) for an individual is $3,900 and $7,800 for a family. Participants enrolled in the CD PPO HDHP have access to a Statewide PPO network, as well as a national network.

Health Plan of Nevada (HPN) HMO

Health Plan of Nevada is a Health Maintenance Organization (HMO) where members can access dependable care at fixed copayments. HPN offers a wide selection of physicians, hospitals, pharmacies and other healthcare providers. The service area includes Clark, Esmeralda, and Nye Counties (available in Lincoln County for participants who reside in the following zip codes: 89001, 89008, and 89017). HPN requires that you select a primary care physician (PCP) when enrolling in this plan. To select a primary care physician, or to view HPN's Evidence of Coverage, visit www.pebp.state.nv.us, or contact HPN at (702) 242-7300 or (800) 777-1840.

Hometown Health Plan (HHP) HMO

Hometown Health is a HMO that offers fixed copayments for primary care, specialty, and urgent care visits. The plan features medical, prescription drug, and vision coverage. Medical services must be received from a network provider. This plan requires that you select a primary care provider (PCP) at initial enrollment. Hometown Health Plan offers its members Open Access. This means you can self-refer yourself to select contracted specialists without first obtaining a referral from your PCP. It is offered to participants residing in Carson City, Churchill, Douglas, Elko, Eureka, Lander, Lincoln, Lyon, Humboldt, Mineral, Pershing, Storey, Washoe, and White Pine Counties. To select a PCP, or to view the HHP Evidence of Coverage Certificate, visit www.pebp.state.nv.us, or contact HHP at (775) 982-3232 or (800) 336-0123.

HMO Reciprocity

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

Medical Plan Comparison

Benefit Category	CD PPO HDHP	Health Plan of Nevada HMO	Hometown Health Plan HMO
	Amount You Pay In-Network	**Amount You Pay In-Network**	**Amount You Pay In-Network**
Medical deductible	$1,900 individual $3,800 family • $2,400 Individual - when two or more family members covered	No deductible	No deductible
Out-of-pocket maximum	$3,900 person $7,800 family (per plan year)	$6,800 person (per calendar year)	$6,200 person $12,400 family (per plan year)
Hospital inpatient	25% coinsurance after deductible	$200 copayment per admission	$1,500 per admission
Outpatient Same Day Surgery	25% coinsurance after deductible	$50 copayment per admission	$1,000 copayment per admission
Primary care visit	25% coinsurance after deductible	$15 copayment	$25 copayment
Specialist visit	25% coinsurance after deductible	$15 copayment	$45 copayment
Urgent Care visit	25% coinsurance after deductible	$15 copayment	$50 copayment
Emergency room visit	25% coinsurance after deductible	$75 copayment, waived if admitted	$300 copayment per visit
General laboratory services	25% coinsurance after deductible	No charge	No charge for outpatient or hospital
Chiropractic services	25% coinsurance after deductible	$15 copayment per visit	$45 copayment per visit $1,000 plan year max
Wellness/ Prevention	No charge for eligible wellness benefits provided in-network	No charge	No charge
Vision exam	25% coinsurance, U& C* after deductible	$10 copayment every 12 months	$15 copayment every 12 months
Vision hardware (frames, lenses, contacts)	No benefit	$10 copayment/ lenses frames - $100 allowance, contacts $115 in lieu glasses	15 to 20% discount

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

Pharmacy Plan Comparison

Benefit Category	CD PPO HDHP	Health Plan of Nevada HMO	Hometown Health Plan HMO
	Amount You Pay In-Network	Amount You Pay In-Network	Amount You Pay In-Network
Plan Deductible	$1,900 individual $3,800 family • $2,400 Individual -when two or more family members covered	No deductible	No deductible
Out-of-pocket (OOP) maximum	$3,900 person $7,800 family (per plan year)	Contact HPN for pharmacy OOP* maximum	Contact HHP for pharmacy OOP* maximum
Retail Pharmacy - 30 day supply			
Preferred Generic (Tier 1)	25% after deductible	$7 copayment	$7 copayment
Preferred Brand (Tier 2)	25% after deductible	$35 copayment	$40 copayment
Non-Formulary (Tier 3)	100% of contracted price - does not apply to deductible or OOP*	$55 copayment	Greater of $75 copayment per script or 40%
Specialty Drugs	25% after deductible - available in 30 day supply only through Walgreen pharmacies	Applicable retail pharmacy copayment will apply	30% coinsurance
Mail Order - 90 day supply			
Preferred Generic (Tier 1)	25% after deductible	$14 copayment	$14 copayment
Preferred Brand (Tier 2)	25% after deductible	$70 copayment	$80 copayment
Non-formulary (Tier 3)	100% of contracted price - does not apply to deductible or OOP*	Not available through mail order	Greater of $150 copayment per script or 40%
Specialty Drugs	25% after deductible, available in 30 day supply only through Walgreens mail order	Applicable retail pharmacy copayment applies	Not available through mail order

Out-of-Pocket Maximum (OOP): The maximum amount of coinsurance each covered person or family is responsible for paying during a plan year before the coinsurance required by the plan cease to apply. When the OOP maximum is reached, the plan will pay 100% of eligible covered expenses for the remainder of the plan year.

CD PPO HDHP

About the CD PPO HDHP	The Consumer-Driven PPO High Deductible Health Plan is an insurance plan that allows you as a participant to use a Health Savings Account (HSA) or PPO Health Reimbursement Arrangement (PPO-HRA) to pay certain healthcare expenses directly, while the high deductible health plan protects you against catastrophic medical expenses.	
Plan Feature	**In-Network (participating provider benefit)**	**Out-of-Network Benefit**
Annual Deductible *Copayments for physician's office visits and prescription drug coverage do not apply to this plan.*	$1,900 Individual $3,800 Family[1] • $2,400 Individual Family Member Deductible	$1,900 Individual $3,800 Family[1] • $2,400 Individual Family Member Deductible
Annual Out-of-Pocket Maximum (Participant pays)	$3,900 Individual[2] $7,800 Family[2]	$10,600 Individual[3] $21,200 Family[3]
Includes annual deductible and coinsurance; excludes any charges in excess of Usual and Customary (U&C)[3] charges when accessing services from out-of-network providers.		

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

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[1] Family Deductible: The $3,800 Family Deductible applies when two or more individuals are covered on the plan. Embedded in the Family Deductible is a $2,400 Individual Family Member Deductible (IFMD). With the IFMD the plan will begin to pay benefits for one individual in the family once that person meets the $2,400 IFMD. The balance of the Family Deductible ($1,400) must be met by one or more other members of the family before the plan will pay benefits for those other family members.

[2]Out-of-Pocket Maximum: The plan will pay 100% of eligible charges once the annual out-of-pocket maximum has been met through deductible and coinsurance. A single individual within a family can be responsible for the entire out-of-pocket maximum.

[3] Services provided out-of-network are subject to 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.

CD PPO HDHP, continued

Medical deductibles and coinsurance for individual or family coverage accumulate separately for in-network and out-of-network expenses. If both in-network and out-of-network providers are used, the deductible will have to be met twice - once for in-network and once for out-of-network.

The following example describes how the in-network "Individual Family Member Deductible" works with the Family Deductible when two or more individuals are covered under the plan:

1.Family member #1 incurs $2,500 in eligible in-network medical expenses, of which $2,400 is applied to the individual in-network deductible and $2,400 is also applied to the family deductible of $3,800. In this example, the individual has met his or her in-network deductible and the remaining in-network family deductible is $1,400. The remaining $100 is paid at the appropriate coinsurance rate which is generally 75%.

2.Family member #2 incurs $2,000 in eligible in-network medical expenses: $1,400 is applied toward the remaining family in-network deductible, which satisfies the $3,800 annual family in-network deductible amount. The remaining $600 is paid at the appropriate coinsurance rate.

For more information, refer to the Plan Year 2013 Master Plan Document at www.pebp.state.nv.us.

CD PPO HDHP, continued

Plan Feature	In-Network (participating provider) benefit	Out-of-Network Benefit
Coinsurance (Plan pays)	• 75% after deductible	• 50% after deductible, Usual and Customary* applies.
Primary Care Physician (PCP) *PCP includes internists, general and family practitioners, pediatricians and obstetricians/gynecologists.*	• 75% after deductible	• 50% after deductible, Usual and Customary* applies.
Specialist Office Visits	• 75% after deductible	• 50% after deductible, Usual and Customary* applies.
Outpatient Short-Term Rehabilitative Therapy • Occupational therapy • Physical therapy • Speech therapy	• 75% after deductible	• 50% after deductible, Usual and Customary* applies.
Emergency Care • Emergency Room Visit • Ambulance Services	• 75% after deductible	• 75% after deductible, Usual and Customary* applies.
Urgent Care	• 75% after deductible	• 50% after deductible, Usual and Customary* applies.
Outpatient Laboratory Services • Outpatient laboratory services (except for pre-admission testing, urgent care facility or emergency room) performed at an acute care hospital will not be covered unless an exception is warranted and approved by the Plan Administrator. • If an outpatient laboratory facility or draw station is not available to you within 50 miles of your residence, you may use an acute care hospital to receive your outpatient laboratory services.	• 75% after deductible when testing performed at an independent free-standing laboratory.	• 50% after deductible, Usual and Customary* applies.

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

CD PPO HDHP, continued

Plan Feature	In-Network (participating provider) benefit	Out-of-Network Benefit
Temporomandibular Joint Disorder (TMJ)	• 50% after deductible	• 50% after deductible, Usual and Customary* applies.
Prevention/Wellness For example (not all inclusive): • Physical exam, screening lab and x-rays • Well child visits and age appropriate immunizations • HPV vaccination • Prostate screening • Routine sigmoidoscopy or colonoscopy • Screening mammogram (in the absence of a diagnosis) • Pelvic exam and Pap smear lab test • Osteoporosis screening • Hypertension screening • Skin Cancer Screening • Routine hearing exam	• 100% - No deductible	• Not covered
Vision Exam	75% after deductible Usual and Customary* applies.	75% after deductible Usual and Customary* applies.

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

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

Health Savings Account (HSA)
For Eligible Active Employees

The Health Savings Account (HSA) is a tax-exempt trust or custodial account that is established through HealthSCOPE Benefits to reimburse certain qualified medical expenses you incur. You must meet certain eligibility requirements for an HSA.

Benefits of an HSA

- Employer (PEBP) contributions are excluded from gross income
- Optional employee contributions through pre-tax payroll deductions
- Employee contributions excluded from gross income
- Employee contribution may be started, increased, decreased or stopped at any time
- Distributions are tax-exempt when used to pay qualifying healthcare expenses
- Interest bearing account and investment options
- Unused dollars carry over from year to year
- Employee owned account (will remain with the employee at termination, retirement, or change of health plans)
- HSA funds may be used for current and future healthcare expenses
- **Optional additional $1,000 contribution by employees 55 or older at the end of the tax year**
- May be used to pay for qualifying healthcare expenses for other members of the tax-family, whether or not they are covered on the employee's health plan.

Qualifying for the HSA

- You must be covered under the CD PPO HDHP;
- No secondary coverage permitted (Medicare, Tricare, Tribal, HMO, etc.) unless the secondary coverage is also a high deductible health plan
- You *cannot* be claimed on someone else's tax return (excludes joint returns), or your spouse has a Medical FSA or an HRA that can be used to pay for your medical expenses
- You cannot be covered under COBRA

When you complete the Open Enrollment process (online/paper form), you must certify whether or not you are eligible for the HSA.

HSA 2012 calendar year maximum limit:

- Individual: $3,100
- Family (two or more): $6,250
- Optional additional $1,000 contribution by employees 55 or older at the end of the tax year

Note: The above limits must be reduced by PEBP's HSA contribution amount.

For PEBP contribution amounts see page 17.

CD PPO HDHP Health Reimbursement Arrangement (HRA)

For retirees and certain active employees enrolled in the CD PPO HDHP

The PPO-Health Reimbursement Arrangement (PPO-HRA) is an employer-owned account establish on behalf of eligible participants (for primary participants enrolled in the CD PPO HDHP and who are not eligible for the HSA), see page 15 for eligibility requirements.

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

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

To determine HRA contributions for active employees, turn to page 17. Retirees enrolled in the CD PPO HDHP will receive HRA contributions as shown below:

HRA Contribution for Retirees Enrolled in the CD PPO HDHP			
Base individual contribution	**One-time supplemental contribution for individuals effective July 1, 2012**	**Total Primary Participant contribution**	**Additional one-time contribution for retirees with 20+ years of service on July 1, 2012**
$700	$400	$1,100	$200
Base dependent contribution	**One-time supplemental contribution for covered dependents effective July 1, 2012**	**Total contribution per dependent (maximum 3 dependents)**	
$200 per dependent (spouse/domestic partner or child) maximum 3 dependents	$100 per dependent (spouse/domestic partner or child) maximum 3 dependents	$300 per dependent (spouse/domestic partner or child)	

HSA and HRA Contribution for Active Employees Enrolled in the CD PPO HDHP			
Base individual contribution	**One-time supplemental contribution for individuals effective July 1, 2012**	**Total primary participant contribution**	**Additional one-time contribution for primary participants aged 45 or older on June 30, 2012**
$700	$400	$1,100	$200
Base dependent contribution	**One-time supplemental contribution for covered dependents effective July 1, 2012**	**Total contribution per dependent (maximum 3 dependents)**	
$200 per dependent (spouse/domestic partner or child) - maximum 3 dependents	$100 per dependent (spouse/domestic partner or child) - maximum 3 dependents	$300 per dependent (spouse/domestic partner or child)	
HSA contribution maximum for calendar year 2012*		**Individual**	**Family (two or more family members)**
The maximum shown is for eligible HSA individuals with high deductible health coverage through December 31, 2012[1]		$3,100	$6,250[2]

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

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

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

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

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

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

Flexible Spending Account

Flexible Spending Accounts (FSA) are regulated by Section 125 of the IRS. FSAs are based on a calendar year (whereas your medical plan is based on a fiscal year from July 1, 2012 through June 30, 2013). To participate in flexible spending, you must enroll each year during open enrollment. Unless you become eligible to enroll mid-year due to a qualifying life status event. If you are thinking about enrolling in flexible spending, you will want to be sure you understand the IRS provisions for medical and dependent care flexible spending before making your election. The Flexible Spending Account Summary Plan Description is available under Publications on the PEBP website at www.pebp.state.nv.us.

You will pay a small fee of $3.50 per month to participate in either one or both flexible spending accounts. There is an additional annual fee of $18 for those selecting the convenience of a FSA debit card.

To enroll in flexible spending, you must be an active employee in one of the State of Nevada payroll centers and, enrolled in health benefits with active coverage through PEBP.

Note: Excludes the Nevada System of Higher Education employees who have a separate plan.

Medical FSA Maximum for Plan Year 2013

The Medical FSA Plan Year Maximum is $2,500 ($208.33 maximum *monthly* contribution or $96.15 per pay period for employees paid biweekly). Note: This is a per employee deduction limitation, not a household limitation. If an employee and his/her spouse are also eligible for the Medical FSA, each individual can establish their own Medical FSA with a $2,500 Plan Year maximum.

Dependent Care FSA 2012 - 2013 Calendar Year Maximum

The Dependent Care FSA calendar year limit is established by IRS. You and your spouse may *together* elect a maximum of $5,000 for both the 2012 and 2013 Tax Years (July 1, 2012 through June 30, 2013). If you are married and do not file a joint tax return, you can set aside up to $2,500 in a Dependent Care FSA.

If you are an active employee enrolled in the Consumer Driven PPO High Deductible Health Plan with a Health Savings Account, Federal rules do NOT allow you to enroll in a Medical FSA. However, you may enroll in the *Limited Scope* FSA which allows you to set aside pre-tax money for vision and dental expenses.

To participate in Flexible Spending, fax your enrollment election before May 31, 2012 to ASI Flex at 877-879-9038. Flexible Spending Account Enrollment Forms are available under the FORMS link at www.pebp.state.nv.us

For more information, contact ASI Flex at 800-659-3035 or visit www.asiflex.com.

	HSA CD PPO HDHP Participants	PPO-HRA CD PPO HDHP Participants	Exchange-HRA Extend Health Medicare Part A Retirees	Medical FSA*	Limited Purpose FSA
Who is eligible?	Certain employees in the CD PPO HDHP. See restrictions on page	Participants not eligible for an HSA	Medicare Part A retirees enrolled in a medical plan through Extend Health	State employees (HMO) **If you have an HSA, you may only enroll in a Limited Purpose FSA*	State employees only enrolled in the CD PPO HDHP with an HSA
Who may contribute?	Employer and employee	Employer only	Employer contributions only based upon retiree years of service.	Employee only	Employee only
What are the funding options?	Funded by PEBP and voluntary employee contributions	Employer funded, paid as incurred (no employee contributions permitted)	Employer funded through the retiree years of service	Funded through employee contributions	Funded through employee contributions
Will the balance carry over?	Yes	Yes, carry over balance determined by the PEBP Board	Yes, carry over balance determined by the PEBP Board	No, although grace period applies	No, although grace period applies
Is this fund account portable?	Yes	No. If the retiree/ employee is no longer covered by the CD PPO HDHP the funds are returned to PEBP	No. If the retiree is no longer covered by the Exchange the funds are returned to PEBP	No	No
Are there interest or investment earnings?	Yes	No	No	No	No
Are contributions taxable income to the employee?	Not if used for qualifying healthcare expenses	No	No	Not if used for qualifying healthcare expenses	Not if used for qualifying dental and vision care expenses

Dental Plan

All PPO and HMO Eligible Participants (optional for Exchange Retirees)

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

- **Family Deductible: Could be met by any combination of eligible dental expenses of three or more members of the same family coverage tier**. No one single family member would be required to contribute more than the equivalent of the individual deductible toward the family deductible. Both in-network and out-of-network deductibles are combined to meet your deductible each plan year.

- **Under no circumstances will the combination of PPO in-network and PPO out-of-network services for Basic and Major benefit payments exceed the plan year maximum benefit $1,000**

Basic Life Insurance *All Eligible Primary Retirees and Employees*	
Employee Basic Life Insurance	Employees enrolled in a PEBP-sponsored medical plan receive $10,000 Basic Life Insurance coverage. Refer to the Life Insurance Certificate at http://*www*.standard.com/mybenefits/nevada for more information about this benefit or call The Standard at 888-288-1270.
Long-Term Disability 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
Retiree Basic Life Insurance	Retirees enrolled in the CD PPO HDHP, HMO plan or a qualifying medical plan through Extend Health receive $5,000 Basic Life insurance coverage. Refer to the Life Insurance Certificate at http://*www*.standard.com/mybenefits/nevada for more information about this benefit.
Medex Travel Assist for Active Employees and Retirees enrolled in the CD PPO HDHP, HMO Plan or a qualifying medical plan through Extend Health.	Medex Travel Assist is designed to respond to most medical care situations and many other emergencies you and your family experience when you travel 100 miles or more from your home. Medex provides a wide-ranging program 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 your home. Simply print out and carry the Medex Travel Assist Card available at http://www.standard.com/mybenefits/nevada/life_add.html#ben

Voluntary Life Insurance

All Eligible Primary Retirees and Employees

Voluntary Life Insurance

The State of Nevada provides a basic amount of Life insurance to help protect your loved ones in the event of your death. Since everyone's needs are different, you also have the opportunity to apply for Voluntary Life insurance from Standard Insurance Company. Plus, your premiums can generally be deducted from your paycheck or from your PERS check (if applicable) for retirees. In certain circumstances, you may be required to provide satisfactory proof of evidence of insurability.

Active Employee	Voluntary Life Insurance may be elected in a multiple of $5,000 to a maximum of $50,000 with a minimum of $5,000 of coverage. Voluntary Life Insurance includes AD & D insurance from The Standard. With Voluntary Life and AD & D, you or your beneficiaries may be eligible to receive an additional benefit in the event of death or dismemberment as a result of an accident. If you are already insured for Voluntary Life, you may be eligible to increase your coverage during open enrollment without submitting evidence of insurability (provided the amount of your Voluntary Life coverage will not exceed $100,000). Contact Standard Insurance at 888-288-1270.
Retiree (Reinstated retirees are not eligible for Basic or Voluntary Life Insurance)	Voluntary Life Insurance may be elected in units of $5,000, to a maximum of $50,000 with a minimum of $5,000 of coverage. Requests for increases may require you to provide evidence of insurability. Contact Standard Insurance at 888-288-1270.

For information on premium rates and eligibility, please contact The Standard at (888) 288-1270 or visit www.standard.com/mybenefits/nevada/index.html.

IMPORTANT!

Participants who decline PEBP-sponsored coverage (CD PPO HDHP, HMO, or medical coverage through Extend Health) will not qualify for Basic or Voluntary Life Insurance.

Exchange Health Reimbursement Arrangement (Exchange-HRA)

For Medicare Retirees Enrolled in a Medical Plan Through Extend Health

Exchange Health Reimbursement Arrangements, or Exchange-HRAs, are PEBP-owned accounts established on behalf of PEBP retirees enrolled in a medical plan offered through Extend Health.

Retirees can use the Exchange-HRA for reimbursement of qualified healthcare expenses, including premiums for Medicare coverage, on a tax-free basis. Exchange-HRAs may also be used for reimbursement of a spouse's qualified healthcare expenses.

Retirees receive a contribution to their Exchange-HRA based upon their years of service. The monthly tax-exempt contribution amount is $10 per month per year of service beginning with five years ($50) to a maximum of twenty years of service ($200). Individuals who retired before January 1, 1994, will receive a flat $150 per month to the Exchange-HRA. Dependents do not receive their own Exchange HRA and no additional funds are contributed for dependents. Individuals hired after January 1, 2010, who retire with less than 15 years of service are not eligible for a contribution.

How it works:

Getting Reimbursed from your Exchange-HRA		
1. You pay premiums and expenses You pay the full premiums directly to your insurance provider (ask Extend Health about the auto-reimbursement option for premiums). You also pay your provider any required out-of-pocket expenses.	**2. You submit out-of-pocket expenses** You submit your claim to Extend Health for your premiums and out-of-pocket healthcare expenses.	**3. Extend Health reimburses you** Extend Health administers your account and will reimburse you from your Exchange-HRA if funds are available.

Exchange-HRA Plan Administrator

Extend Health is the Exchange-HRA plan administrator responsible for processing expense reimbursements for retirees.

Retiree Medicare Enrollment and Coverage Options

If you (the primary insured participant) are a **retiree with Medicare Parts A and B** and you also cover a spouse/domestic partner or child(ren) **without** Medicare Parts A and B, or if you are a retiree without Medicare Part A and B and you cover a spouse or domestic partner with Medicare Part A, you will have the option to combine or split coverage (see Options 2 and 3).

To determine your plan options, go to column A and choose who you wish to cover on July 1, 2012. Then go to column B and select your coverage option.

Column A Choose Who You Want to Cover	Column B Choose your Coverage Option
If you would like to cover: • *Only yourself and you are eligible for Medicare Part A and B,* refer to **Coverage option #1.**	**Option #1** **Extend Health** You must select a medical plan through Extend Health before June 30, 2012. If you do not select a medical plan through Extend Health by June 30, 2012, you will lose all PEBP coverage.
If you would like to cover: • Y*ourself and your spouse or domestic partner and you both are eligible for free Medicare Part A*, refer to **Coverage Option #1.**	
If you would like to cover: • *Yourself and one or more dependents and at least one person you are covering is not eligible for free Medicare Part A,* refer to **Coverage options #2 or #3** **After selecting your option from this page, turn to page 25 to find out what to do next.** **Declining Retiree Coverage** • Retirees have the option to decline coverage. By declining coverage, a retiree loses medical, dental, prescription drug, and Basic Life and Voluntary Life insurance coverage.	**Option #2** **PEBP's PPO/HMO Coverage** You *and* your spouse or domestic partner *and/or* child(ren) may remain on the CD PPO HDHP or an HMO plan. To continue PEBP coverage, you must complete the Open Enrollment Form (or go online at www.pebp.state.nv.us) before May 31, 2012. **Option #3** **Split Coverage -** Enroll in Separate Plans **(Extend Health &PEBP CD PPO HDHP/HMO)** Medicare Part A individual(s) may enroll in an individual medical plan through Extend Health. Individuals who are ineligible for Medicare Part A may select the CD PPO HDHP or an HMO plan by calling the PEBP office to request the Benefit Enrollment and Change Form.

Retiree Medicare Enrollment and Coverage Options

Select Your Coverage Option below	Your Next Steps - Actions You Must Take
Option #1 Enroll in coverage through Extend Health	**Option #1 - Extend Health** 1. Contact Extend Health to enroll for coverage before May 31, 2012 at 1-888-598-7545. 2. Complete the PEBP Open Enrollment Form (or complete your enrollment online at www.pebp.state.nv.us) by May 31, 2012. Select Extend Health with or without PEBP Dental.
Option #2 Enroll in the CD PPO HDHP or HMO Coverage	**Option #2 - PEBP's PPO/HMO Coverage** 1. Review the Open Enrollment Guide to learn about the plan changes and premium rates. 2. After learning about the plan options and costs of each plan, if you wish to select Option #2, complete item 3 in this list. 3. Complete the PEBP Open Enrollment Form (or complete your enrollment online at www.pebp.state.nv.us) before May 31, 2012.
Option #3 Enroll in Separate Plans Extend Health and either the CD PPO HDHP or an HMO plan	**Option #3 - Split Coverage** 1. Contact Extend Health at 1-888-598-7545 to learn about plan options and premium rates and review the Open Enrollment Guide to learn about the PPO and HMO plan changes/rates. 2. Complete the following: 3. To split coverage the Medicare Part A individual(s) (either the primary insured or the spouse/domestic partner) will contact Extend Health at 1-888-598-7545 to enroll in medical coverage. 4. You (the primary insured) must complete the PEBP Open Enrollment Form (or complete your enrollment online at www.pebp.state.nv.us) and select Extend Health *with or without* dental coverage. Return the form to PEBP by May 31, 2012. 5. If the non-Medicare individual is the spouse or domestic partner, contact PEBP to request the appropriate form to establish their PEBP account.

State Active Rates

Effective July 1, 2012 - June 30, 2013

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

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

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

State Retiree Rates

Effective July 1, 2012 - June 30, 2013

State Retiree	Statewide PPO	Statewide HMO
	Consumer Driven PPO High Deductible Health Plan	**Hometown Health Plan and Health Plan of Nevada**
	Participant Premium	Participant Premium
Retiree only	227.28	307.03
Retiree + Spouse	557.49	734.45
Retiree + Child(ren)	329.08	492.89
Retiree + Family	662.41	920.32
Surviving/Unsubsidized Dependent	631.32	602.01
Surviving/Unsubsidized Spouse + Child(ren)	813.12	863.79
Note: State retirees in the HMO in the "Retiree Only" coverage tier will not pay more than $602.01 per month after factoring in the appropriate Years of Service Subsidy. **To determine your final premium, turn to page 29.**		

State Retiree with *Domestic Partner* Rates	Statewide PPO	Statewide HMO
	Consumer Driven PPO High Deductible Health Plan	**Hometown Health Plan and Health Plan of Nevada**
	Participant Premium	Participant Premium
Retiree + DP	557.49	734.45
Retiree + DP's Child(ren)	329.08	492.89
Retiree + Children of both	329.08	492.89
Retiree + DP + Retiree's Child(ren)	662.41	920.32
Retiree + DP + DP's Child(ren)	662.41	920.32
Retiree + DP + Children of both	662.41	920.32
To determine your final premium, turn to page 29.		

Non-State Active and Retiree Rates

Effective July 1, 2012 - June 30, 2013

Non-State Active Employee Rates	Statewide PPO	Statewide HMO
	Consumer Driven PPO High Deductible Health Plan	**Hometown Health Plan and Health Plan of Nevada**
	Participant Premium	Participant Premium
Employee Only	846.62	623.98
Employee + Spouse	1,651.57	1,247.96
Employee + Child(ren)	1,229.01	930.55
Employee + Family	2,033.96	1,554.53
To determine your final premium, turn to page 29.		

Non-State Retiree Rates	Statewide PPO	Statewide HMO
	Consumer Driven PPO High Deductible Health Plan	**Hometown Health Plan and Health Plan of Nevada**
	Participant Premium	Participant Premium
Retiree only	836.15	602.01
Retiree + Spouse/DP	1,630.63	1,204.02
Retiree + Child(ren)	1,213.83	864.69
Retiree + Family	2,008.31	1,466.70
Surviving/Unsubsidized Dependent	836.15	602.01
Surviving/Unsubsidized Spouse/DP + Child(ren)	1,213.83	864.69
To determine your final premium, turn to page 29.		

Years of Service Subsidy

State Retiree Subsidy
For Retirees Enrolled in the PPO/HMO Plan

YOS	Subsidy
5	+354.48
6	+319.03
7	+283.58
8	+248.14
9	+212.69
10	+177.24
11	+141.79
12	+106.34
13	+70.90
14	+35.45
15 (Base)	-
16	-35.45
17	-70.90
18	-106.34
19	-141.79
20	-177.24

Non-State Retiree Subsidy
For Retirees Enrolled in the PPO/HMO Plan

YOS	Subsidy
5	-118.16
6	-153.61
7	-189.06
8	-224.50
9	-259.95
10	-295.40
11	-330.85
12	-366.30
13	-401.74
14	-437.19
15 (Base)	-472.64
16	-508.09
17	-543.54
18	-578.98
19	-614.43
20	-649.88

- Participants who retired before January 1, 1994, subtract the 15 year (base) subsidy from the participant premium in the selected plan and tier.
- For participants who retired on or after January 1, 1994, add or subtract the appropriate subsidy above to or from the participant premium in the selected plan and tier. In no case will your premium be less than $0.
- 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. Employees initially hired on or after January 1, 2012 will not receive the years of service subsidy.
- If you are a retiree (or survivor) enrolled in the PEBP CD PPO HDHP or an HMO plan and you pay for Medicare Part B, **deduct $99.90** from your premium cost. Dependents do not qualify for the Part B credit.

Exchange-HRA Contribution and Optional Dental Coverage

Retirees Enrolled in Extend Health

Exchange-HRA Contribution for Medicare Retirees Enrolled in Extend Health	
Years of Service	**Contribution**
5	+50.00
6	+60.00
7	+70.00
8	+80.00
9	+90.00
10	+100.00
11	+110.00
12	+120.00
13	+130.00
14	+140.00
15 (Base)	+150.00
16	+160.00
17	+170.00
18	+180.00
19	+190.00
20	+200.00

- Extend Health participants who retired before January 1, 1994, receive the base 15 year Exchange-HRA contribution.
- Extend Health participants who retired on or after January 1, 1994, receive the Exchange-HRA contribution that corresponds to the number of years the retiree worked for a Nevada public entity.
- 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 an Exchange-HRA contribution.
- Retirees initially hired on or after January 1, 2012 will not receive an Exchange HRA contribution.

Voluntary Dental Coverage Option

Optional dental coverage for retirees enrolled in an Extend Health Medical Plan

Voluntary Dental Coverage	State Retiree Rate	Non-State Retiree Rate
Retiree only	38.87	30.63
Retiree + Spouse/DP	77.73	61.27
Surviving/Unsubsidized Spouse/DP	38.87	30.63

Retirees and their spouses or domestic partners enrolled in a health care plan offered through Extend Health have the option of purchasing PEBP's dental coverage. To elect PEBP's dental coverage you will need to select Extend Health's medical coverage and PEBP's dental coverage on the Open Enrollment Form. Retirees enrolling in the PEBP PPO Dental Plan effective July 1, 2012 will be responsible to cancel any other dental coverage through Extend Health by June 30, 2012.

Unsubsidized Dependent Rates

For dependents of Medicare Exchange retirees

Effective July 1, 2012 - June 30, 2013

STATE - Unsubsidized Dependent	CD PPO HDHP Plan	HMO
Spouse/Domestic Partner or Child	631.32	602.01
Child(ren)	813.12	863.79
Spouse/DP + Child(ren)	813.12	863.79

NON-STATE Unsubsidized Dependent	CD PPO HDHP Plan	HMO
Child or Spouse/Domestic Partner	836.15	602.01
Children	1,213.83	864.69
Spouse/DP + Child(ren)	1,213.83	864.69

COBRA Rates

State and Non-State Employee or Retiree

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

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

PEBP Important Notices

HIPAA Privacy Practices

The 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.

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

- Consumer Driven PPO High Deductible 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.

CD PPO HDHP Vendor Contact List

Medical, Dental and Pharmacy Contacts

CD PPO HDHP Medical and PPO Dental Claims Administrator • Claim status inquiries • 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
National Provider Network • For participants who reside in Nevada who access healthcare services outside of Nevada	**First Health Network** P.O. Box 91603 Lubbock, TX 79490-1603 Customer Service: 800-226-5116 www.myfirsthealth.com
National Provider Network • For participants who reside outside of Nevada who access healthcare services outside of Nevada	**GWH-CIGNA** 1000 Great-West Drive Kennett, MO 63857-3749 888-763-8232 www.myCignaforhealth.com
Dental PPO Network • Statewide dental PPO providers • Dental provider directory	**Diversified Dental Services** Northern Nevada: (866) 270-8326 Southern Nevada: (800) 249-3538
CD PPO HDHP Pharmacy Plan Administrator • Prescription drug information • Retail network pharmacies • Prior authorization • Non-network retail claims payment • Mail order service and mail order forms	**Retail Pharmacy Services** **Catalyst Rx** (800) 799-1012 (702)933-4521 (Las Vegas) **Walgreens Mail Order** (866) 845-3590 www.catalystrx.com User Name: nevada Password: benefit
APS Healthcare • Pre-certification • Case Management	**APS Healthcare** Pre-certification and Customer Service (888) 323-1461 www.apshealthcare.com
U.S. Preventive Medicine • Live Well, Be Well Prevention Plan • Diabetes Care Management • Obesity Care Management Program	**U.S. Preventive Medicine (USPM)** **The Prevention Plan** (877) 800-8144 www.ThePreventionPlan.com

HMO and Voluntary Products Vendor Contact List

Northern HMO Plan • Provider network • Provider directories • Appeals • Benefit Information • Additions/deletions of providers	**Hometown Health Plan** Customer Service: (775) 982-3232 or (800) 336-0123 http://stateofnv.hometownhealth.com or www.pebp.state.nv.us
Southern HMO Plan • 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 or www.pebp.state.nv.us
Medicare Exchange Medicare supplemental plans and HRA administrator for retirees with Medicare Parts A and B	**Extend Health** Customer Service: (888) 598-7545 www.ExtendHealth.com/PEBP
Life and AD&D 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 or www.pebp.state.nv.us
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	**Colonial Life UNUM** Customer Service: (877) 433-5334 www.pebp.state.nv.us
Flexible Spending • Medical • Dependent Care **Enrollment forms:** www.asiflex.com **or** www.pebp.state.nv.us	**ASI Flex** Customer Service: (800) 659-3035 Fax: (866) 381-9682 P.O. Box 6044, Columbia, MO 65205 www.asiflex.com
Home and Auto Insurance	**Liberty Mutual** Customer Service: (800) 637-7026 gary.bishop@libertymutual.com **Travelers'** Customer Service: (888) 695-4640 www.travelers.com/nevada

Plan Year 2013 Open Enrollment Meeting Schedule

May 8	**North Las Vegas**	**Cashman Center** Rooms 101, 102, 103 and 104 850 Las Vegas Blvd.	9:00 a.m. - 11:00 a.m. 2:00 p.m. - 4:00 p.m. 5:30 p.m. - 7:30 p.m.
May 9	**North Las Vegas**	**Cashman Center** Rooms 101, 102, 103 and 104 850 Las Vegas Blvd.	9:00 a.m. - 11:00 a.m. 2:00 p.m. - 4:00 p.m. 5:30 p.m. - 7:30 p.m.
May 14	**Carson City**	**National Guard Auditorium*** 2460 Fairview Drive	9:00 a.m. - 11:00 a.m. 2:00 p.m. - 4:00 p.m. 5:30 p.m. - 7:30 p.m.
May 15	**Carson City**	**National Guard Auditorium*** 2460 Fairview Drive	9:00 a.m. - 11:00 a.m. 2:00 p.m. - 4:00 p.m. 5:30 p.m. - 7:30 p.m.
May 16	**Reno**	**Grand Sierra Resort** **Silver State Rooms S2, S3** 2500 East Second Street (located inside the South entrance on the Arcade floor - across from the Golf Range)	9:00 a.m. - 11:00 a.m. 2:00 p.m. - 4:00 p.m. 5:30 p.m. - 7:30 p.m.
May 17	**Reno**	**Grand Sierra Resort** **Silver State Rooms S2, S3** 2500 East Second Street (located inside the South entrance on the Arcade floor - across from the Golf Range)	9:00 a.m. - 11:00 a.m. 2:00 p.m. - 4:00 p.m. 5:30 p.m. - 7:30 p.m.
May 22	**Winnemucca** *Video-conference*	**NDOT** **Conference Room** 725 W. 4th Street	9:00 a.m. - 11:00 a.m. 1:00 p.m. - 3:00 p.m.
May 22	**Tonopah** *Video-conference*	**NDOT** **Conference Room** 805 S. Main	9:00 a.m. - 11:00 a.m. 1:00 p.m. - 3:00 p.m.
May 23	**Ely** *Video-conference*	**Great Basin College** **Room 112** 2115 Bobcat Drive	9:00 a.m. - 11:00 a.m. 1:00 p.m. - 3:00 p.m.
May 23	**Elko** *Video-conference*	**Great Basin College** **Greenhaw Tech. Arts Building, Room 130** 1500 College Parkway	9:00 a.m. - 11:00 a.m. 1:00 p.m. - 3:00 p.m.

***Photo ID required at entrance**

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NRS 287.0245 (1) (d) II

Introduction to Employee Benefits,

Plan Year 2013

Introduction to Employee Benefits

Plan Year 2013

STATE OF NEVADA

Public Employees' Benefits Program

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Plan Year 2013

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

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Fax: (775) 684-7028
www.pebp.state.nv.us
memberservices@peb.state.nv.us

Plan Year 2013
July 1, 2012 - June 30, 2013

State of Nevada

Public Employees' Benefits Program

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

Welcome

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

How to Enroll

As a new benefits eligible employee, your prompt enrollment will ensure you receive your medical ID cards on or before the date your coverage becomes effective. New employees are encouraged to enroll or decline coverage within seven days after receiving this benefit packet.

If you are adding dependents to your coverage, please submit the applicable supporting document(s) for each dependent you wish to enroll. For more information regarding dependent eligibility and supporting documents turn to page 4.

Complete your enrollment by doing one of the following:

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

Employee Benefit Enrollment and Change Form (E-BECF)
If you do not have access to the Internet, please contact PEBP to request the Employee Benefit Enrollment and Change Form at 775-684-7000 or 800-326-5496. Return your completed enrollment form and any supporting eligibility documents (if adding dependents) to the PEBP office within 7 days or as soon as possible after receiving this packet to:

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

Forms must be original. No copies or facsimiles accepted.

Included with this packet:

☑ **Standard Insurance Beneficiary Designation Form**
Mail the Standard Insurance Beneficiary Designation Form to:

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

About Your Enrollment

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

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

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

Start of Coverage

New Hire

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

Reinstated Employee

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

Rehire Employee

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

Dependent Eligibility

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

Changes to Eligibility

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

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

Child to age 26

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

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

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

Disabled child

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

Spouse/domestic partner

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

Summary of Supporting Eligibility Documents

Dependent Type	Social Security Number	Marriage Certificate	Birth Certificate	Hospital Birth Confirmation	Adoption Decree	Nevada Certification of Domestic Partnership	Legal Permanent guardianship signed by a judge	Physician's Disability Certification
Newborn child	√		√	√				
Child - birth to age 26	√		√					
Adopted Child	√		√		√			
Permanent Legal Guardianship of a child	√		√				√	
Stepchild	√	√	√					
Domestic Partner's child	√		√			√		
Domestic Partner's adopted child	√		√		√	√		
Disabled child	√		√					√
Disabled stepchild	√	√	√					√
Domestic Partner's disabled child	√		√			√		√
Spouse*	√	√						
Domestic Partner*	√					√		

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

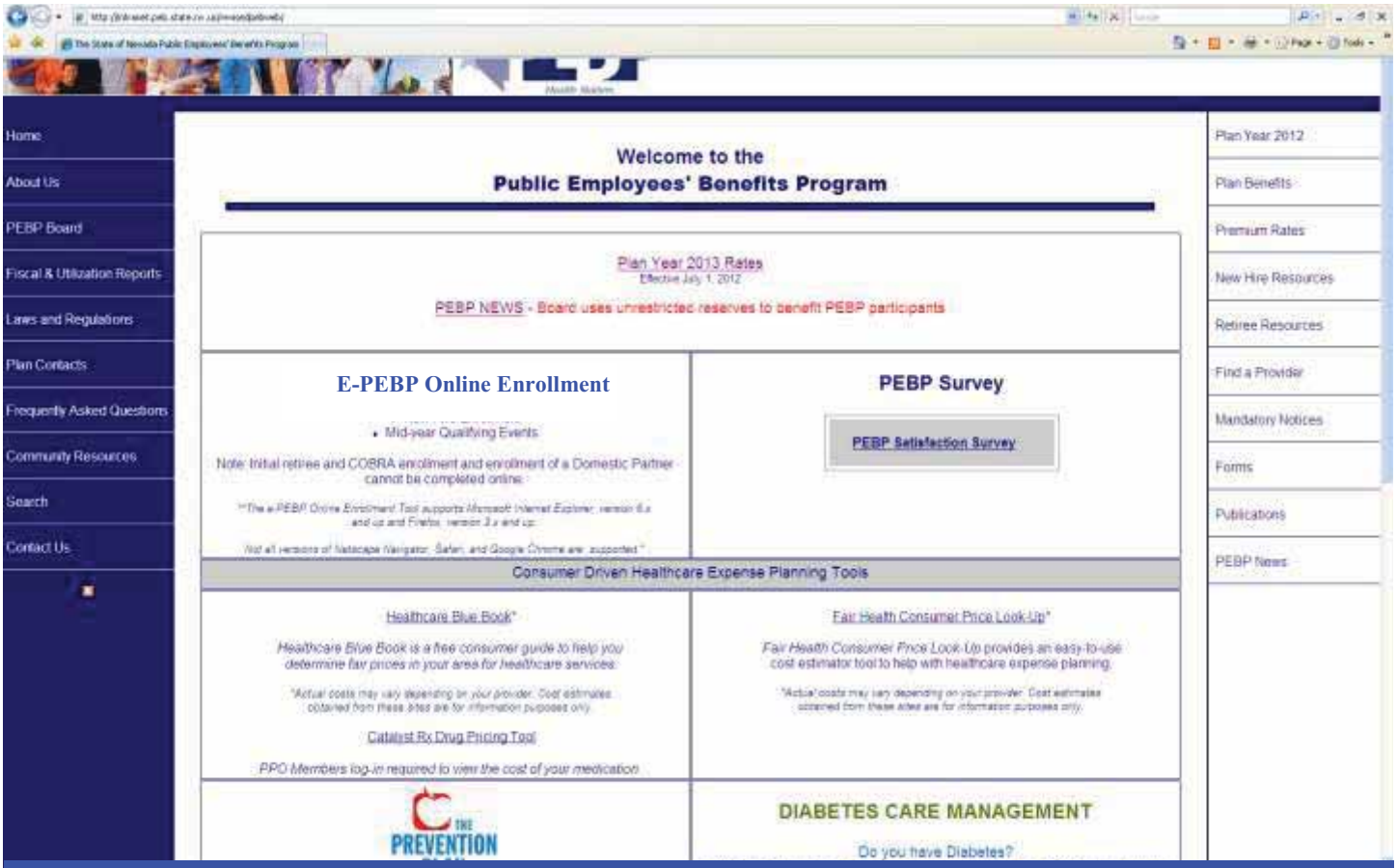
The list above is not exhaustive, PEBP reserves the right to request additional documentation as required to establish dependent eligibility.

Summary of Employee Benefit Options

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

New Hire Resources

www.pebp.state.nv.us



What You Will Find at www.pebp.state.nv.us	
Board Meeting Calendar, Agenda, Transcripts, and Audio Recordings	Wellness Programs for the CD PPO HDHP and the HMO plans
Laws and Regulations	New Hire Resources (online enrollment, HRA, Basic Life Insurance, Voluntary Benefits, and contact information for all PEBP vendors.)
Plan Contacts	CD PPO HDHP Master Plan Document, Evidence of Coverage Certificates for the HMO plans, Benefit Summaries, and Formularies
Frequently Asked Questions	Provider Search
Community Resources	Forms
Plan Benefits	Publications
Premium Rates	PEBP News

Medical Plan Comparison

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

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

Pharmacy Plan Comparison

Benefit Category	CD PPO HDHP Amount You Pay In-Network	Health Plan of Nevada Amount You Pay In-Network	Hometown Health Plan Amount You Pay In-Network
Plan Deductible	$1,900 individual $3,800 family • $2,400 Individual -when two or more family members covered	No deductible	No deductible
Annual Out-Of-Pocket (OOP) Maximum*	$3,900 person $7,800 family (per plan year)	Contact HPN for pharmacy OOP* maximum	Contact HHP for pharmacy OOP* maximum
Retail Pharmacy - 30 day supply			
Preferred Generic (Tier 1)	25% after deductible	$7 copayment	$7 copayment
Preferred Brand (Tier 2)	25% after deductible	$35 copayment	$40 copayment
Non-Formulary (Tier 3)	100% of contracted price - does not apply to deductible or OOP*	$55 copayment	Greater of $75 copayment per script or 40%
Specialty Drugs	25% after deductible - available in 30 day supply only through Walgreen pharmacies	Applicable retail pharmacy copayment will apply	30% coinsurance
Mail Order - 90 day supply			
Preferred Generic (Tier 1)	25% after deductible	$14 copayment	$14 copayment
Preferred Brand (Tier 2)	25% after deductible	$70 copayment	$80 copayment
Non-formulary (Tier 3)	100% of contracted price - does not apply to deductible or OOP*	Not available through mail order	Greater of $150 copayment per script or 40%
Specialty Drugs	25% after deductible, available in 30 day supply only through Walgreens mail order	Applicable retail pharmacy copayment applies	Not available through mail order

***Annual Out-of-Pocket Maximum (OOP):** The maximum amount of coinsurance each covered person or family is responsible for paying during a plan year before the coinsurance required by the plan cease to apply. When the OOP maximum is reached, the plan will pay 100% of eligible covered expenses for the remainder of the plan year.

CD PPO HDHP

Plan Feature	In-Network (participating provider benefit)	Out-of-Network Benefit
Coinsurance (plan pays)	75% after deductible	50% after deductible, Usual and Customary* applies.
Primary Care Physician (PCP) *PCP includes internists, general and family practitioners, pediatricians and obstetricians/gynecologists.*	75% after deductible	50% after deductible, Usual and Customary* applies.
Specialist Office Visits	75% after deductible	50% after deductible, Usual and Customary* applies.
Outpatient Short-Term Rehabilitative Therapy • Occupational therapy • Physical therapy • Speech therapy	75% after deductible	50% after deductible, Usual and Customary* applies.
Emergency Care • Emergency Room Visit • Ambulance Services	75% after deductible	75% after deductible, Usual and Customary* applies.
Urgent Care	75% after deductible	50% after deductible, Usual and Customary* applies.
Outpatient Laboratory Services • Outpatient laboratory services (except for pre-admission testing, urgent care facility or emergency room) performed at an acute care hospital will not be covered unless an exception is warranted and approved by the Plan Administrator. • If an outpatient laboratory facility or draw station is not available to you within 50 miles of your residence, you may use an acute care hospital to receive your outpatient laboratory services.	75% after deductible when testing performed at an independent free-standing laboratory.	50% after deductible, Usual and Customary* applies.

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

CD PPO HDHP		
Plan Feature	**In-Network (participating provider benefit)**	**Out-of-Network Benefit**
Temporomandibular Joint Disorder (TMJ)	50% after deductible	50% after deductible, Usual and Customary applies.
Prevention/Wellness Benefit Examples of Preventive Wellness Screenings: ◆ Physical exam, screening lab and x-rays ◆ Well child visits and services ◆ HPV Vaccination ◆ Prostrate screening ◆ Routine sigmoidoscopy or colonoscopy ◆ Adult immunizations ◆ Screening mammograms (in the absence of a diagnosis) ◆ Pelvic exam and Pap smear lab test ◆ Osteoporosis screening ◆ Hypertension screening ◆ Skin Cancer screening ◆ Routine hearing exam ◆ Medically supervised weight loss ◆ Stress management For an expanded list of covered preventive/wellness services, please refer to the Plan Year 2013 Master Plan Document available at www.pebp.state.nv.us.	100% - No deductible	Not covered
Vision Exam	75% after deductible Usual and Customary applies.	75% after deductible Usual and Customary applies.

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

CD PPO HDHP Pharmacy Benefit

Benefit Category	Retail 30 Day Supply Amount You Pay In-Network	Retail 90 Day Supply Amount You Pay In-Network	Mail Order 90 Day Supply Amount You Pay In-Network
Plan Deductible	$1,900 individual $3,800 family • $2,400 Individual (two or more family members)	$1,900 individual $3,800 family • $2,400 Individual (two or more family members)	$1,900 individual $3,800 family • $2,400 Individual (two or more family members)
Out-Of-Pocket (OOP) Maximum*	$3,900 person $7,800 family (per plan year)	$3,900 person $7,800 family (per plan year)	$3,900 person $7,800 family (per plan year)
	Retail 30 Day Supply	**Retail 90 Day Supply**	**Mail Order 90 Day Supply**
Preferred Generic (Tier 1)	25% after deductible	25% after deductible	25% after deductible
Preferred Brand (Tier 2)	25% after deductible	25% after deductible	25% after deductible
Non-Formulary (Tier 3)	100% of contracted price - does not apply to deductible or OOP*	100% of contracted price - does not apply to deductible or OOP*	100% of contracted price does not apply to deductible or OOP*
Specialty Medications Limited to 30 day supply—available through Walgreens Specialty Pharmacy 866-823-2712	25% after deductible - available in 30 day supply only through Walgreen pharmacies	90 day supply not available through retail pharmacies	90 day supply not available through mail order

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

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

Program Benefits:

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

Covered Supplies:	• **Annual** Blood Glucose Monitor • Blood Glucose Test Strips • Lancets	• Spring-Powered device for Lancets • Syringes • Alcohol Pads • B-D Pens • 3cc Novo Pens	$50 Copay applies to each 90 day supply item. If the actual cost is less, you pay the actual cost. No cost for the blood glucose monitor.

***Out-of-Pocket Maximum (OOP):** The maximum amount of coinsurance each covered person or family is responsible for paying during a plan year before the coinsurance required by the plan cease to apply. When the OOP maximum is reached, the plan will pay 100% of eligible covered expenses for the remainder of the plan year.

CD PPO HDHP - Diabetes Care Management Program

Opt-In Program - Accompanied with Benefit Enhancements

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

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

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

Diabetes Pharmacy Benefit Enhancement

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

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

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

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

CD PPO HDHP - Obesity and Overweight Care Management Program

Opt-In Program - Accompanied with Benefit Enhancements

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

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

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

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

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

CD PPO HDHP - Live Well, Be Well Prevention Plan

The Live Well, Be Well Prevention Plan is offered to CD PPO HDHP participants and their covered spouses or domestic partners. For Plan Year 2013, new hires are eligible if their CD PPO HDHP coverage effective date is on or before August 1, 2012. This program provides an online portal that features a broad range of educational material, such as health and wellness webinars, a comprehensive medical library with reliable resources where one can learn about nutrition, healthy living, medical tests and procedures, health and wellness activities, and various disease states. Participants also have access to a confidential health journal for tracking physician office visits, lab results, medications, and preventive screenings. Participants who complete the Health Assessment Questionnaire (HAQ) and annual biometric screening receive a Prevention Plan report that identifies their top five health risks and action plans to help lower those risks.

To learn more about the Live Well, Be Well Prevention Plan, visit www.pebp.state.nv.us or call U.S. Preventive Medicine at 877-800-8144.

Consumer Driven PPO High Deductible Health Plan

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

Each year, before the plan begins to pay benefits, you are responsible for paying all of your eligible medical and prescription drug expenses up to the plan year deductible. Eligible medical and prescription drug expenses are applied to the deductibles in the order in which claims are received by the plan. Only eligible medical, prescription drug and vision care expenses can be used to satisfy the plan deductible. Deductibles accumulate on a plan year basis and reset to zero at the start of each new plan year.

Plan Year Deductible

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

Plan Year Out-of-Pocket Maximum

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

Statewide PPO Network

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

Consumer Driven PPO High Deductible Health Plan

First Health

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

Pre-certification Review

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

Case Management

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

Diabetes Care Management Program

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

CD PPO HDHP Pharmacy Plan

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

Consumer Driven PPO High Deductible Health Plan

Prior Authorization

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

Retail Drugs

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

Mail Order Prescription Drug Service

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

Retail 90 Program

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

Specialty Medications

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

Diabetic Supplies

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

Health Savings Account (HSA)
For Eligible Active Employees Enrolled in the CD PPO HDHP

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

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

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

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

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

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

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

Health Savings Account (HSA)

For Eligible Active Employees

Health Savings Accounts are similar to Individual Retirement Accounts (IRAs), but for health care. However, unlike an IRA, HSA distributions are tax-exempt when used to pay qualifying health care expenses. The HSA is an interest bearing account and investment options are available for account balances in excess of $2,000. Unused dollars in the account carry over from year to year while the account value increases through tax free earned interest and investment growth. Employees who wish to contribute to their HSA may do so through pre-tax payroll deductions. The accounts are portable; therefore, should an employee leave employment or change to a non-qualifying health plan in future years, the HSA remains with the individual.

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

Important

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

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

Health Reimbursement Arrangement (HRA)
For Eligible Active Employees

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

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

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

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

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

Hometown Health Plan
Northern Nevada HMO Plan

Category	Member Responsibility
Deductible	No Deductible
Out-of-Pocket Maximum	$6,200 Individual $12,400 Family
Coinsurance • **Special Pharmaceuticals** • **Separate out-of-pocket maximum $2,000 Individual/$6,000 Family**	30% Coinsurance
Primary Care Visit	$25 Copayment
Specialist Visit	$45 Copayment
Urgent Care Visit	$50 Copayment
Emergency Room Visit	$300 Copayment Waived if admitted as an inpatient
Ambulance - Ground & Air	$150/$200 Copayment
Hospital Services (inpatient)	$1,500 Copayment per admission
Outpatient Surgery	$1,000 Copayment
Diagnostic Endoscopy	$150 Copayment
Chiropractic Visit • **$1,000 plan year maximum**	$45 Copayment
General Laboratory Services	No charge
Durable Medical Equipment • **$3,500 plan year maximum** • **Pre-authorization in excess of $250**	No charge
Mental Health Visit (outpatient)	$25 Copayment
X-ray & Diagnostic Services	
CT Scan, MRI & Nuclear Medicine	$250 Copayment per service
Pet Scan	$350 Copayment
All other X-rays: • **PCP or specialist** • **Hospital or outpatient**	 -- Included in office visit copay -- $75 Copayment
Diagnostic Mammogram	$45 Copayment

Hometown Health Plan
Northern Nevada HMO Plan

Category	Member Responsibility
Wellness Benefit	
Wellness visit, pap smear, PSA, colorectal screening & mammogram	No charge
Healthy Tracks Program Online tools to improve your health Includes: Health Risk Assessment, Biometric Screenings, preventive exams, healthy living programs, online seminars, quarterly wellness challenges, nutritional information and recipes/grocery list	No charge
Health Management Services • Diabetes • Asthma • Quit Tobacco • Pulmonary Rehabilitation • Heart and Nutrition/Weight Management Programs	No charge
VSP Vision Plan	
Eye Exam every 12 months	$15 Copayment
Prescription Glasses	20% discount off doctor's U & C fee for prescription glasses when a complete pair is purchased
Contact Lenses	15% discount off contact lens fitting/evaluation fees
Laser Vision Care	Discounts & Preferred pricing for PRK and LASIK

HMO Prescription Benefits - Catalyst Rx 888-341-8574		
Category	**Retail - 30 Day Supply**	**Mail - 90 Day Supply**
Tier 1 - Formulary Generic Drug **Tier 2 - Formulary Brand Drug** **Tier 3 - Non-Formulary Brand Drug**	$7 Copayment $40 Copayment Greater of $75 or 40% coinsurance	$14 Copayment $80 Copayment Greater of $150 or 40% coinsurance
Special Pharmaceuticals	30% coinsurance per script	30% coinsurance per script
Diabetic Supplies	$7 Generic $40 Brand	$14 Generic $80 Brand
HTH Diabetic Sense Program 866-896-7303 Administered through Liberty Medical Supply - Member must enroll in this program to receive benefits	No charge for glucose meter (Bayer HealthCare Ascensia & Roche Diagnostic Accu-Check), test strips, lancets, syringes and alcohol pads	

Hometown Health Plan

Northern Nevada HMO Plan

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

Important Plan Information

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

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

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

Prior Authorization required for the following:

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

Hometown Health Plan
Northern Nevada HMO Plan

Primary Care Physician (PCP)

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

My Hometown Benefits - personalized online access to information

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

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

Retail Prescription Drugs

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

Mail-Order Drug Program

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

VSP Vision Care for Life

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

Hometown Health Plan
Northern Nevada HMO Plan

Selecting and changing your Primary Care Physician (PCP)

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

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

- Primary Care Physicians include: General Practice Physician, Internal Medicine, and Pediatrics.

- When you have selected the PCP, you will find the identifying PCP number for the PCP. Please use the PCP number in the space provided on your Benefit Enrollment and Change Form to identify the PCP for each member enrolling in the Hometown Health Plan.

- If you wish to change your PCP, contact Hometown Health Customer Service at 775-982-3232 or 800-336-0123, Monday through Friday 7:30 a.m. until 5:30 p.m. Your PCP change will be effective immediately.

- You will not need a referral to a specialist except for specific services. Please refer to the Hometown Health Evidence of Coverage Certificate (EOC) for more information on this topic. The EOC is available at www.pebp.state.nv.us.

HMO Reciprocity

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

Health Plan of Nevada (HPN) Southern Nevada HMO Plan	
Category	Member Responsibility
Deductible	No Deductible
Out-of-Pocket Maximum	$6,800 per person per calendar year
Primary Care Visit	$15 Copayment per visit
Specialist Visit	$15 Copayment per visit
Urgent Care Facility	$15 Copayment per visit
Emergency Services • Emergency Room • Hospital Admission • Ground Ambulance	 • $75 Copayment per visit • $200 per admission • No charge
Hospital Services—Elective Procedures	
Inpatient Hospital **Outpatient**	$200 Copayment per admission $50 Copayment per admission
Physician Surgical Services	
Inpatient Hospital **Outpatient** **Physician's Office (in addition to office visit copayment)** • Primary Care Physician • Specialist • Anesthesia	No charge No charge No charge $15 per visit No charge
Wellness Services	
Preventative Health Services	No charge
Retail Prescription Drug Benefit - Up to a 30 Day Therapeutic Supply	
Tier I: Preferred Generic Covered Drug Tier II: Preferred Brand Name Covered Drug* Tier III: Non-Preferred Generic /Brand Name Covered Drug*	$7 Copayment $35 Copayment $55 Copayment
Mail Order Plan Pharmacy	
Preferred Maintenance Covered Drugs	The Member pays two (2) of the applicable copayments as outlined above for up to a 90-day Maintenance Supply for Preferred Maintenance Covered Drugs.

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

Health Plan of Nevada (HPN)
Southern Nevada HMO Plan

Vision Benefit

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

Health Plan of Nevada (HPN)

Southern Nevada HMO Plan

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

Important Plan Information

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

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

Services Requiring Prior-Authorization

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

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

Vision - Eye Med Vision Care

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

Health Plan of Nevada (HPN)

Southern Nevada HMO Plan

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

HPN Pharmacy Benefits

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

Mail Order Pharmacy Program

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

Health Education and Wellness (HEW)

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

Health Plan of Nevada (HPN)

Southern Nevada HMO Plan

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

We're At Your Service

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

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

HMO Reciprocity

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

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

- **Family Deductible: Could be met by any combination of eligible dental expenses of three or more members of the same family coverage tier**. No one single family member would be required to contribute more than the equivalent of the individual deductible toward the family deductible. Both in-network and out-of-network deductibles are combined to meet your deductible each plan year.

- **Under no circumstances will the combination of PPO and Non-PPO benefit payments exceed the plan year maximum benefit $1,000**

Group Basic Life and Long Term Disability Insurance Included with all plan options	
Benefit Description	**Benefit Features** All Eligible Participants
Group Basic Life Insurance	Employees enrolled in a PEBP-sponsored medical plan receive $10,000 Basic Life Insurance coverage. Refer to the Life Insurance Certificate at http://www.standard.com/mybenefits/nevada/life_add.html for more information about this benefit. 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 PricewaterhouseCoopers. Services include a beneficiary guide about settling an estate and other important topics, personal financial counseling, financial analysis, 12 months of unlimited toll-free telephone access to financial counselors, a financial web site and newsletter "Your Money, Your Future." See the Beneficiary Counseling Brochure at http://www.standard.com/mybenefits/nevada/life_add.html#ben for more information.
Medex Travel Assist	Medex Travel Assist is designed to respond to most medical care situations and many other emergencies you and your family experience when you travel 100 miles or more from your home. Medex provides a wide range of information, referral, coordination, and assistance services. These services include pre-trip assistance, medical assistance, emergency transportation, travel and technical assistance, legal services, and medical supplies. Assistance is available 24 hours a day, 365 days a year whether you are 100 or 10,000 miles away from home. Simply print and carry the Medex Travel Assist Card available at http://www.standard.com/mybenefits/nevada/life_add.html#ben
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 http://www.standard.com/mybenefits/nevada/ltd.html.

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. Important! 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 http://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 http://www.standard.com/mybenefits/nevada/ or contact The Standard Insurance Company at 888-288-1270.

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

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

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

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

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

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

COBRA Rates
State and Non-State Employee

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

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

Completing the

Employee Benefit Enrollment and Change Form (E-BECF)

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

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

Section 2: Enter Participant information

Section 3: Select your health plan, e.g., Consumer Driven PPO High Deductible Health Plan, Hometown Health Plan or Health Plan of Nevada.
If declining coverage, place a check-mark in the Decline/waive coverage box.
Note: By declining coverage, you lose your eligibility for all PEBP medical benefits, including Basic Life and Long-Term Disability Insurance.

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

Section 5: Choose your coverage tier

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

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

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

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

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

Copies and facsimiles of forms will not be accepted

Group Basic Life Insurance Beneficiary Designation

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

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

Mail completed Beneficiary Designation and Change Forms to:

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

Beneficiary Information

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

Designating Beneficiaries:

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

Voluntary Flexible Spending Accounts (FSA)

For State Active Employees Only

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

When you enroll in an FSA, you decide how much to contribute to each account for the remaining months in the plan year (July 1, 2011- June 30, 2012). The amount you elect to contribute is then deducted from your second monthly paycheck, pre-tax (before Federal & State income taxes and FICA taxes are deducted) in equal amounts over the course of the months remaining in the plan year. After you incur expenses that qualify for reimbursement, you submit reimbursement requests (claims) to ASIFlex to request tax-free withdrawals from your Medical FSA.

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

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

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

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

IMPORTANT!

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

Domestic Partner Eligibility

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

Voluntary Flexible Spending Accounts (FSA)

For State Active Employees Only

Dependent Care FSA

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

- IRS regulations disallow Dependent Care FSA reimbursement for services that have not yet been provided. You can only claim service periods that have already occurred.

- Eligible expenses include day care and baby sitting for dependents under the age of 13; or for older dependents that live with you at least 8 hours each day and are incapable of self-care.

- The IRS allows no more than $5,000 per household ($2,500 if you are married and file a separate tax return) be set-aside in the Dependent Care FSA in a calendar year.

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

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

Voluntary Life Insurance

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

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

Voluntary Life and Accidental Death and Dismemberment (AD & D) Insurance	
Employees	Any multiple of $10,000 to a maximum of $500,000
Spouses/Domestic Partners	Any multiple of $10,000 to a maximum of $250,000
Child(ren)	Any multiple of $2,500 to a maximum of $10,000

Voluntary Short Term Disability (STD)

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

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

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

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

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

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

Liberty Mutual **800-637-7026**	**Travelers' Insurance** **888-695-4640**

Long-term Care Insurance Offered By UNUM Provident

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

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

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

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

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

Important Information About Your Coverage

Dual PEBP Coverage Not Permitted

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

Moving Outside the Plan's Coverage Area

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

Open Enrollment

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

Pre-Existing Conditions

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

Family Medical Leave of Absence

If you have completed 12 months or 1,250 hours of employment, you are entitled by law for up to 12 weeks each year of unpaid family medical leave for specified family or medical purposes, such as a birth or adoption of a child, or provide care of a spouse/domestic partner or child or parent who is seriously ill, or for your own serious illness. This plan uses a rolling 12-month period, measured from the date an employee uses any FMLA leave.

Employees on family or medical leave can maintain health care coverage for themselves and any covered dependents in effect during that family or medical leave period by continuing to pay any required contributions during that period.

At the conclusion of the family or medical leave period, employees returning from leave shall have their coverage reinstated (on the first day of the month in which the employee resumes working 80 hours) to the same medical plan and coverage tier that was in place prior to taking the leave.

Important Information About Your Coverage

Leave Without Pay (LWOP)

A state agency that employs an individual who is on LWOP shall NOT pay any amount of the cost of premium or contributions for group insurance for that employee, unless the employee receives a minimum compensation of 80 hours in the month for work actually performed, accrued annual leave or sick leave, or any combination thereof.
An employee who is on approved LWOP may pay the full cost of premiums for their coverage and insurance to PEBP. An employee on LWOP is not eligible for coverage as a dependent of another PEBP covered participant (spouse/domestic partner, child, etc.).
At the initial start of leave, it is the employee's responsibility to inform PEBP of their coverage preference while on leave. If the employee fails to inform PEBP of his or her coverage preference while on leave, PEBP will continue the same medical plan and coverage tier that the employee had in affect prior to taking that leave.

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

- Employees on active military service (for up to 31 days) may elect to continue health care coverage during that leave period by paying any premium contributions due for that coverage while on leave.

- If the employee goes into active military service for 31 days or more, the employee is eligible to enroll him/herself and family in health care coverage provided by the military the day the employee is activated for military duty. The employee is also eligible to purchase continued health coverage for him/herself and their family for up to 24 months in a manner similar to the provisions of COBRA. When the employee returns from military leave within the required reemployment period, there will be an immediate reinstatement of PEBP-sponsored medical coverage with no waiting period.

Workers' Compensation Leave

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

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

Public Employees' Benefits Program

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

Initial COBRA Notification

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

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

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

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

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

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

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

Initial COBRA Notification

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

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

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

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

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

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

Initial COBRA Notification

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

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

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

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

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

Initial COBRA Notification

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

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

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

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

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

Public Employees' Benefits Program

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

COBRA ADDRESS NOTIFICATION FORM

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

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

1. COVERED DEPENDENT ADDRESS INFORMATION

Name of covered dependent:_____

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

Street Address:_____

City:_____State:_____Zip:_____

2. COVERED DEPENDENT ADDRESS INFORMATION

Name of covered dependent:_____

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

Street Address:_____

City:_____State:_____Zip:_____

3. COVERED DEPENDENT ADDRESS INFORMATION

Name of covered dependent:_____

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

Street Address:_____

City:_____State:_____Zip:_____

CD PPO HDHP Vendor Contact List

Medical, Dental and Pharmacy Contacts

CD PPO HDHP Medical and PPO Dental Claims Administrator • Claim status inquiries • 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
National Provider Network • For participants accessing healthcare outside Nevada	**First Health Network** P.O. Box 91603 Lubbock, TX 79490-1603 Customer Service: 800-226-5116 www.myfirsthealth.com
Dental PPO Network • Statewide dental PPO providers • Dental provider directory	**Diversified Dental Services** Northern Nevada: (866) 270-8326 Southern Nevada: (800) 249-3538
CD PPO HDHP Pharmacy Plan Administrator • Prescription drug information • Retail network pharmacies • Prior authorization • Non-network retail claims payment • Mail order service and mail order forms	**Retail Pharmacy Services** **Catalyst Rx** (800) 799-1012 (702)933-4521 (Las Vegas) **Walgreens Mail Order** (866) 845-3590 www.catalystrx.com User Name: nevada Password: benefit
APS Healthcare • Pre-certification • Case Management	**APS Healthcare** Pre-certification and Customer Service (888) 323-1461 www.apshealthcare.com
U.S. Preventive Medicine • Live Well, Be Well Prevention Plan • Diabetes Care Management • Obesity Care Management Program	**U.S. Preventive Medicine (USPM)** **The Prevention Plan** (877) 800-8144 www.ThePreventionPlan.com

HMO and Voluntary Products Vendor Contact List

Northern HMO Plan • Provider network • Provider directories • Appeals • Benefit Information • Additions/deletions of providers	**Hometown Health Plan** Customer Service: (775) 982-3232 or (800) 336-0123 http://stateofnv.hometownhealth.com or www.pebp.state.nv.us
Southern HMO Plan • 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 or www.pebp.state.nv.us
Life and AD&D 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 or www.pebp.state.nv.us
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	**Colonial Life UNUM** Customer Service: (877) 433-5334 www.pebp.state.nv.us
Flexible Spending • Medical • Dependent Care **Enrollment forms:** www.asiflex.com **or** www.pebp.state.nv.us	**ASI Flex** Customer Service: (800) 659-3035 Fax: (866) 381-9682 P.O. Box 6044, Columbia, MO 65205 www.asiflex.com
Home and Auto Insurance	**Liberty Mutual** Customer Service: (800) 637-7026 gary.bishop@libertymutual.com **Travelers'** Customer Service: (888) 695-4640 www.travelers.com/nevada

D-3

NRS 287.0245 (1) (d) III

Retiree Enrollment Guide,

Plan Year 2013

Retiree Enrollment Guide

STATE OF NEVADA

Public Employees' Benefits Program

Plan Year 2013

- Enrollment & Eligibility
- Medical Plan Options
- Dental Plan Options
- Basic Life Insurance
- Retiree Rates
- Years of Service Subsidy
- Exchange HRA Contributions
- HRA Contributions
- Voluntary Products
- Contact Information

901 S. Stewart St., Suite 1001
Carson City, NV 89701
(775) 684-7000 or (800) 326-5496
Fax: (775) 684-7028

mservice@peb.state.nv.us
www.pebp.state.nv.us

Plan Year 2013
July 1, 2012 - June 30, 2013

Plan Year 2013 Retiree Benefits Guide

Table of Contents

This document is for informational purposes only. Any discrepancies between the information contained herein and the *Plan Year 2013 Master Plan Document/HMO Evidence of Coverage Certificates, or the 2012Medicare & You handbook* shall be superseded by the plans' official documents.

Revised 07232012

Introduction

Dear Retiring Employee:

The Public Employees' Benefits Program (PEBP) would like to extend its sincere congratulations to you as you enter into retirement. As an employee retiring from the State of Nevada or a participating local governmental entity, you may have the option to enroll in retiree coverage offered by the Public Employees' Benefits Program.

The information contained herein is for Plan Year 2013 (July 1, 2012 - June 30, 2013). The benefits and premiums described are subject to change beginning July 1 of each plan year. On or about mid-April you will receive an Open Enrollment letter describing the changes for the next plan year and instructions on where to find additional information. It is important to review the Open Enrollment material to stay informed of any changes that might occur in the future.

After reading through this guide in its entirety, you will gain an understanding of retiree plan options, dependent eligibility, enrollment timeframe, years of service subsidy, premium cost, and the steps to enroll in coverage as retiree. For additional information, contact the PEBP office at 775-684-7000 or 800-326-5496 or email: mservice@peb.state.nv.us.

Eligibility for Retiree Insurance

Pursuant to NAC 287.135, retirees with 5 or more years of service credit (or 8 or more years of service credit for retired Legislators; NRS 287.047) are eligible for retiree coverage if the public officer or employee's last employer is participating in PEBP with its active employees and the retired public officer or employee is receiving retirement benefit distributions from one or more of the following:

- Public Employees' Retirement System (PERS)
- Legislators' Retirement System (LRS)
- Judges' Retirement System (JRS)
- Retirement Plan Alternative (RPA) for professional employees of the Nevada System of Higher Education
- A long-term disability plan of the public employer

Retired public officers and employees who wish to enroll in coverage at initial retirement must complete the enrollment process within 60 days following the date of retirement as determined by PERS or NSHE. Failure to enroll within 60 days will result in termination of coverage.

Eligibility for Retiree Benefits

Non-State Retiree Eligibility (NAC 287.542, 287.548)

Employees retiring after November 30, 2008 from a **participating** local government are eligible to enroll in PEBP retiree coverage However, if the local government opts to leave the program in the future, the retirees described above must also leave the program.

Retiree Coverage for Employees hired on or after January 1, 2010

Employees with an "initial date of hire" on or after January 1, 2010, but prior to January 1, 2012 and who subsequently retire with less than 15 years of service are eligible to elect retiree coverage, but will not qualify for a subsidy or Exchange HRA contribution unless the retirement occurs under a long-term disability plan.

The "initial date of hire" is defined by NAC 287.059 as "the *first date on which service credit is earned by a participant during the participant's last period of continuous employment with a public employer*, as determined by PERS or NSHE.

"Continuous employment" as defined by NAC 287.021, "includes a break in employment of less than 1 year; and does not include a break in employment of 1 year or more."

Retiree Coverage for Employees hired on or after January 1, 2012

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

Coverage for Survivors of Active Employees

If an active employee dies with 10 or more years of service credit, the employee's covered dependent(s) may continue coverage by re-joining the program within 60 days of the employee's death. Surviving dependents may include the spouse, domestic partner and children covered on the employee's medical plan on the date of death.

Coverage for Survivors of Retirees

Covered dependents of deceased retirees will retain coverage through the end of the month in which the retiree dies. To continue coverage beyond the end of the month; the covered dependent(s) must reenroll in Survivor's coverage within 60 days following the retiree's death. Survivors are not required to receive a survivor's pension benefit.

Eligibility for Retiree Benefits

Coverage for Survivors of Police Officer or Firefighter Killed in the Line of Duty

The surviving spouse and any child of a police officer or firefighter who was employed by a participating public agency and who was killed in the line of duty may join or continue coverage under PEBP if the individual was eligible to participate on the date of death. The survivor must submit written notification of intent to enroll to the agency that employed the police officer or firefighter within 60 days after the date of death. If such a dependent elects to join PEBP, the dependent or legal guardian of the child must submit written notification of intent to enroll to PEBP within 60 days after the date of death.

The participating public agency that employed the police officer or firefighter shall pay the entire cost of the premiums or contributions to PEBP for any covered surviving dependent who meets the requirements to enroll. A surviving spouse is eligible to receive coverage for the duration of life. A surviving child is eligible to receive coverage until the child reaches age 26.

Retirees and Covered Spouses/Domestic Partners Eligible for Medicare Part A

Retirees and covered spouses/domestic partners aged 65 and older must provide verification of *premium-free* Medicare Part A enrollment or Part A ineligibility to the PEBP office. Failure to provide verification of Medicare Part A status as indicated below may result in termination of coverage. For more information, refer to the PEBP and Medicare Guide available at www.pebp.state.nv.us.

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

- For newly retiring employees, the Part A card or denial letter must be received within 60 days of the retirement coverage effective date.
- For retirees aging in to Medicare with a birthday that occurs on the first day of the month, the Part A card or denial letter must be received no later than the last day of the month the individual turns 65.
- For retirees aging in to Medicare with a birthday that does NOT occur on the first day of the month, the Part A card or denial letter must be received no later than the last day of the month, following the 65th birthday month.

Eligibility for Medicare Part A typically begins at age 65 and is determined by the Social Security Administration (SSA). Contact the SSA at 800-772-1213 to inquire about Medicare Part A.

Disability Retirement

The PERS retirement date for an employee retiring under a long-term disability plan becomes effective on the day immediately following the employee's last day of employment, or the day immediately following the last day of earning creditable service, whichever is later. The timeframe for submitting retiree enrollment paperwork to PEBP for a disability retirement is 60 days following the date of retirement. PEBP will confirm the retirement date with PERS prior to activating retiree coverage.

Eligibility for Retiree Benefits

Medicare Part B

Retirees and their covered dependents aged 65 and older are required to buy Medicare Part B and submit a copy of the Part B card to the PEBP office. Retirees enrolled in the CD PPO HDHP or HMO plan receive a $99.90 Part B premium credit equal to the 2012 base cost of Part B coverage. The Part B credit will not apply until the first of the month, following PEBP's receipt of the Part B card or the effective date of Part B, whichever occurs later. Spouses/ domestic partners do not receive a Part B premium credit.

A copy of the Part B card must be received in the PEBP office as follows:

- For newly retiring employees, the Part B card must be received within 60 days of the retirement coverage effective date.
- For retirees aging in to Medicare with a birthday that occurs on the first day of the month, the Part B card must be received no later than the last day of the month the individual turns 65.
- For retirees aging in to Medicare with a birthday that does NOT occur on the first day of the month, the Part B card must be received no later than the last day of the month, following the 65th birthday month.

Failure to enroll in Medicare Part B and provide proof of enrollment could result in increased premiums and out-of-pocket medical costs *for those who are not eligible for premium-free Medicare Part A* and termination of PEBP coverage for retirees *who are eligible for premium-free Medicare Part A, but do not purchase Part B.*

Eligibility for Medicare Part B typically begins at age 65 and is determined by the SSA. Contact the SSA at 800-772-1213 to inquire about enrolling in Medicare Part B.

Retiree Late Enrollment

Retirees of the State, NSHE, participating local government, or a surviving spouse of a deceased retiree can reinstate coverage during any Open Enrollment period if the retiree *did not have more than one period during which he or she was not covered under PEBP on or after October 1, 2011*, *or on or after the date of retirement, whichever is later.* To take advantage of the annual Retiree Late Enrollment, contact PEBP between April 1 and May 31 of any calendar year. Retirees enrolling for coverage during the Retiree Late Enrollment are not eligible for the Basic Life Insurance benefit.

Returning to Active Employment with a Participating Public Employer

Retirees who return to active work status with the *State of Nevada* or a *participating non-state agency* may risk losing the years of service subsidy or Exchange years of service contribution at re-retirement as follows: Eligibility for a subsidy at retirement is based on the "initial date of hire" as defined by NAC 287.059 as "the *first date on which service credit is earned by a participant during the participant's last period of continuous employment with a public employer* (as determined by PERS or NSHE). "Continuous employment" (defined by NAC 287.021) "includes a break in employment of less than 1 year; and does not include a break in employment of 1 year or more." For more information, turn to page 2.

Enrollment

Complete the Retiree Benefits Enrollment and Change Form (R-BECF)

Submit the Retiree Benefit Enrollment and Change Form 30-60 days before retirement or no later than 60 days after the date of retirement.

Years of Service Certification Form

Submit Years of Service Certification Form to PEBP 30 - 60 days before retirement or as soon as possible, but no later than 60 days after the date of retirement.

Medicare Parts A and B

Retirees and covered spouses/domestic partners (DP) aged 65 or older must submit copies of the Medicare Parts A card (or Part A denial letter for the Social Security Administration) and a copy of the Part B card as follows:

- For newly retiring employees, the Part B card must be received within 60 days of the retirement coverage effective date.
- For existing retirees and covered dependents aging-in to Medicare with a birthday that occurs on the first day of the month, the Part B card must be received no later than the last day of the month the individual turns 65.
- For existing retirees and covered dependents aging-in to Medicare with a birthday that does NOT occur on the first day of the month, the Part B card must be received no later than the last day of the month, following the 65th birthday month.

Mail "ORIGINAL" Forms to the following::

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

Note: Copied forms or facsimiles will not be accepted.

Voluntary Life Insurance Enrollment and Change Form

Retirees who wish to purchase Voluntary Life Insurance coverage from Standard Insurance must complete the Voluntary Life Enrollment and Change Form within 60 days following the date of retirement to the following:

Mail "VOLUNTARY" Life Insurance Form to the following:

State of Nevada Life Insurance Team

Enrollment

How to Enroll in Initial Retiree Coverage

Complete the Retiree-Benefit Enrollment and Change Form and Years of Service Certification Form (if applicable) and submit to the PEBP within 60 days of the retirement date.

When Retiree (CD PPO HDHP or HMO) Coverage Starts

Retiree coverage becomes effective on the first day of the month concurrent with or following the date of retirement. For example, for a retirement date of June 1, coverage becomes effective June 1. However, for a retirement date of June 2, retiree coverage becomes effective July 1.

Extend Health Medicare Exchange (new retirees aged 65 and older)

Retirees *aged 65 or older* at initial retirement must enroll in premium-free Medicare Part A (if eligible) and purchase Medicare Part B as follows:.

Retiring Employees and Covered Dependents Aged 65+

The enrollment timeframe for newly retiring employees starts on the first day of the month following the employee's retirement date. (PEBP considers an employee retired on the first day of the month following the last day of the month in which he or she worked or was in paid status.) For example, Mary work on November 14 and retires November 15. Her retiree coverage becomes effective December 1st. Mary can apply for Medicare any time between September, October, and November, but no later than December 31st.

PEBP will require proof of Medicare Part A enrollment status through the submission of a copy of the Part A card or a copy of the denial letter issued by the Social Security Administration and a copy of the Part B card as follows:

- For newly retiring employees, the Part A card (or Part A denial letter) and Part B card must be received within 60 days of the retirement coverage effective date. For more information, refer to the PEBP and Medicare Guide available at www.pebp.state.nv.us.

Coverage Changes at Retirement

- Select a new medical plan option
- Enroll new or delete covered dependent(s)
- Decline retiree coverage

Declining (terminating) Retiree Coverage

Retirees may decline PEBP coverage at any time by submitting a written request. Declining coverage will terminate medical, dental, vision, prescription drug coverage, $5,000 Basic Life Insurance, Voluntary Life Insurance (if applicable), years of service premium subsidy and Exchange-HRA contribution. Termination requests received prior to the requested date of termination will occur on the last day of the month; otherwise, coverage will terminate on the first day of the month following PEBP's receipt of the written request.

Enrollment

Extend Health - Exchange Health Reimbursement Arrangement (Exchange-HRA)

Eligible retirees enrolled in a medical plan through Extend Health receive an Exchange Health Reimbursement Arrangement (Exchange-HRA) contribution based upon the employee's retirement date and years of service (earned service credit only). If the retiree is eligible for the Exchange-HRA, the monthly contribution will commence concurrent with the effective date of the medical coverage through Extend Health. For monthly Exchange-HRA contribution amounts, turn to page 43. Note: The Exchange-HRA contribution is provided only to eligible retirees enrolled in a medical plan through Extend Health. NRS 287.046 (6) (a) (b).

Years of Service Subsidy for Retirees in the PPO and HMO Plans

Eligible retirees enrolled in the CD PPO HDHP or HMO plan receive a *Years of Service Premium Subsidy Adjustment* (based upon earned service credit only). The subsidy adjustment is based on the employee's retirement date and service credit earned from all Nevada public employers. The subsidy adjustment will commence concurrent with the effective date of retiree coverage. To determine the amount of your subsidy adjustment turn to page 42.

Monthly Premium Cost

The monthly insurance premium is determined by the medical plan option, coverage tier (e.g., retiree only, retiree plus spouse/domestic partner, etc.) and the years of service subsidy adjustment. Note: purchased months/years of service do not count toward the years of service subsidy. Turn to pages 40 - 42 for premium rates and subsidy.

The monthly cost for medical plans through Extend Health will vary depending on the plan selected. Contact Extend Health at 888-598-7545 to learn about plan options and premium cost.

Paying for CD PPO HDHP or HMO Coverage

PEBP will coordinate with PERS to establish monthly premium deductions from the retiree's pension check. Each monthly deduction pays for medical coverage for that month. In the following circumstances, PEBP may bill the retiree directly:

- During the first few months of retirement, pending PEBP's receipt of the years of service audit.
- Retiree's monthly pension check is insufficient to cover the premium cost.
- NSHE retiree who participates in an alternative retirement plan.
- Direct Payers: Payment for the current month's coverage is due on the 20th of the month. Any account past due is subject to termination retroactive to the last day of the month for which payment was received. To pay by credit card, please call 775-684-7000 or 800-326-5496

Summary of Supporting Eligibility Documents

Dependent Type	Social Security Number	Marriage Certificate	Birth Certificate	Hospital Birth Confirmation	Adoption Decree	Nevada Certification of Domestic Partnership	Legal Permanent guardianship signed by a judge	Physician's Disability Certification
Newborn child	√		√	√				
Child - birth to age 26	√		√					
Adopted Child	√		√		√			
Permanent Legal Guardianship of a child	√		√				√	
Stepchild	√	√	√					
Domestic Partner's child	√		√			√		
Domestic Partner's adopted child	√		√		√	√		
Disabled child	√		√					√
Disabled stepchild	√	√	√					√
Domestic Partner's disabled child	√		√			√		√
Spouse*	√	√						
Domestic Partner*	√					√		

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

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

Plan Options

	Retiree plus spouse or Domestic Partner **both without** Medicare Part A	Retiree plus spouse or Domestic Partner **both with** Medicare Part A	Retiree plus spouse or Domestic Partner , **one with and one without Medicare**	Retiree only, **without** Medicare Part A	Retiree only **with** Medicare Part A	Survivor **without** Medicare Part A	Survivor **with** Medicare Part A
	State and Non-State Retiree			**State and Non-State Retiree's Surviving spouse/domestic partner**			
Medical Plan Options							
Consumer Driven PPO High Deductible Health Plan with HRA	√		√	√		√	
Health Plan of Nevada (Southern Nevada HMO) - Clark, Esmeralda and Nye Counties	√		√	√		√	
Hometown Health Plan (Northern Nevada HMO)	√		√	√		√	
Extend Health with (Retiree) HRA		√	√		√		√
Extend Health *without* HRA (Spouse/DP/ Survivor) w/Medicare		√	√				
Dental Benefits							
Dental Plan	√	√	√	√	√	√	√
Basic Life Insurance							
Basic Life Insurance*	√	√	√	√	√		
Voluntary Insurance Options							
Long-term Care Ins.	√	√	√	√	√	√	√
Home and Auto Ins.	√	√	√	√	√	√	√
Voluntary Life Ins.	√	√	√	√	√		

- Basic Life Insurance is not offered to reinstated retirees.
- Dental benefits included with all PPO and HMO medical plans.
- Optional voluntary of PEBP's dental plan available to retirees enrolled through Extend Health..

Summary of Benefits for Non-Medicare Retirees

The following benefits are offered to pre-Medicare retirees, retirees with Medicare Part B only and retirees with Medicare Part A who cover pre-Medicare dependent(s). For more detail on these benefits see the Plan Year 2013 Master Plan Document.

Benefits for Non-Medicare Retirees

Benefit Type	Description
Medical, Pharmacy, Vision Benefits	Plan Options: CD PPO HDHP, Health Plan of Nevada and Hometown Health Plan depending on your geographic location.
Dental Benefit	$1,000 annual maximum for Basic and Major dental services included with your medical benefits.
Basic Life Insurance	$5,000 Basic Life Insurance Coverage (eligible retirees)
Health Reimbursement Arrangement (HRA)	Retirees enrolled in the CD PPO HDHP receive an HRA and a tax-exempt PEBP contribution to pay for qualifying out-of-pocket health care expenses.
State Retiree Years of Service Premium Subsidy	Eligible State retirees receive a premium subsidy based upon retirement date and years of service.
Non-State Retiree Years of Service Premium Subsidy	Eligible non-State retirees receive a premium subsidy based upon retirement date and years of service.

Summary of Benefits for Retirees with Medicare Parts A and B

The following benefits are offered to retirees with Medicare Parts A and B and covered spouses/domestic partners or surviving spouses/domestic partners with Medicare Parts A and B,

Benefit Options for Retirees with Medicare Parts A and B

Benefit Type	Description
Medical, Pharmacy, Vision Benefits	Retirees with Medicare Parts A and B may select medical, pharmacy, and vision benefits from a variety of plan options e.g., Medicare Advantage Plan, Medigap, and Medicare Part D Prescription Drug plans through Extend Health.
Dental Benefits	Option to purchase PEBP's dental plan or select a dental plan through Extend Health
Basic Life Insurance	Eligible retirees enrolled in a medical plan through Extend Health also receive $5,000 Basic Life Insurance coverage. Note: Spouses/domestic partners and surviving spouses/domestic partners are not eligible for Basic Life Insurance coverage.
Exchange- Health Reimbursement Arrangement (HRA) with a monthly Years of Service Contribution	Retirees enrolled in a medical plan through the Extend Health receive an Exchange-HRA and a monthly tax-exempt contribution based upon the retiree years of service. Note: Spouses/domestic partners and surviving spouses/domestic partners are not eligible for the Exchange-HRA.

Retiree Resources

www.pebp.state.nv.us

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

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

Medical Plan Comparison

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

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

Pharmacy Plan Comparison

Benefit Category	CD PPO HDHP Amount You Pay In-Network	Health Plan of Nevada Amount You Pay In-Network	Hometown Health Plan Amount You Pay In-Network
Plan Deductible	$1,900 individual $3,800 family • $2,400 Individual -when two or more family members covered	No deductible	No deductible
Annual Out-Of-Pocket (OOP) Maximum*	$3,900 person $7,800 family (per plan year)	Contact HPN for pharmacy OOP* maximum	Contact HHP for pharmacy OOP* maximum
Retail Pharmacy - 30 day supply			
Preferred Generic (Tier 1)	25% after deductible	$7 copayment	$7 copayment
Preferred Brand (Tier 2)	25% after deductible	$35 copayment	$40 copayment
Non-Formulary (Tier 3)	100% of contracted price - does not apply to deductible or OOP*	$55 copayment	Greater of $75 copayment per script or 40%
Specialty Drugs	25% after deductible - available in 30 day supply only through Walgreen pharmacies	Applicable retail pharmacy copayment will apply	30% coinsurance
Mail Order - 90 day supply			
Preferred Generic (Tier 1)	25% after deductible	$14 copayment	$14 copayment
Preferred Brand (Tier 2)	25% after deductible	$70 copayment	$80 copayment
Non-formulary (Tier 3)	100% of contracted price - does not apply to deductible or OOP*	Not available through mail order	Greater of $150 copayment per script or 40%
Specialty Drugs	25% after deductible, available in 30 day supply only through Walgreens mail order	Applicable retail pharmacy copayment applies	Not available through mail order

***Annual Out-of-Pocket Maximum (OOP):** The maximum amount of coinsurance each covered person or family is responsible for paying during a plan year before the coinsurance required by the plan cease to apply. When the OOP maximum is reached, the plan will pay 100% of eligible covered expenses for the remainder of the plan year.

Consumer-Driven PPO High Deductible Health Plan (CD PPO HDHP)

Plan Feature	In-Network (participating provider benefit)	Out-of-Network Benefit
Coinsurance (Plan pays)	75% after deductible	50% after deductible, Usual and Customary applies.
Primary Care Physician (PCP) *PCP includes internists, general and family practitioners, pediatricians and obstetricians/gynecologists.*	75% after deductible	50% after deductible, Usual and Customary applies.
Specialist Office Visits	75% after deductible	50% after deductible, Usual and Customary applies.
Outpatient Short-Term Rehabilitative Therapy • Occupational therapy • Physical therapy • Speech therapy	75% after deductible	50% after deductible, Usual and Customary applies.
Emergency Care • Emergency Room Visit • Ambulance Services	75% after deductible	75% after deductible, Usual and Customary applies.
Urgent Care	75% after deductible	50% after deductible, Usual and Customary applies.
Outpatient Laboratory Services • Outpatient laboratory services (except for pre-admission testing, urgent care facility or emergency room) performed at an acute care hospital will not be covered unless an exception is warranted and approved by the Plan Administrator. • If an outpatient laboratory facility or draw station is not available to you within 50 miles of your residence, you may use an acute care hospital to receive your outpatient laboratory services.	75% after deductible when testing performed at an independent free-standing laboratory.	50% after deductible, Usual and Customary applies.
Usual and Customary Charge (as defined in the Plan Year 2012 Master Plan Document available at www.pebp.state.nv.us) for medically necessary services or supplies, subject to the plan's deductibles, coinsurance (on non-discounted services), limitations and exclusions.		

CD PPO HDHP		
Plan Feature	**In-Network (participating provider benefit)**	**Out-of-Network Benefit**
Temporomandibular Joint Disorder (TMJ)	50% after deductible	50% after deductible, Usual and Customary applies.
Prevention/Wellness Benefit Examples of Preventive Wellness Screenings: ◆ Physical exam, screening lab and x-rays ◆ Well child visits and services ◆ HPV Vaccination ◆ Prostrate screening ◆ Routine sigmoidoscopy or colonoscopy ◆ Adult immunizations ◆ Screening mammograms (in the absence of a diagnosis) ◆ Pelvic exam and Pap smear lab test ◆ Osteoporosis screening ◆ Hypertension screening ◆ Skin Cancer screening ◆ Routine hearing exam ◆ Medically supervised weight loss ◆ Stress management For an expanded list of covered preventive/wellness services, please refer to the Plan Year 2013 Master Plan Document available at www.pebp.state.nv.us.	100% - No deductible	Not covered
Vision Exam	75% after deductible Usual and Customary applies.	75% after deductible Usual and Customary applies.

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

CD PPO HDHP Pharmacy Benefit

Benefit Category	Retail 30 Day Supply	Retail 90 Day Supply	Mail Order 90 Day Supply
	Amount You Pay In-Network	Amount You Pay In-Network	Amount You Pay In-Network
Plan Deductible	$1,900 individual $3,800 family • $2,400 Individual (two or more family members)	$1,900 individual $3,800 family • $2,400 Individual (two or more family members)	$1,900 individual $3,800 family • $2,400 Individual (two or more family members)
Out-Of-Pocket (OOP) Maximum*	$3,900 person $7,800 family (per plan year)	$3,900 person $7,800 family (per plan year)	$3,900 person $7,800 family (per plan year)
	Retail 30 Day Supply	**Retail 90 Day Supply**	**Mail Order 90 Day Supply**
Preferred Generic (Tier 1)	25% after deductible	25% after deductible	25% after deductible
Preferred Brand (Tier 2)	25% after deductible	25% after deductible	25% after deductible
Non-Formulary (Tier 3)	100% of contracted price - does not apply to deductible or OOP*	100% of contracted price - does not apply to deductible or OOP*	100% of contracted price does not apply to deductible or OOP*
Specialty Medications Limited to 30 day supply—available through Walgreens Specialty Pharmacy 866-823-2712	25% after deductible - available in 30 day supply only through Walgreen pharmacies	90 day supply not available through retail pharmacies	90 day supply not available through mail order

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

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

Program Benefits:

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

Covered Supplies:	• **Annual** Blood Glucose Monitor • Blood Glucose Test Strips • Lancets	• Spring-Powered device for Lancets • Syringes • Alcohol Pads • B-D Pens • 3cc Novo Pens	$50 Copay applies to each 90 day supply item. If the actual cost is less, you pay the actual cost. No cost for the blood glucose monitor.

***Out-of-Pocket Maximum (OOP):** The maximum amount of coinsurance each covered person or family is responsible for paying during a plan year before the coinsurance required by the plan cease to apply. When the OOP maximum is reached, the plan will pay 100% of eligible covered expenses for the remainder of the plan year.

CD PPO HDHP - Diabetes Care Management Program

Opt-In Program - Accompanied with Benefit Enhancements

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

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

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

Diabetes Pharmacy Benefit Enhancement

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

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

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

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

CD PPO HDHP - Obesity and Overweight Care Management Program

Opt-In Program - Accompanied with Benefit Enhancements

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

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

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

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

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

CD PPO HDHP - Live Well, Be Well Prevention Plan

The Live Well, Be Well Prevention Plan is offered to CD PPO HDHP participants and their covered spouses or domestic partners. For Plan Year 2013, new hires are eligible if their CD PPO HDHP coverage effective date is on or before August 1, 2012. This program provides an online portal that features a broad range of educational material, such as health and wellness webinars, a comprehensive medical library with reliable resources where one can learn about nutrition, healthy living, medical tests and procedures, health and wellness activities, and various disease states. Participants also have access to a confidential health journal for tracking physician office visits, lab results, medications, and preventive screenings. Participants who complete the Health Assessment Questionnaire (HAQ) and annual biometric screening receive a Prevention Plan report that identifies their top five health risks and action plans to help lower those risks.

To learn more about the Live Well, Be Well Prevention Plan, visit www.pebp.state.nv.us or call U.S. Preventive Medicine at 877-800-8144.

Consumer Driven PPO High Deductible Health Plan

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

Each year, before the plan begins to pay benefits, you are responsible for paying all your eligible medical and prescription drug expenses up to the plan year deductible. Eligible medical and prescription drug expenses are applied to the deductibles in the order in which claims are received by the plan. Only eligible medical, prescription drug and vision care expenses can be used to satisfy the plan deductible. Deductibles accumulate on a plan year basis and reset to zero at the start of each new plan year.

Plan Year Deductible

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

Plan Year Out-of-Pocket Maximum

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

Statewide PPO Network

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

Consumer Driven PPO High Deductible Health Plan

First Health

The First Health preferred provider network is the CD PPO HDHP's national network for participants residing outside Nevada or Nevada residents who wish to access healthcare outside Nevada. Providers in the First Health 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 providers in the First Health network, contact First Health at 800-226-5116 or search for providers online at www.myCIGNAfor health.com.

Pre-certification Review

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

Case Management

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

Diabetes Care Management Program

The diabetes Care Management Program is available to all primary CD PPO HDHP participants, spouses and domestic partners with diabetes. Participants who are diagnosed with diabetes and who are *actively engaged* in the Diabetes Care Management Program will be eligible to receive a benefit enhancement for diabetes related medications, see pages 17 - 18 for a description of benefits.

CD PPO HDHP Pharmacy Plan

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

Prior Authorization

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

Consumer Driven PPO High Deductible Health Plan

Retail Drugs

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

Mail Order Prescription Drug Service

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

Retail 90 Program

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

Specialty Medications

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

Diabetic Supplies

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

PPO Health Reimbursement Arrangement (HRA)
For Eligible Retirees

The PPO-Health Reimbursement Arrangement (PPO-HRA) is an employer-owned account established on behalf of retirees enrolled in the CD PPO HDHP.

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

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

Retirees enrolled in the CD PPO HDHP will receive HRA contributions as shown below:

HRA	Individual	Family (two or more family members)
PEBP HRA contribution (Retiree covered on July 1, 2012) Note: New hires receive a prorated contribution based upon the coverage effective date and months remaining in the plan year.	$700	$700 for the retiree and $200 for each covered dependent (maximum 3 dependents or $1,300 total for the family)
Additional one-time contribution for retirees and dependents with coverage effective July 1, 2012	$400	$100 per dependent (maximum 3 dependents)
Additional one-time contribution for retirees covered on the CD PPO HDHP on July 1, 2012 with 20+ years of service.	$200	$200

Coverage Options for Medicare Retirees

Retiree is eligible for premium free Medicare Part A, but covers a dependent that is not eligible for Part A:

1. The retiree may enroll in a medical plan through Extend Health and the non-Medicare individual may enroll in the CD PPO HDHP or HMO plan as an unsubsidized dependent. Unsubsidized dependents; or
2. The retiree may retain coverage in the CD PPO HDHP or HMO plan with the non-Medicare dependent(s) until the spouse/domestic partner ages into Medicare and the child(ren) reach age 26 and are no longer eligible for coverage as a dependent.
3. The retiree may enroll in a medical plan through Extend Health and decline coverage for any covered dependent not eligible for Medicare.
    - Optional: An employee's spouse/domestic partner who has Medicare Part A and B may enroll in a medical plan through Extend Health.

Retiree under age 65 and not yet eligible for Medicare, but covers a spouse/domestic partner who has Medicare Parts A and B.

1. The dependent may enroll in a medical plan through Extend Health. The dependent will be responsible for paying the entire premium to the insurance company and will not receive a Health Reimbursement Arrangement contribution.
2. The participant may cover the dependent under the CD PPO HDHP or HMO plan the until the retiree ages-in to Medicare; or
3. The participant may drop the spouse/domestic partner from his or her PEBP plan.

Qualifying Events

Any qualifying event (e.g., divorce, marriage or a spouse/domestic partner becomes eligible for Medicare Part A) which creates a situation where the Medicare retiree is no longer covering a non-Medicare dependent(s) will result in the retiree and the Medicare spouse/domestic partner (if applicable) having to enroll in a medical plan through Extend Health.

Medicare Part D Coverage

If a retiree or covered spouse/domestic partner of a retiree covered under the CD PPO HDHP or HMO plan enrolls in Medicare Part D prescription coverage, that individual will lose PEBP PPO prescription drug coverage for the remainder of the plan year. Additionally, there will be reduction to the participant premium/contribution. If the Medicare Part D coverage is discontinued, the PEBP coverage will not be reinstated until the next plan year.

Medicare Retiree Enrollment Options

If a retiree **with** Medicare Parts A and B and also covers a spouse or domestic partner or child(ren) **without** Medicare, or the retiree is not yet eligible for Medicare Parts A and B, but he or she covers a spouse or domestic partner with Medicare Parts A and B, the retiree will have the option to remain on the PEBP CD PPO HDHP or HMO plan with the Medicare dependent, or the Medicare dependent can enroll in a medical plan through Extend Health.(see Options 2 and 3).

To determine your plan options, go to column A and choose who you wish to and choose who you want to cover. Then go to column B and select your coverage option.

<table>
<tr><th>Column A
Choose Who You Want to Cover</th><th>Column B
Choose your Coverage Option</th></tr>
<tr><td><u>If you would like to cover</u>:
• Only yourself and you are eligible for free Medicare Part A, refer to Coverage option #1.

<u>If you would like to cover</u>:
• Yourself and your spouse or domestic partner and you both are eligible for free Medicare Part A, refer to Coverage Option #1.</td><td>Option #1
Extend Health
You must select a medical plan through Extend Health</td></tr>
<tr><td rowspan="2"><u>If you would like to cover</u>:
• Yourself and one or more dependents and at least <u>one</u> person you are covering is not eligible for free Medicare Part A, refer to Coverage options #2 or #3

<u>Declining Retiree Coverage</u>
• Retirees have the option to decline coverage. By declining coverage, a retiree loses medical, dental, prescription drug, and life insurance coverage.</td><td>Option #2
PEBP’s PPO/HMO Coverage
You and your spouse or domestic partner and/or child(ren) may remain on the CD PPO HDHP or an HMO plan.</td></tr>
<tr><td>Option #3
Split Coverage - Enroll in Separate Plans
(Extend Health & CD PPO HDHP or HMO)
Medicare Part A individual may enroll in a medical plan through Extend Health.
Non-Medicare individuals may select the CD PPO HDHP or HMO plan by calling the PEBP office to request the Retiree Benefit Enrollment and Change Form (Retiree-BECF).</td></tr>
</table>

Medicare Retiree Enrollment and Coverage Options

Select Your Coverage Option below	Your Next Steps - Actions You Must Take
Option #1 Enroll in coverage through Extend Health	**Option #1 - Extend Health** Contact Extend Health to enroll for coverage at 1-888-598-7545 Complete the Retiree Benefit Enrollment and Change Form. Select Extend Health *with or without* PEBP Dental.
Option #2 Enroll in the CD PPO HDHP or HMO Coverage	**Option #2 - CD PPO HDHP or HMO Coverage** Complete the Retiree Benefit Enrollment and Change Form within 60 days of your retirement date.
Option #3 Enroll in Separate Plans Extend Health and either the CD PPO HDHP or an HMO plan	**Option #3 - Split Coverage** The individual with Medicare Parts A and B (either the primary insured or the spouse/domestic partner) enrolls for coverage through Extend Health by calling 888-598-7545. <u>Retiree with Medicare enrolls through Extend Health and non-Medicare dependent stays on the CD PPO HDHP or HMO Plan</u> ▪ Complete the Retiree Benefit Enrollment and Change Form by selecting Extend Health with or without PEBP Dental coverage. ▪ Contact the PEBP office to request the Unsubsidized Dependent Form to establish a separate PEBP account for dependent(s) and select CD PPO HDHP or HMO coverage. <u>Retiree *without* Medicare covering a Spouse/DP *with* Medicare</u> ▪ Spouse/DP enrolls through Extend Health. If selecting PEBP dental coverage, the spouse/DP contacts PEBP to request the Unsubsidized Dependent Form to establish a separate PEBP account. Otherwise, no form is required. ▪ Retiree completes the Retiree Benefit Enrollment and Change Form selecting CD PPO HDHP or HMO coverage.

Exchange Health Reimbursement Arrangement

For Medicare Retirees Enrolled in a Medical Plan Through Extend Health

Exchange Health Reimbursement Arrangements or Exchange-HRAs are PEBP-owned accounts established on behalf of PEBP retirees enrolled in a medical plan offered through Extend Health.

Retirees can use the Exchange-HRA for reimbursement of qualified health care expenses including premiums for Medicare coverage, on a tax-free basis. Exchange-HRAs may also be used for reimbursement of a spouse's qualified health care expenses.

Retirees receive a contribution to their Exchange-HRA based upon years of service. The monthly tax-exempt contribution for Plan Year 2013 is $10 per month per year of service beginning with five years ($50) to a maximum of twenty years of service ($200). Individuals who retired before January 1, 1994, will receive a flat $150 per month to the Exchange-HRA. Dependents do not receive their own Exchange HRA and no additional funds are contributed for dependents.

Exchange-HRA Plan Administrator

Extend Health is the Exchange-HRA plan administrator responsible for processing expense reimbursements for retirees.

Getting Reimbursed from your Exchange-HRA		
1. You pay premiums and expenses	**2. You submit out-of-pocket expenses**	**3. Extend Health Reimburses you**
You pay the full premiums directly to your insurance provider (ask Extend Health about the auto-reimbursement option for premiums). You also pay your provider any required out-of-pocket expenses.	You submit your claim to Extend Health for your premiums and out-of-pocket health care expenses.	Extend Health administers your account and will reimburse you from your Exchange-HRA if funds are available.

Establishing the Exchange-HRA

PEBP will automatically establish your Exchange-HRA once you have enrolled in a medical plan through Extend Health. Once established, you will receive the Extend Health-HRA kit with information on how to use the Exchange-HRA and claim forms.

Exchange Health Reimbursement Arrangement

Examples of Eligible Medical Expenses for Exchange-HRA Retirees

An eligible expense is defined as those expenses paid for care as described in Section 213 (d) of the Internal Revenue Code. Below are examples of eligible medical expenses that may be reimbursement through the Exchange-HRA.

For more detailed information, please refer to IRS Publication 502 title, "Medical and Dental Expenses," if tax advice is required, you should seek the services of a competent professional.

Other Important Points About the Exchange HRA

Deductible Medical Expenses

- Medical insurance premium
- Dental premium
- Pharmacy plan premium
- Ambulance
- Anesthetist
- Arch supports
- Artificial limbs
- Blood tests
- Blood transfusions
- Braces
- Cardiographs
- Chiropractor
- Contact Lenses
- Crutches
- Dental Treatment
- Dental X-rays
- Dentures
- Dermatologist
- Drugs (prescription)
- Eyeglasses
- Gynecologist
- Hearing aids
- Insulin treatment
- Lab tests
- Neurologist
- Ophthalmologist
- Optician
- Optometrist
- Oral surgery
- Orthopedic shoes
- Orthopedist
- Psychiatrist
- Psychoanalyst
- Psychologist
- Psychotherapy
- Radium Therapy
- Registered nurse
- Vaccines
- Wheelchair
- Osteopath
- Oxygen and oxygen equipment
- Physician
- Physiotherapist
- Podiatrist

Upon the death of the retiree, surviving dependents may access retiree HRA funds for claims incurred up to the date of death of the retiree. Reimbursement claims must be submitted within 6 months of the retiree's date of death.

Hometown Health Plan Northern Nevada HMO Plan	
Category	Member Responsibility
Deductible	No Deductible
Out-of-Pocket Maximum	$6,200 Individual $12,400 Family
Coinsurance • **Special Pharmaceuticals** • **Separate out-of-pocket maximum $2,000 Individual/$6,000 Family**	30% Coinsurance
Primary Care Visit	$25 Copayment
Specialist Visit	$45 Copayment
Urgent Care Visit	$50 Copayment
Emergency Room Visit	$300 Copayment Waived if admitted as an inpatient
Ambulance - Ground & Air	$150/$200 Copayment
Hospital Services (inpatient)	$1,500 Copayment per admission
Outpatient Surgery	$1,000 Copayment
Diagnostic Endoscopy	$150 Copayment
Chiropractic Visit • **$1,000 plan year maximum**	$45 Copayment
General Laboratory Services	No charge
Durable Medical Equipment • **$3,500 plan year maximum** • **Pre-authorization in excess of $250**	No charge
Mental Health Visit (outpatient)	$25 Copayment
X-ray & Diagnostic Services	
CT Scan, MRI & Nuclear Medicine	$250 Copayment per service
Pet Scan	$350 Copayment
All other X-rays: • **PCP or specialist** • **Hospital or outpatient**	 Included in office visit copay $75 Copayment
Diagnostic Mammogram	$45 Copayment

Hometown Health Plan
Northern Nevada HMO Plan

Category	Member Responsibility
Wellness Benefit	
Wellness visit, pap smear, PSA, colorectal screening & mammogram	No charge
Healthy Tracks Program Online tools to improve your health Includes: Health Risk Assessment, Biometric Screenings, preventive exams, healthy living programs, online seminars, quarterly wellness challenges, nutritional information and recipes/ grocery list	No charge
Health Management Services • Diabetes • Asthma • Quit Tobacco • Pulmonary Rehabilitation • Heart and Nutrition/Weight Management Programs	No charge
VSP Vision Plan	
Eye Exam every 12 months	$15 Copayment
Prescription Glasses	20% discount off doctor's U & C fee for prescription glasses when a complete pair is purchased
Contact Lenses	15% discount off contact lens fitting/evaluation fees
Laser Vision Care℠	Discounts & Preferred pricing for PRK and LASIK

HMO Prescription Benefits - Catalyst Rx 888-341-8574		
Category	**Retail - 30 Day Supply**	**Mail - 90 Day Supply**
Tier 1 - Formulary Generic Drug	$7 Copayment	$14 Copayment
Tier 2 - Formulary Brand Drug	$40 Copayment	$80 Copayment
Tier 3 - Non-Formulary Brand Drug	Greater of $75 or 40% coinsurance	Greater of $150 or 40% coinsurance
Special Pharmaceuticals	30% coinsurance/script	30% coinsurance/script
Diabetic Supplies	$7 Generic $40 Brand	$14 Generic $80 Brand
HTH Diabetic Sense Program 866-896-7303 Member must enroll in this program to receive benefits	No charge for glucose meter (Bayer HealthCare Ascensia & Roche Diagnostic Accu-Check), test strips, lancets, syringes and alcohol pads	

Hometown Health Plan

Northern Nevada HMO Plan

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

Important Plan Information

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

The following services require PCP referral and Hometown Health Plan authorization:

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

Prior Authorization required for the following:

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

Hometown Health Plan Option

Northern Nevada HMO Plan

Primary Care Physician (PCP)

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

My Hometown Benefits - personalized online access to information

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

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

Retail Prescription Drugs

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

Mail-Order Drug Program

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

VSP Vision Care for Life

Hometown Health utilizes VSP as the Vision Plan Administrator. For a summary of vision benefits available through Hometown Health Plan turn to page 30. For a listing of VSP providers, visit: www.hometownhealth.com.

Hometown Health Plan Option

Northern Nevada HMO Plan

Selecting and changing your Primary Care Physician (PCP)

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

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

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

HMO Reciprocity

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

Health Plan of Nevada (HPN) Southern Nevada HMO Plan	
Category	**Member Responsibility**
Deductible	No Deductible
Out-of-Pocket Maximum	$6,800 per person per calendar year
Primary Care Visit	$15 Copayment per visit
Specialist Visit	$15 Copayment per visit
Urgent Care Facility	$15 Copayment per visit
Emergency Services • Physician's Services • Emergency Room • Hospital Admission • Ground Ambulance	 • $25 Copayment per visit • $50 Copayment per visit • $200 per admission • No charge
Hospital Services—Elective Procedures	
Inpatient Hospital **Outpatient**	$200 Copayment per admission $50 Copayment per admission
Physician Surgical Services	
Inpatient Hospital **Outpatient** **Physician's Office (in addition to office visit copayment)** • Primary Care Physician • Specialist • Anesthesia	No charge No charge No charge $15 per visit No charge
Wellness Services	
Preventative Health Services	No charge
Retail Prescription Drug Benefit - Up to a 30 Day Therapeutic Supply	
Tier I: Preferred Generic Covered Drug Tier II: Preferred Brand Name Covered Drug* Tier III: No-Preferred Generic or Brand Name Covered Drug*	$7 Copayment $35 Copayment $55 Copayment
* If a Generic Covered Drug equivalent is available, Member pays the Tier I Drug copayment plus the difference between the eligible medical expenses of the Generic Drug and the medical expense of the Brand Name Covered Drug to the Plan Pharmacy for each Therapeutic supply. For more information regarding HPN's Prescription Drug benefit, contact HPN at 702-242-7300 or 800-777-1840.	
Mail Order Plan Pharmacy	
Preferred Maintenance Covered Drugs	The Member pays two (2) of the applicable copayments as outlined above for up to a 90-day Maintenance Supply for Preferred Maintenance Covered Drugs.

Health Plan of Nevada (HPN)
Southern Nevada HMO Plan

Vision Benefit

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

Health Plan of Nevada

Southern Nevada HMO Plan

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

Important Plan Information

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

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

Services Requiring Prior-Authorization

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

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

Vision - Eye Med Vision Care

Benefits are only available through participating providers who have agreed to provide services to Health Plan of Nevada members. For a complete list of providers, hours, and locations, contact EyeMed Vision Care at 877-226-1115. For a summary of vision benefits available through HPN, turn to page 35.

Health Plan of Nevada

Southern Nevada HMO Plan

HPN Pharmacy Benefits

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

Mail Order Pharmacy Program

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

Education and Wellness (HEW)

HPN's Health Education and Wellness (HEW) offers health education in a face-to-face setting and on the Internet. ***MyHEWOnline*** programs include: Diabetes, Heart Health, Pregnancy, Preventive Healthcare, Stop Smoking, and Weight Management.

Another feature of ***MyHEWOnline*** is the Health Risk Assessment (HRA). The HRA is your first step to better health. It is designed to help you identify your health and lifestyle profile. After completing the questionnaire, you will receive a personalized profile with recommendations to help improve your overall health. For more information about HPN's Health Education and Wellness visit HPN's website at www.stateofnvhpnbenefits.com

Health Plan of Nevada

Southern Nevada HMO Plan

We're At Your Service

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

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

HMO Reciprocity

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

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

- **Family Deductible: Could be met by any combination of eligible dental expenses of three or more members of the same family coverage tier**. No one single family member would be required to contribute more than the equivalent of the individual deductible toward the family deductible. Both in-network and out-of-network deductibles are combined to meet your deductible each plan year.

- **Under no circumstances will the combination of PPO and Non-PPO benefit payments exceed the plan year maximum benefit $1,000**

State Retirees Rates

Effective July 1, 2012 - June 30, 2013

State Retiree	Statewide PPO	Statewide HMO
	Consumer Driven PPO High Deductible Health Plan	Hometown Health Plan and Health Plan of Nevada
	Participant Premium	Participant Premium
Retiree only	227.28	307.03
Retiree + Spouse	557.49	734.45
Retiree + Child(ren)	329.08	492.89
Retiree + Family	662.41	920.32
Surviving/Unsubsidized Dependent	631.32	602.01
Surviving/Unsubsidized Spouse + Child(ren)	813.12	863.79

State Retiree with *Domestic Partner* Rates	Statewide PPO	Statewide HMO
	Consumer Driven PPO High Deductible Health Plan	Hometown Health Plan and Health Plan of Nevada
	Participant Premium	Participant Premium
Retiree + DP	557.49	734.45
Retiree + DP's Child(ren)	329.08	492.89
Retiree + Children of both	329.08	492.89
Retiree + DP + Retiree's Child(ren)	662.41	920.32
Retiree + DP + DP's Child(ren)	662.41	920.32
Retiree + DP + Children of both	662.41	920.32

Note: State retirees in the HMO in the "Retiree Only" coverage tier will not pay more than $525.10 per month.

To determine your final premium, turn to page 42.

Non-State Retiree Rates

Effective July 1, 2012 - June 30, 2013

Non-State Active Employee Rates	Statewide PPO	Statewide HMO
	Consumer Driven PPO High Deductible Health Plan	Hometown Health Plan and Health Plan of Nevada
	Participant Premium	Participant Premium
Employee Only	836.15	602.01
Employee + Spouse	1,630.63	1,204.02
Employee + Child(ren)	1,213.83	864.69
Employee + Family	2,008.31	1,466.70

Non-State Retiree Rates	Statewide PPO	Statewide HMO
	Consumer Driven PPO High Deductible Health Plan	Hometown Health Plan and Health Plan of Nevada
	Participant Premium	Participant Premium
Retiree only	836.15	602.01
Retiree + Spouse/DP	1,630.63	1,204.02
Retiree + Child(ren)	1,213.83	864.69
Retiree + Family	2,008.31	1,466.70
Surviving/Unsubsidized Dependent	836.15	602.01
Surviving/Unsubsidized Spouse/DP + Child(ren)	1,213.83	864.69

To determine your final premium, turn to page 42.

Retiree Years of Service Subsidy

Effective July 1, 2012 - June 30, 2013

State Retiree Subsidy

For Retiree's Enrolled in the PPO/HMO Plan

YOS	Subsidy
5	+354.48
6	+319.03
7	+283.58
8	+248.14
9	+212.69
10	+177.24
11	+141.79
12	+106.34
13	+70.90
14	+35.45
15 (Base)	-
16	-35.45
17	-70.90
18	-106.34
19	-141.79
20	-177.24

Non-State Retiree Subsidy

For Retiree's Enrolled in the PPO/HMO Plan

YOS	Subsidy
5	-118.16
6	-153.61
7	-189.06
8	-224.50
9	-259.95
10	-295.40
11	-330.85
12	-366.30
13	-401.74
14	-437.19
15 (Base)	-472.64
16	-508.09
17	-543.54
18	-578.98
19	-614.43
20	-649.88

- Participants who retired before January 1, 1994, subtract the 15 year (base) subsidy from the participant premium in the selected plan and tier.
- For participants who retired on or after January 1, 1994, add or subtract the appropriate subsidy above to or from the participant premium in the selected plan and tier. In no case will your premium be less than $0.
- 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.
- If you are a retiree (or survivor) enrolled in the PEBP CD PPO HDHP or HMO plan and pay for Medicare Part B, deduct $99.90 from your premium cost. For information about the Medicare Part B credit, turn to page 4.

Exchange-HRA Contribution and Optional Dental Coverage

Exchange-HRA Contribution for Medicare Retirees Enrolled in Extend Health	
Years of Service	**Contribution**
5	+50.00
6	+60.00
7	+70.00
8	+80.00
9	+90.00
10	+100.00
11	+110.00
12	+120.00
13	+130.00
14	+140.00
15 (Base)	+150.00
16	+160.00
17	+170.00
18	+180.00
19	+190.00
20	+200.00

- Extend Health participants who retired before January 1, 1994, receive the base 15 year Exchange-HRA contribution.
- Extend Health participants who retired on or after January 1, 1994, receive the Exchange-HRA contribution that corresponds to the number of years the retiree worked for a Nevada public entity.
- 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 an Exchange-HRA contribution.

Voluntary Dental Coverage Option for Medicare Retirees

Optional dental coverage for participants enrolled in an Extend Health Medical Plan

Voluntary Dental Coverage	State Retiree Rate	Non-State Retiree Rate
Retiree only	38.87	30.63
Retiree + Spouse/DP	77.73	61.27
Surviving/Unsubsidized Spouse/DP	38.87	30.63

Retirees and their spouses or domestic partners enrolled in a medical plan through the Extend Health Medicare Exchange have the option to purchase PEBP's dental coverage. To elect PEBP's dental coverage you will need to select Extend Health's medical coverage and PEBP's dental coverage when you enroll. If you are a PERS retiree, you may pay your monthly dental premium from your PERS pension benefit.

COBRA Rates
State and Non-State Retiree

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

* COBRA participants do not qualify for Life Insurance
* Participants on Regular COBRA do not receive a subsidy.

Retiree Group Basic Life Insurance
For All Plan Options

Description	**Benefit Features** All Eligible Participants
Retiree Basic Life Insurance	Retirees enrolled in a PEBP-sponsored medical plan receive $5,000 Basic Life. Refer to the Life Insurance Certificate at http://www.standard.com/mybenefits/nevada/life_add.html for more information about this benefit.
Beneficiary Financial Counseling	The beneficiary of a deceased retiree may be eligible to receive comprehensive and objective financial counseling through an arrangement with PricewaterhouseCoopers. Services include a beneficiary guide about settling an estate and other important topics, personal financial counseling, financial analysis, 12 months of unlimited toll-free telephone access to financial counselors, a financial web site and newsletter "Your Money, Your Future." See the Beneficiary Counseling Brochure at http://www.standard.com/mybenefits/nevada/life_add.html#ben for more information.
Medex Travel Assist	Medex Travel Assist is designed to respond to most medical care situations and many other emergencies you and your family experience when you travel 100 miles or more from your home. Medex provides a wide-ranging program 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 your home. Simply print out and carry the Medex Travel Assist Card available at http://www.standard.com/mybenefits/nevada/life_add.html#ben

Important for Owners of Group (Basic and/or Voluntary) Life Insurance, Long Term Care, and any other voluntary group policy you may have purchased during your active employment.

You may have the option to convert any voluntary life coverage, long-term care insurance and other voluntary products that you purchased during your active employment. Most companies require you to request a conversion within 31 days of the date you terminate (including retirement). If you currently own a voluntary product and would like to maintain your coverage, contact the voluntary product carrier directly for information regarding your conversion/portability rights. For contact information, turn to page 46.

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. Important! You must apply in writing and pay the first premium to us 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 http://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 http://www.standard.com/mybenefits/nevada/ or contact The Standard Insurance Company at 888-288-1270.

Voluntary Life Insurance
Long-Term Care Insurance

Voluntary Life Insurance

The State of Nevada provides a $5,000 Basic Life Insurance benefit 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 PERS check in most instances for retired participants.

You may also purchase Voluntary Life insurance at group rates. Voluntary Life amounts may be elected in a multiple of $5,000 to a maximum of $50,000 with a minimum of $5,000 of coverage.

Voluntary Life premiums are calculated based on the retiree's age as of each July 1. This means that regardless of the amount of insurance elected, retired participants will pay premiums based on their age and the amount of coverage elected.

In certain circumstances, you may be required to provide satisfactory proof of evidence of insurability.

Voluntary Long-Term Care Insurance Offered by UNUM Provident

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

For more information about Long-Term Care Insurance or to request an application, please call please call UNUM Provident at 800-227-4165.

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

Years of Service Certification Form (YOSC)

Step 1: Enter social security number, date of birth, gender, last name, first name, and retirement date.

Step 2: List your most recent Nevada public employer on the first line. Employer codes are located on the Employer Code list included in this guide. List each of your former Nevada public employers. *Note: If your former employer cannot be located on the list, write the employer's name without entering a code number.*

Step 3: Enter the years and months you worked for each Nevada public employer; do not round days up to the next month; do not round months up to the next year.

Example: employee worked for the City of Las Vegas from 03-26-82 (Mar 1982) to 03-17-87 (Mar 1987); this is equal to 4 years and 11 months of service.

Step 4: Enter any extra service credit that was purchased on your behalf. Note: do not list repayment of refunded contributions as purchased service credit.

Step 7: Sign and date the form.

Refer to the Years of Service Certification - Employer Code List beginning on page 49; identify your former Nevada public employer according to the following:

If you worked for various state agencies within the State of Nevada, enter the total years that you worked for all state agencies on one line.

Note: Various state agencies include employees who worked for a state department, division, board, commission, PERS, LCB, and classified employees working for the Nevada System of Higher Education (contributing to PERS). Enter the following code:

Code 9999 State

If you worked for the Nevada System of Higher Education as a faculty member (under contract) and you are retiring under the Retirement Plan Alternatives program (defined contribution retirement plan) such as TIAA-CREF, VALIC, or Fidelity Investments (non-PERS employee), enter the applicable code below:

9858 University of Nevada, Reno

9859 University of Nevada, Las Vegas

Note: The subsidy or contribution amount is determined using each full year of service credit (12 months) to a maximum of 20 years. Purchased service does not apply to the years of service subsidy or contribution allocation.

Years of Service Certification Form (YOSC)

Employer Code	Employer Name
State Agencies	
9999	Use this code if you worked for a state department, division, board, commission, PERS, LCB, or you are a PERS retiree from the Nevada System of Higher Education
9856	Legislator's Retirement System
9858	Nevada System of Higher Education - North (Non-PERS)
9859	Nevada System of Higher Education - South (Non-PERS)
Cities	
9713	Carson City
9712	City of Boulder
9790	City of Caliente
9785	City of Carlin
9714	City of Elko
9715	City of Ely
9716	City of Fallon
9819	City of Fernley
9860	City of Gabbs
9717	City of Henderson
9718	City of Las Vegas
9818	City of Lovelock
9786	City of Mesquite
9719	City of North Las Vegas
9720	City of Reno
9722	City of Sparks
9816	City of Wells
9724	City of West Wendover
9817	City of Winnemucca
9725	City of Yerington
Counties	
9711	Churchill County
9727	Clark County
9731	Douglas County
9733	Elko County

Years of Service Certification Form (YOSC)	
Employer Code	**Employer Name**
Counties	
9791	Esmeralda County
9737	Eureka County
9740	Humboldt County
9743	Lander County
9746	Lincoln County
9752	Lyon County
9809	Mineral County
9758	Nye County
9763	Pershing County
9771	Storey County
9779	Washoe County
9782	White Pine County
School Districts	
9704	Carson City School District
9709	Churchill County School District
9726	Clark County School District
9729	Douglas County School District
9732	Elko County School District
9735	Esmeralda County School District
9736	Eureka County School District
9739	Humboldt County School District
9742	Lander County School District
9744	Lincoln County School District
9751	Lyon County School District
9753	Mineral County School District
9759	Nye County School District
9761	Pershing County School District
9770	Storey County School District
9777	Washoe County School District
9781	White Pine County School District
Charter Schools	
9791	Esmeralda County
9737	Eureka County

Years of Service Certification Form (YOSC)	
Employer Code	**Employer Name**
Charter Schools	
9874	100 Academy of Excellence
9803	Academy for Career Education
9800	Andre Agassi College Preparatory Academy
9799	Bailey Charter Elementary School
9873	Carson Montessori School
9726	Clark County Team Academy, Clark County
9798	Coral Academy of Science Charter School
9801	Explore Knowledge Academy Charter School
9709	Gateways To Success Charter School, Churchill County
9870	Halima Academy
9804	High Desert Montessori School
9792	I Can Do Anything Charter High School
9875	Innovations Charter
9726	Keystone Academy Charter High School, Clark County
9802	Mariposa Academy of Language And Learning
9777	Nevada Leadership Academy, Washoe County
9872	Nevada State High School
9867	Odyssey Charter School
9876	Rainbow Dreams Academy
9868	Rainshadow Charter School
9871	Sierra Crest Academy
9796	Sierra Nevada Academy
9869	Silver State High School
9777	Team A Washoe Charter School, Washoe County
Police/Fire Protection	
9842	Austin Volunteer Fire Department
9839	Battle Mountain Volunteer Fire Dept.
9700	Central Lyon County Fire Protection District
9710	Churchill County Volunteer Fire Department
9721	City of Reno Firefighters
9723	City of Wells Volunteer Fire Department
9829	Elko Volunteer Fire Department

Years of Service Certification Form (YOSC)	
Employer Code	**Employer Name**
Police/Fire Protection	
9852	Grass Valley Volunteer Fire Department
9749	Las Vegas Metropolitan Police Dept.
9828	Lovelock Volunteer Fire Department
9755	No. Lake Tahoe Fire Protection District
9699	North Lyon County Fire Protection District
9835	Pershing Volunteer Fire Department
9893	Rye Patch Vol Fire Dpt
9885	Sierra Fire Prot Dist
9773	Tahoe-Douglas Fire Protection District
9840	Winnemucca Rural Volunteer Fire District
9783	Winnemucca Volunteer Fire Department
Hospitals/Clinics/Health Districts	
9702	Battle Mountain General Hospital
9705	Carson Tahoe Hospital
9728	Clark County Health District
9738	Grover C. Dils Medical Center
9741	Humboldt General Hospital
9789	Lyon Health Center
9754	Mount Grant General Hospital
9861	Nevada Rural Health Consortium
9760	Nye Regional Medical Center
9878	Pahrump Medical Center
9764	Pershing General Hospital
9775	University Medical Center of Southern Nevada
9780	Washoe County Hospital
9784	William Bee Ririe Hospital
Utilities/Planning Districts	
9815	Alamo Sewer & Water General Improvement District
9822	Beatty Water & Sanitation District
9703	Caliente Public Utilities
9850	Canyon General Improvement District
9820	Carson Water Sub. District

Years of Service Certification Form (YOSC)	
Employer Code	**Employer Name**
Utilities/Planning Districts	
9706	Carson-Truckee Water Conservancy Dist.
9707	CC Communications
9806	Clark County Water Reclamation District
9899	Clean Water Coalition
9730	Douglas County Sewer District
9879	Ely Water Dept
9882	Fernley Town Utilities
9838	Gardnerville-Ranchos General Improvement District
9853	Gerlach General Improvement District
9837	Indian Hills Improvement District
9841	Kingsbury General Improvement District
9813	Lander County Sewer & Water #2
9745	Lincoln County Power District
9788	Lovelock Meadows Water District
9845	McGill-Ruth Consolidated Sewer & Water General Improvement
9827	Minden-Gardnerville Sanitation Distriict
9880	Mineral County Power
9812	Moapa Valley Water District
9889	Northeast NV Develop
9811	Overton Power District #3
9844	Palomino Valley General Improvement District
9762	Pershing County Water Conservation District
9823	Redevelopment Authority of Sparks
9886	Regional Plan Washoe Co
9836	Regional Planning Agency of Washoe County
9765	Regional Transportation Commission
9884	Regional Water Planning
9768	Round Hill General Improvement
9894	RTC of Southern NV
9883	So Nevada Water Authority
9831	Stagecoach General Improvement
9772	Sun Valley General Improvement District
9887	Tahoe Regional Plan.
9825	Tahoe-Douglas District

Years of Service Certification Form (YOSC)	
Employer Code	**Employer Name**
Utilities/Planning Districts	
9881	Tonopah Utilities
9890	Tri-County Development Authority
9836	Truckee Meadows Regional Planning Agency
9848	Truckee Meadows Water Authority
9774	Truckee-Carson Irrigation District
9814	Virgin Valley Water District
9776	Walker River Irrigation District
9778	Washoe County Water Conservation District
Library District	
9862	Boulder City Library District
9849	Henderson District Public Libraries
9750	Las Vegas/Clark County Library District
Convention and Visitor Authorities	
9826	Elko Convention & Visitors Authority
9747	Las Vegas Convention/Visitors Authority
9767	Reno/Sparks Convention/Visitors Authority
9810	White Pine County Tourism & Recreation Board
Housing Authorities	
9748	Clark County Housing Authority
9748	Las Vegas Housing Authority
9833	Mineral County Housing Authority
9757	Nevada Rural Housing Authority
9748	North Las Vegas Housing Authority
9766	Reno Housing Authority
9748	Southern Nevada Regional Housing Authority
Judicial	
9713	Carson City JRS
9718	City of Las Vegas JRS
9720	City of Reno JRS
9722	City of Sparks JRS
9895	Commission on Judicial Discipline
9731	Douglas County JRS
9737	Eureka County JRS
9857	Judicial Retirement System (State)

Years of Service Certification Form (YOSC)	
Employer Code	**Employer Name**
Judicial	
9746	Lincoln County JRS
9752	Lyon County JRS
9701	Airport Authority of Washoe County
9898	Carson City Airport Authority
9846	Central Dispatch Administrative Authority
9832	Churchill Mosquito Abate District
9843	Conservation District of Southern Nevada
9834	East Fork Swimming Pool District
9888	Elko Area Recreation Comm
9866	Elko Co Schl Lunch Prog
9808	Elko County Agricultural Assoc.
9892	Lander Co Fair And Rec
Other	
9891	LV Housing-Force Acct
9830	Nevada Association of Counties
9863	Nevada Employment Security Department
9851	Nevada Tahoe Conservation District
9807	NEVADAWORKS
9713	RSVP
9877	Rural Bi-Co Delinq Prev
9854	Southern Nevada Workforce Investment Board (SNWIB)
9864	Wild Horse Preserv Comm

CD PPO HDHP Vendor Contact List

Medical, Dental and Pharmacy Contacts

CD PPO HDHP Medical and PPO Dental Claims Administrator • Claim status inquiries • 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
National Provider Network • For participants who reside in Nevada who access healthcare services outside of Nevada	**First Health Network** P.O. Box 91603 Lubbock, TX 79490-1603 Customer Service: 800-226-5116 www.myfirsthealth.com
National Provider Network • For participants who reside outside of Nevada who access healthcare services outside of Nevada	**GWH-CIGNA** 1000 Great-West Drive Kennett, MO 63857-3749 888-763-8232 www.myCignaforhealth.com
Dental PPO Network • Statewide dental PPO providers • Dental provider directory	**Diversified Dental Services** Northern Nevada: (866) 270-8326 Southern Nevada: (800) 249-3538
CD PPO HDHP Pharmacy Plan Administrator • Prescription drug information • Retail network pharmacies • Prior authorization • Non-network retail claims payment • Mail order service and mail order forms	**Retail Pharmacy Services** **Catalyst Rx** (800) 799-1012 (702)933-4521 (Las Vegas) **Walgreens Mail Order** (866) 845-3590 www.catalystrx.com User Name: nevada Password: benefit
APS Healthcare • Pre-certification • Case Management	**APS Healthcare** Pre-certification and Customer Service (888) 323-1461 www.apshealthcare.com
U.S. Preventive Medicine • Live Well, Be Well Prevention Plan • Diabetes Care Management • Obesity Care Management Program	**U.S. Preventive Medicine (USPM)** **The Prevention Plan** (877) 800-8144 www.ThePreventionPlan.com

HMO, Extend Health and Voluntary Products Vendor Contact List

Northern HMO Plan • Provider network • Provider directories • Appeals • Benefit Information • Additions/deletions of providers	**Hometown Health Plan** Customer Service: (775) 982-3232 or (800) 336-0123 http://stateofnv.hometownhealth.com or www.pebp.state.nv.us
Southern HMO Plan • 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 or www.pebp.state.nv.us
Extend Health • Medigap Supplement Plans • Medicare Advantage Plans • Prescription Drug Plans • Dental and Vision Plans	**Extend Health** Customer Service: (888) 598-7545 www.extendhealth.com/pebp
Life and AD&D 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 or www.pebp.state.nv.us
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	**Colonial Life UNUM** Customer Service: (877) 433-5334 www.pebp.state.nv.us
Home and Auto Insurance	**Liberty Mutual** Customer Service: (800) 637-7026 gary.bishop@libertymutual.com **Travelers'** Customer Service: (888) 695-4640 www.travelers.com/nevada

Public Employees' Benefits Program

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

PEBP and Medicare

901 S. Stewart St., Suite 1001
Carson City, NV 89701
(775) 684-7000 or (800) 326-5496
Fax: (775) 684-7028
Email: mservices@peb.state.nv.us

Table of Contents

Introduction

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). PEBP provides a variety of benefits to eligible retirees and dependents such as medical, dental, life insurance, and other voluntary insurance products.

Certain medical plan options and eligibility changes may occur at age 65 for retirees and dependents entitled to Medicare Parts A and B. This document will explain the various coverage options available to Medicare beneficiaries, including, when to enroll in Medicare and other required actions that may need to be completed by the retiree and/or dependent.

For additional information on the items listed below, visit www.pebp.state.nv.us.

- PEBP Master Plan Document
- NRS Chapter 287 and NAC Chapter 287
- Information about Extend Health (Medicare exchange)
- Voluntary product offerings
- Online access to your account information
- Frequently asked questions and answers
- Retiree enrollment guide
- Newsletters

Public Employees' Benefits Program (PEBP)

For questions regarding voluntary PEBP Dental coverage, eligibility or to request publications or enrollment forms, please call 775-684-7000 or 800-326-5496 or email mservices@peb.state.nv.us. Phone calls are confidential and Member Services staff is available 8:00 a.m. to 5:00 p.m. Pacific time, Monday through Friday, except holidays. To ensure you receive accurate and courteous service, telephone calls may be monitored.

Extend Health

For questions related to medical, dental, prescription drug, and vision plans offered through the Medicare exchange, please call Extend Health at 888-598-7545, or visit: **www.extendhealth.com/pebp**.

This publication is provided for informational purposes only. Any discrepancies in the content herein and NRS Chapter 287, NAC Chapter 287, the Social Security Administration, Medicare, and the PEBP Master Plan Document shall be superseded by PEBP's official documents and State and Federal law.

Medicare Part A

At age 65, PEBP requires retirees and covered spouses/domestic partners, and surviving spouses/domestic partners to enroll in *premium-free* Medicare Part A if deemed eligible by the Social Security Administration (SSA).

Most people age 65 or older who are citizens or permanent residents of the United States are eligible for *premium-free* Medicare hospital insurance (Part A). You are eligible at age 65 if:

- You receive or are eligible to receive Social Security benefits; or
- You receive or are eligible to receive railroad retirement benefits; or
- You or your spouse (living or deceased, including divorced spouses to whom you were married at least 10 years) worked long enough in a job where Medicare taxes were paid.

To determine your eligibility for *premium-free* Medicare Part A, contact the Social Security Administration approximately three months before your 65th birthday at 1-800-772-1213.

You Are Entitled to *Premium-Free* Medicare Part A

If you **are eligible** for *premium-free* Part A, PEBP will require you to enroll in Part A coverage approximately three months before your 65th birthday. You are also required to provide verification of your Part A coverage through the submission of a copy of the Part A card. If you are enrolling in a medical plan through Extend Health, your Medicare information may be obtained from Extend Health after you have completed your enrollment process in a Medicare Supplement or Medicare Advantage plan. However, if you are retaining CD PPO HDHP or HMO coverage because you are covering a non-Medicare dependent(s), you must submit a copy of your Part A card to PEBP.

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

If you are **not entitled** to *premium-free* Part A, PEBP will require a copy of the Part A denial letter issued by the Social Security Administration. Failure to provide the Part A denial letter may result in termination of your PEBP coverage, Exchange HRA contribution and/or $5,000 Basic Life Insurance (if eligible).

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

- For birthdays occurring on the first day of the month, the Part A card or denial letter must be received no later than the last day of the month the individual turns 65.
- For birthdays NOT occurring on the first day of the month, the Part A card or denial letter must be received no later than the last day of the month, following the 65th birthday month.
- For newly retiring employees, the Part A card or denial letter must be received within 60 days of the retirement coverage effective date.

Medicare Part B

Whether you are retired or getting ready to retire, at age 65 PEBP will require you to purchase Medicare Part B. Additionally, your covered spouse or domestic partner aged 65 or older will be required to purchase Part B coverage.

The Social Security Administration (SSA) offers a 7-month Initial Enrollment Period (IEP) for ***retired*** individuals turning age 65. The IEP begins 3 months before the 65th birthday, during the month of the 65th birthday, and 3 months after the 65th birthday.

Although the SSA offers this 7 month IEP, PEBP will require retired individuals to enroll in Part B by the last day of the 65th birthday month (for birthdays occurring between the second day and the last day of the month) or no later than the last day of the month preceding the 65th birthday (for birthdays occurring on the first day of the month).

Part B Eligibility

You can purchase Medicare Part B coverage at age 65 if you are a:

- U.S. citizen; or
- lawfully admitted non-citizen who has lived in the United States for at least five years.

To enroll in Medicare Part B coverage, contact the Social Security Administration approximately 3 months before your 65th birthday at 1-800-772-1213.

If you are a retiring active employee (or a dependent of a retiring active employee) aged 65 or older, you will also be required to enroll in Medicare Part B. Failure to enroll in Part B coverage may result in termination of coverage.

A copy of the Part B card must be submitted to the PEBP office as follows:

- For birthdays occurring on the first day of the month, the Part B card must be received no later than the last day of the month the individual turns 65.
- For birthdays NOT occurring on the first day of the month, the Part B card must be received no later than the last day of the month, following the 65th birthday month.
- For newly retiring employees, the Part B card must be received within 60 days of the retirement coverage effective date.

Note: Active employees and dependents of active employees aged 65 or older are not required to buy Part B until retirement.

Enrolling in Medicare Parts A and Part B

For Medicare purposes, individuals attain age 65 the day *before* their actual 65th birthday and Part A is effective on the first day of the month upon attainment of age 65. Therefore, if an individual's birthday occurs on the first day of the month, the earliest date Medicare can become effective is on the first day of the month *preceding* the individual's 65th birthday month.

Retiree (and covered dependent) 65th birthday is on the first day of the month:
Retirees and covered dependents whose birthday occurs on the first day of the month can apply for Medicare as early as three months before the month they turn 65 for coverage on the first of the month, preceding their 65th birthday. For example, Mr. Kim's 65th birthday is July 1. If he applies for Medicare Part A and B in March, April, or May, his coverage will start on June 1. If Mr. Kim waits until June 30th to apply for Medicare, his coverage will start July 1. In accordance with PEBP's Medicare enrollment provisions, the latest date Mr. Kim can apply for Medicare is June 30.

Retiree (and covered dependent) 65th birthday is NOT on the first day of the month:
Individuals with birthdays occurring between the second and last day of the month must apply for Medicare before the month they turn 65 for Medicare coverage effective the first day of the their 65th birthday month. The latest these individuals can apply (to comply with PEBP's Medicare provisions) is no later than the last day of their 65th birthday month for coverage effective the first day of the month following their 65th birthday. For example, Mr. Green's 65th birthday is July 20. If he applies for Medicare in April, May, or June, his coverage will start July 1. If he delays applying for Medicare until July 31, his coverage will start August 1, which is in compliance with PEBP's Medicare enrollment provisions.

Retiring Employee and Covered Dependent Aged 65+
The enrollment timeframe for newly retiring employees starts on the first day of the month following the employee's retirement date. (PEBP considers an employee retired on the first day of the month following the last day of the month in which he or she worked or was in paid status.) For example, if Mary works on November 14 and retires November 15, her retiree coverage would become effective December 1st. Mary can apply for Medicare any time between August and January 31st.

Extend Health Medicare Exchange
PEBP requires retirees (and their covered spouses/domestic partners) with Medicare Parts A and B to enroll for medical coverage through Extend Health (except when covering non-Medicare dependents). For enrollment timeframes, turn to pages 8-10.

Active Employee and Covered Dependent Aged 65+
PEBP does not require an active employee or an employee's dependent age 65 or older to enroll in Medicare until retirement. Employees enrolled in the PPO High Deductible Health Plan with a Health Savings Account (HSA) and who obtain Medicare can keep their HSA; however, per IRS provisions, Medicare individuals cannot contribute to a HSA. Upon notification of an employee's Medicare enrollment, PEBP will modify the employee's record to reflect a Health Reimbursement Arrangement (HRA).

Coverage Options for Medicare Retirees and Dependents

Generally, at age 65, retirees and covered spouses/domestic partners with Medicare Parts A and B, must enroll in a medical plan through Extend Health. The following describes the coverage options based on the Medicare status of a primary retiree and covered dependent (if any):

Retiree ages-in to Medicare Parts A and B (no covered dependents)

→ Retiree must enroll in medical coverage through Extend Health to receive the Exchange-Health Reimbursement Arrangement (Exchange-HRA), PEBP Dental coverage, and Basic Life Insurance benefits (if applicable).

Turn to page 6 for Required Action.

Retiree ages-in to Medicare Parts A and B and covers a dependent *without* Medicare.

→ Retiree may enroll in a medical plan through Extend Health and the non-Medicare spouse/domestic partner or child(ren) may stay on the CD PPO HDHP or HMO plan as an unsubsidized dependent(s). Refer to the unsubsidized rates for dependents shown on page 12; or

→ Retiree may stay on the CD PPO HDHP or HMO plan with the non-Medicare spouse/domestic partner (or child/ren) until spouse/domestic partner enrolls in Medicare. In the case of a dependent child, the retiree may stay on a PEBP plan until the child ceases to be an eligible dependent; or

→ Retiree may enroll in a medical plan through Extend Health and remove any covered dependents from his or her plan.

Turn to page 6 for Required Action.

Retiree *without* Medicare covers a dependent *with* Medicare Parts A and B

→ Medicare *dependent* may enroll in a medical plan through Extend Health. The non-Medicare retiree may stay on the CD PPO HDHP or HMO coverage; or

→ Both the retiree and the Medicare dependent may remain on the CD PPO HDHP or HMO coverage until both become eligible for Medicare Parts A and B. In the case of a child, the retiree may retain PEBP coverage until the child ceases to be an eligible dependent.

Turn to page 7 for Required Action.

Retiree is not entitled to premium-free Medicare Part A

→ Retiree may remain on the CD PPO HDHP or HMO plan, but must purchase Medicare Part B.

Turn to page 7 for Required Action.

Required Action

Retiree ages into Medicare Parts A and B (no covered dependents).

→ Retiree must enroll for medical coverage through Extend Health.

- Submit a copy of the Medicare Parts A and B card to the PEBP office by fax at 775-684-7028, through the mail, in person, or through the enrollment process with Extend Health.
- Contact Extend Health at 888-598-7545 to enroll in a medical, prescription drug, vision and/or dental plan.
- Complete the Retiree Benefit Enrollment and Change Form selecting Medicare Exchange *with or without* PEBP Dental.
- Submit the Retiree Benefit Enrollment and Change Form to the PEBP office within 60 days of the 65th birthday.

Turn to page 8 for enrollment timeframe.

Retiree ages into Medicare Parts A and B and covers a dependent *without* Medicare.

→ If the retiree elects to enroll in medical coverage through Extend Health and retain coverage for the non-Medicare dependent(s) on the CD PPO HDHP or HMO plan, do the following:

- Submit a copy of the Medicare Parts A and B card to the PEBP office by fax at 775-684-7028, through the mail, in person, or through enrollment through with Extend Health.
- Contact Extend Health at 888-598-7545 to enroll in a medical, prescription drug, vision and/or dental plan.
- Complete the Retiree Benefit Enrollment and Change Form selecting Medicare Exchange *with or without* PEBP Dental.

→ If the retiree wishes to continue coverage for the non-Medicare dependent(s) on the CD PPO HDHP or HMO plan, contact PEBP at 775-684-7000 or 800-326-5496 to request the Benefit Enrollment and Change Form for Unsubsidized Dependents. Note: Failure to submit this form to the PEBP office will result in termination of coverage for all dependent(s).

Turn to page 8 for enrollment timeframe.

Required Action, cont'd

Retiree *without* Medicare covers a dependent *with* Medicare Parts A and B

→ If the Medicare dependent wishes to enroll in a medical plan through Extend Health, do the following:

- Medicare dependent contacts Extend Health at 888-598-7545 to enroll in a medical, prescription drug, vision and/or dental plan; and
- If electing PEBP dental coverage, contact the PEBP office to request the Benefit Enrollment and Change Form for Unsubsidized Dependents; or
- If both the retiree and the Medicare dependent are staying on the CD PPO HDHP or HMO coverage, submit a copy of the dependent's Medicare Parts A and B card to the PEBP office by fax at 775-684-7028, by mail, or in person.

Retiree is not entitled to *premium-free* Medicare Part A

→ Retiree may remain on the CD PPO HDHP or HMO coverage with his or her dependent(s) if applicable.

- Retiree must purchase Medicare Part B; and
- Obtain a Part A denial letter from the Social Security Administration; and
- Submit copies of both documents to the PEBP office as follows:
  - For birthdays occurring on the first day of the month, the documents must be received no later than the last day of the month the individual turns 65.
  - For birthdays NOT occurring on the first day of the month, submit the documents no later than the last day of the month, following the 65th birthday month.
  - For newly retiring employees, submit the documents within 60 days of retirement coverage effective date.

Active employee's dependent ages-in to Medicare Parts A and B

→ If the Medicare dependent wishes to enroll in a medical plan through Extend Health, do the following:

- Medicare dependent contacts Extend Health at 888-598-7545 to enroll in a medical, prescription drug, vision and/or dental plan; and
- If electing PEBP dental coverage, contact the PEBP office to request the Benefit Enrollment and Change Form for Unsubsidized Dependents; and
- Employee completes the Benefit Enrollment and Change Form dropping the Medicare dependent for his or her coverage.

Retiree Ages into Medicare AFTER Retirement

Birthday Month If your birthday is on the first day of the month see below*	**1** **Medicare Parts A and B** Enroll in Medicare during one of the following months:	**2** **Extend Health and PEBP** Enroll in Extend Health no later than this month:	**3** **You complied with 1 and 2** Extend Health coverage must start no later than the first day of the following month:	**4** **You did not comply with 1 and 2** PEBP coverage terms no later than the last day of this month
January	Oct - Jan 31	Jan 31	Jan, Feb	Jan 31
February	Nov - Feb 28	Feb 28	Feb, Mar	Feb 28
March	Dec - Mar 31	Mar 31	Mar, Apr	Mar 31
April	Jan - Apr 30	Apr 30	Apr, May	Apr 30
May	Feb - May 31	May 31	May, Jun	May 31
June	Mar - Jun 30	Jun 30	Jun, Jul	Jun 30
July	Apr - Jul 31	Jul 31	Jul, Aug	Jul 31
August	May - Aug 31	Aug 31	Aug, Sept	Aug 31
September	Jun - Sep 30	Sep 30	Sept, Oct	Sep 30
October	Jul - Oct 31	Oct 31	Oct, Nov	Oct 31
November	Aug - Nov 30	Nov 30	Nov, Dec	Nov 30
December	Sep - Dec 31	Dec 31	Dec, Jan	Dec 31

- For Medicare purposes, individuals attain age 65 the day before their actual 65th birthday and Part A is effective on the first day of the month upon attainment of age 65. For an individual whose 65th birthday is on the first day of the month, Part A is effective on the
- first day of the month preceding their birth month. For example, if an individual's birthday is on December 1, Part A is effective on November 1 since for Medicare purposes, he or she attained age 65 on November 30. Therefore, for birthdays that occur on the first day of the month, use the preceding month on the table to determine your enrollment period with Medicare and Extend Health.

Dependent of Non-Medicare Retiree

Birthday Month If your birthday is on the first day of the month see below*	**1** **Medicare Parts A and B** Enroll in Medicare during one of the following months:	**2** **Extend Health and PEBP** Enroll in Extend Health no later than this month:	**3** **You complied with 1 and 2** Extend Health coverage must start no later than the first day of the following month:	**4** **You did not comply with 1 and 2** You cannot enroll through Extend health until the retiree ages-in or Open Enrollment
January	Oct - Jan 31	Jan 31	Jan, Feb	-
February	Nov - Feb 28	Feb 28	Feb, Mar	-
March	Dec - Mar 31	Mar 31	Mar, Apr	-
April	Jan - Apr 30	Apr 30	Apr, May	-
May	Feb - May 31	May 31	May, Jun	-
June	Mar - Jun 30	Jun 30	Jun, Jul	-
July	Apr - Jul 31	Jul 31	Jul, Aug	-
August	May - Aug 31	Aug 31	Aug, Sept	-
September	Jun - Sep 30	Sep 30	Sept, Oct	-
October	Jul - Oct 31	Oct 31	Oct, Nov	-
November	Aug - Nov 30	Nov 30	Nov, Dec	-
December	Sep - Dec 31	Dec 31	Dec, Jan	-

* For Medicare purposes, individuals attain age 65 the day before their actual 65th birthday and Part A is effective on the first day of the month upon attainment of age 65. For an individual whose 65th birthday is on the first day of the month, Part A is effective on the first day of the month preceding their birth month. For example, if an individual's birthday is on December 1, Part A is effective on November 1 since for Medicare purposes, he or she attained age 65 on November 30. Therefore, for birthdays that occur on the first day of the month, use the preceding month on the table to determine your enrollment period with Medicare and Extend Health.

Retiring Employee Ages into Medicare

Month of retirement	**1 Medicare Parts A and B**	**2 Extend Health and PEBP**	**3 You complied with 1 and 2**	**4 You did not comply with 1 and 2**
	Enroll in Medicare prior to or during one of these months:	Enroll in Extend Health no later than the following:	Extend Health coverage must start no later than the first day of the following:	PEBP coverage terms no later than the last day of the following:
January	Oct - Mar	Mar 31	Feb, Mar or Apr	Jan, Feb or Mar
February	Nov - Apr	Apr 30	Mar , Apr or May	Feb, Mar or Apr
March	Dec - May	May 31	Apr, May or Jun	Mar, Apr or May
April	Jan - Jun	Jun 30	May, Jun or Jul	Apr, May or Jun
May	Feb - Jul	Jul 31	Jun, Jul or Aug	May, Jun or Jul
June	Mar - Aug	Aug 31	Jul, Aug or Sept	Jun, Jul or Aug
July	Apr - Sept	Sept 30	Aug, Sept or Oct	Jul, Aug or Sept
August	May - Oct	Oct 31	Sept, Oct or Nov	Aug, Sept or Oct
September	Jun - Nov	Nov 30	Oct, Nov or Dec	Sept, Oct or Nov
October	Jul - Dec	Dec 31	Nov, Dec or Jan	Oct, Nov or Dec
November	Aug - Jan	Jan 31	Dec, Jan or Feb	Nov, Dec or Jan
December	Sep - Feb	Feb 28	Jan 1, Feb or Mar	Dec, Jan or Feb

The effective date of your retirement is the first day of the month after the month in which your last day work occurred or your last day in paid status.

Example: Employee retires November 15, retiree coverage becomes effective December 1. You must enroll in medical coverage through Extend Health no later than January 31 with an effective date of February 1.

Exchange-Health Reimbursement Arrangement (Exchange-HRA)

Retirees enrolled in a medical plan through Extend Health receive a monthly years of service contribution to an Exchange Health Reimbursement Arrangement (Exchange-HRA).

The monthly tax-exempt contribution is $10 per month, per year of service, beginning with five years ($50) to a maximum of twenty years of service ($200). Individuals who retired before January 1, 1994, receive a flat $150 per month. Note: Employees *hired* after January 1, 2010, who retire with fewer than 15 years of service do not qualify for the Exchange-HRA contribution.

Dependents and survivors do NOT qualify for the Exchange HRA.

The Exchange-HRA funds may be used for reimbursement of qualified health, dental, and pharmacy expenses, Medicare Part B premiums and qualifying out-of-pocket health care expenses for both retirees and their dependents as defined by IRS Publication 502 available at www.irs.gov.

Retiring employees aged 65 or older will receive HRA-Exchange funding concurrent with the medical plan effective date through Extend Health and after PEBP receives the retiree's Medicare information from Extend Health

PEBP Dental Plan Option

Retirees and covered spouses/domestic partners enrolled in a medical plan through Extend Health and who wish to enroll in the PEBP Dental Plan must complete the Retiree Benefit Enrollment and Change Form (or Benefit Enrollment and Change Form for Unsubsidized Dependents) selecting Medicare Exchange with PEBP Dental. The completed form must be received in the PEBP office on or before the medical plan effective date through Extend Health.

Voluntary Dental Coverage Option for Medicare Retirees Optional for Medicare retirees and covered spouses/domestic partners enrolled through Extend Health		
Voluntary Dental Coverage	**State Retiree Rate**	**Non-State Retiree Rate**
Retiree only	$38.87	$30.63
Retiree + Spouse/DP	$77.73	$61.27
Surviving/Unsubsidized Spouse/DP	$38.87	$30.63

Unsubsidized Rates State Retiree Dependents	**PPO Plan**	**HMO**
Child or Spouse/Domestic Partner	$631.32	$602.01
Children	$813.12	$863.79
Spouse/DP + Child(ren)	$813.12	$863.79

Unsubsidized Rates Non-State Retiree Dependents	**PPO Plan**	**HMO**
Child or Spouse/Domestic Partner	$836.15	$602.01
Children	$1,213.83	$864.69
Spouse/DP + Child(ren)	$1,213.83	$864.69

Contact Information

Public Employees' Benefits Program

901 South Stewart Street, Suite 1001
775-684-7000
800-326-5496 www.pebp.state.nv.us
mservices@peb.state.nv.us

Extend Health

888-598-7545
www.ExtendHealth.com/PEBP

Social Security Administration

800-772-1213
www.ssa.gov

Centers for Medicare and Medicaid Services

800-633-4223
www.cms.gov

D-4

NRS 287.0245 section 1 (d) -4

Plan Year 2013 Plan Design and Rates

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BRIAN SANDOVAL
Governor

JAMES R. WELLS, CPA
Executive Officer

LEO M. DROZDOFF, P.E.
Board Chairman

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 29, 2012

Item Number: VII

Title: Plan Year 2013 Plan Design and Rates

Summary

This report presents the proposed rates and participant contributions for the Plan Year 2013 (July 1, 2012 – June 30, 2013). The report discusses each of the following topics in association with the PY 2012 rates:

1. Plan Design Changes
2. Self Funded Claim and HMO Trend
3. Plan Reserves and Other Assumptions
4. Enrollment Assumptions
5. Rate Structure
6. State Subsidies
7. Domestic Partner Subsidization
8. Health Savings Account and Health Reimbursement Arrangement Contributions
9. Proposed Rates and Contributions

Report

Plan Design Changes

In December 2011 and January 2012, the Board approved several minor plan design changes effective July 1, 2012. These changes primarily deal with clarifications of the plan and management of high dollar claims. The plan design changes are summarized here.

A. No limit will be placed on the amount of funds in the Consumer Driven PPO High Deductible Health Plan (CD PPO HDHP) Health Reimbursement Arrangement (HRA) that can be carried over from one year to the next. The Board will review the liability associated with unused CD PPO HDHP HRA funds on an annual basis to determine whether a carryover limit should be imposed in the future.
B. No limit will be placed on the amount of funds in the Medicare Exchange HRA that can be carried over from one year to the next. The Board will review the liability associated with unused Medicare Exchange HRA funds on an annual basis to determine whether a carryover limit should be imposed in the future.
C. The full amount of contributions toward HSAs and CD PPO HDHP HRA accounts will be made on the first business day of the plan year.
D. CD PPO HDHP Plan members will be required to use a Center of Excellence hospital for organ and tissue transplants and bariatric surgeries. The Center of Excellence will be identified by PEBP's National PPO Network or PEBP's third party claims administrator.
E. The CD PPO HDHP Plan will allow for the payment of travel and hotel accommodations for the patient and one additional individual person (spouse/domestic partner, family member or friend) when associated with the use of a Center of Excellence for organ/tissue transplants and bariatric weight loss surgery, subject to the following limitations:
    1. Patient must be a covered PEBP CD PPO HDHP Plan member;
    2. Travel expenses will be covered only when the distance to a Center of Excellence is 100 miles or more from the participant's residence;
    3. Travel expenses must be preapproved by PEBP or PEBP's designee. Travel expenses not preapproved by PEBP or PEBP's designee will not be covered;
    4. Travel expenses will be covered when incurred in conjunction with the patients transplant surgery (does not include pre-surgery evaluations) or bariatric weight loss surgery (does not include pre-surgery evaluations) and for one year post transplant or bariatric weight loss surgery;
    5. The maximum benefit for travel and hotel accommodations will be based on the expected time the patient will spend at the Center of Excellence and the United States General Services Administration (GSA) per diem limits in effect at the time and for the place of the travel; and
    6. Travel meals are payable under the same rules in effect for employee of the agency.
F. The subrogation/third party liability provision in the PEBP Master Plan Document will be replaced in its entirety with updated industry standard language providing greater protection to the Plan.
G. The existing medical precertification requirements will be expanded to include participants seeking treatment for:
    1. Placement or replacement of a cardiac pacemaker,
    2. Illnesses requiring chemotherapy, and

3. Kidney dialysis (inpatient, outpatient and home dialysis).

H. The preventive dental benefits will not be charged against the individual annual maximum benefit.

I. The benefits and limitations for hearing aids are:
   1. **Maximum Benefit:** Continue to apply the PPO allowable rate or Usual and Customary rates to hearing aids and other related services such as fitting fees, molding and programming.
   2. **Frequency of Benefit:** Limit the payment of benefits for hearing aids to once every 5 years.
   3. **Replacement:** Replacement of a hearing aid(s) due to a change in the participant's/covered dependent's physical condition that makes the original device no longer functional would be eligible for benefits prior to the 5 year frequency limitation. The provider of service would need to provide documentation to PEBP's third party administrator that replacement prior to the 5 year frequency limitation is warranted.
   4. **Hearing loss requirement:** The current requirement that the participant/covered dependent present at least a 50% hearing loss in one ear will remain in force.
   5. **Coinsurance level:** The 50% coinsurance level would continue for in-network and out of network providers.
   6. **Annual Out of Pocket and Annual Deductible:** The 50% participant coinsurance will apply towards the individual or family annual out of pocket maximum subject to proof of payment by the participant.

J. Addition of an Obesity Care Management program for participants and dependents.

K. Addition of the eligibility of diabetic children to participate in the Diabetic Care Management program.

Self Funded Claim and HMO Trend

Aon Hewitt prepared self-funded claim cost estimates using the overall blended growth rates shown below. These trend numbers represent medical, prescription and dental inflation before plan design and utilization changes.

Group	Medical	Prescription	Dental	Blended
All	8.75%	8.75%	4.0%	8.4%

After accounting for plan and expected utilization changes, the self-funded trend is as follows:

Group	Medical	Prescription	Dental	Blended
State	1.9%	-20.2%	38.5%	0.6%
Non-State	32.0%	0.2%	18.0%	26.0%

Note: The large percentage increase in dental trend is due to the prior year's rates only including the preventive dental plan.

HMO medical and prescription trend is 5.6% for Hometown Health HMO for both State and Non-State groups. For Health Plan of Nevada, medical and prescription trend is 6.95% for State groups and 28.63% for Non-State groups. Overall statewide HMO trend is 18.0% for State groups and 32.0% for Non-State groups. This combined trend is higher than the individual trend components because the actual migration experienced in Plan Year 2012 (minimal migration to Hometown Health HMO and approximately 1,000 participants migrating to the lower cost Health Plan of Nevada HMO) did not occur. Instead, approximately 800 migrated out of lower cost Health Plan of Nevada HMO while approximately 700 migrated into higher cost Hometown Health HMO. Staff is not projecting any significant migration between plans for the upcoming Plan Year.

Plan Reserves and Other Assumptions

The proposed rates have been calculated to fund reserve levels as recommended by Aon Hewitt and adjusted for changes to claims costs due to plan design and enrollment changes:

Reserve	**June 30, 2013 Level**
Incurred but not Reported (IBNR)	37,923,000
Catastrophic	29,250,000

Staff estimates the Program will end Fiscal Year 2012 with approximately $108.3 million in Cash On Hand. The Cash On Hand is used to fund the unused Health Reimbursement Arrangement (HRA) balances, the estimated IBNR Liability and the Catastrophic Reserve. Any funds in excess of those reserves are to be returned to Plan Participants in future years.

Given the current spending rate, staff estimates there will be approximately $9.0 million in unused HRA funds at the end of the Fiscal Year. This number represents amounts contributed to CD PPO HDHP participants and Extend Health Medicare Exchange participants but not expended in Plan Year 2012. In its original budget, the balance of unused HRA funds was projected to be $2.1 million. Pursuant to Board approval in December 2011, the total amount of unused HRA funds can be rolled over from one year to the next allowing the entire $9.0 million to be expended by the participants in future years.

Aon Hewitt has estimated the IBNR to be $34.9 million and the Catastrophic Reserve to be $35.0 as of June 30, 2012. The reduction of the Catastrophic Reserve from $35.0 at June 30, 2012 to $29.3 at June 30, 2013 has already been built into the rates.

Subtracting the HRA, IBNR and Catastrophic Reserves from the projected Cash On Hand leaves approximately $29.4 million in "Excess Reserves". This is down from the $37.7

million "Excess Reserves" on a cash basis as of June 30, 2011 ($43.3 million on a fully accrued basis in the June 30, 2011 audited financial statements) and the $46.7 million projected in December 2011 but exceeds the original forecast of $17.6 million included in the PEBP budget approved by the Legislature.

The largest factor in the decrease from December's projections is the removal of the Early Retiree Reimbursement Program (ERRP) funds that were projected to be received in Fiscal Year 2012 ($12.5 million). PEBP has been informed that the US Department of Health & Human Services has exhausted the $5 Billion allotted for this program. While PEBP submitted a claim for $13.6 million in January, it is unlikely at this time that PEBP will receive funds from the ERRP. The remaining decrease indicates the volatility of making projections during the current plan year since it is the first year under the Consumer Driven High Deductible Health Plan.

The Rates also account for the following considerations:

- Supplemental Subsidies will not be provided for Plan Year 2013. As discussed with the Board in 2011, the new rate setting structure (discussed below) mitigates the need for supplemental subsidies. Depending on the rate components approved by the Board, the final rates are not anticipated to meet the criteria required for providing a supplemental subsidy of participant contributions being greater than one and a half times the blended medical trend as provided by the plan actuaries and exceeding $100. The most significant increases in rates are due to the projected versus actual variation in the blending of rates between Northern Nevada and Southern Nevada for the HMO plans.

- Live Well, Be Well Prevention Plan Premium Incentive – Based on current Live Well, Be Well Prevention Plan participation and historical experience provided by US Preventive Medicine, staff expects the premium incentive to cost approximately $2.0 million for Plan Year 2013. This cost has been allocated to CD PPO HDHP rates.

- HSA/HRA Contributions – State participants who cover children, on average, cover 1.67 children and will receive average HSA/HRA contributions of $1,034 (Participant Plus Child(ren)) and $1,234 (Participant Plus Family). Non-State participants who cover children, on average, cover 1.47 children and will receive average HSA/HRA contributions of $994 (Participant Plus Child(ren)) and $1,194 (Participant Plus Family). These average calculations exclude children beyond the three dependent maximum contribution cap.

- It was estimated last year that 90% of eligible CD PPO HDHP active employees would set up an HSA and contributions to the HSA were estimated at approximately $11.6 million. The actual number of eligible CD PPO HDHP active employees who established an HSA was 71% and contributions to HSAs

will be approximately $9.6 million for Plan Year 2012 including new hires enrolling during the year. Those employees on the CD PPO HDHP who do not set up an HSA will receive contributions to an HRA of approximately $3.8 million. Retirees on the CD PPO HDHP will receive HRA contributions of approximately $4.4 million. This difference in the selection of HSA versus HRA by employees accounts for part of the increase in the projected unused HRA funds noted earlier. Staff is not projecting a change in the number of HSA versus HRA enrollees for Plan Year 2013.

- The average years of service for State and non-State Medicare retirees are 16.25 and 17.08, respectively. Based on projected enrollment, HRA contributions to retirees participating in the Medicare Exchange are estimated to be approximately $9.8 million for State retirees and $9.3 million for non-State retirees. HRA contributions for Medicare retirees are in lieu of a subsidy and are expenses of the Retired Employee Group Insurance (REGI) account or the local government employer not the Program.

  The chart below shows the estimated total HSA/HRA contributions (in $ millions).

	PPO HSA	PPO HRA	Exchange HRA	Total
State Employee	$9.14	$3.14	$0.00	$12.28
State Retiree	$0.00	$2.44	$9.81	$12.25
Non-State Employee	$0.07	$0.03	$0.00	$0.10
Non-State Retiree	$0.00	$1.68	$9.28	$10.96
Total	$9.21	$7.29	$19.09	$35.59

- HRA Returns – In August 2010, Aon Hewitt estimated that 15% of all HRA contributions for CD PPO HDHP plan participants and 5% of all HRA funds for Medicare Exchange participants would be forfeited due to coverage termination, transfers from the CD PPO HDHP to the Exchange and deaths. These forfeitures, totaling approximately $2.05 million, are credited to the CD PPO HDHP plan.

- Employer Excess Subsidy – Pursuant to NRS 287.046(3), any employer subsidy that exceeds the actual cost of coverage must be credited to the Program. When the base rates are used, this calculation only generates a negligible amount. This amount has not been included in the rate calculations.

- Medicare Part B Premium Credit – The Medicare Part B base premium for retirees who do not deduct their premium from their Social Security check is currently $99.90. It is expected the Part B premium credit will cost approximately $1.08 million. This cost is distributed among all rates.

Enrollment Assumptions

Enrollment estimates are used to allocate expenses and revenues over each population. The following enrollment assumptions were made:

1. Average changes in all population groups are based upon the past 48 months.
2. No new non-State retiree enrollment (due to SB 544 (2007)).
3. Migration of an average of 55 non-State retirees per month to the Medicare Exchange based on the age of the participants.
4. No migration changes have been estimated between the HMO and CD PPO HDHP as rates and plan designs will not change significantly for the Plan Year 2013.
5. The actual enrollment in tiers with spouses declined by almost 3,000 due to eligibility restrictions imposed for spouses and domestic partners and plan design changes. No additional changes are projected for Plan Year 2013.
6. All Medicare retirees are transitioned to the Medicare Exchange with the following exceptions:
    a. All retirees with Medicare Part B only (237 State; 182 non-State) remain on the CD PPO HDHP or HMO plans;
    b. Approximately 5% of Medicare eligible retirees will remain on the CD PPO HDHP or HMO plans because they enroll non-Medicare dependents.

Average enrollment projected for PY 2013 is as follows:

	State	Non-State	Total
Active Employees	23,497	223	23,720
Non-Exchange Retirees	4,088	3,796	7,884
Exchange Retirees	5,034	4,526	9,560
Total Retirees	9,122	8,322	17,444
Total	32,619	8,545	41,164

Rate Structure

The Board approved changes to the rate structure effective for Plan Year 2012 (July 1, 2011). Under the current structure, rates increase when adding dependents using a factor of $X to represent the costs of an adult and $Y to represent the cost to cover children. The rates for each tier are set as follows:

- Participant Only = $X
- Participant Plus Spouse = $2X
- Participant Plus Child(ren) = $X + $Y
- Participant Plus Family = $2X + $Y

This results in larger rating pools that combine all adults and all children and spread variations in utilization more evenly among the tiers. An additional benefit is the

decrease in the likelihood a supplemental subsidy will be necessary because there should be fewer increases resulting from poor experience of individual tiers.

State Subsidies

In January 2012, the Board approved the following rating and subsidization policies as part of its annual review of the Board Duties, Policies and Procedures:

1. Rates for the Northern and Southern HMOs will be blended so there is a single statewide HMO rate.
2. Any variation in rate blending caused by a difference in the estimated HMO enrollment to the actual HMO enrollment in the current plan year will be added to or subtracted from HMO rates in the subsequent plan year.
3. The base subsidy percentage for the primary active employee in the CD PPO HDHP plan would be 91% (+/- 1.0%).
4. The base subsidy percentage for the primary retiree in the CD PPO HDHP plan would be 61% (+/- 1.0%).
5. Subsidy percentages for the primary insured in the HMO plans will be equal to the base subsidy percentages for the primary insured in the CD PPO HDHP plan less 15%.
6. Subsidy percentages for dependents will be equal to the subsidy percentages for the primary insured in each plan less 20%.

In Plan Year 2012, the base subsidy allocation was 92.8% for active employees and 63.8 for retirees. Due to lower than expected rate increases for Plan Year 2013 and higher than anticipated reserves, **staff recommends** increasing the subsidization rate to 93.0% for active employees on the CD PPO HDHP plan and 64.0% for retirees on the CD PPO HDHP plan.

The following chart shows the change in subsidization percentages for all members:

	Plan Year 2012		Plan Year 2013 Approved		Plan Year 2013 Recommended	
	PPO	HMO	PPO	HMO	PPO	HMO
Active Primary	92.8%	77.8%	91.0%	76.0%	93.0%	78.0%
Active Dependent	72.8%	57.8%	71.0%	56.0%	73.0%	58.0%
Retiree Primary	63.8%	48.8%	61.0%	46.0%	64.0%	49.0%
Retiree Dependent	43.8%	28.8%	41.0%	26.0%	44.0%	29.0%

Based on the current subsidization rates for Plan Year 2012, on a composite basis, the percentage of cost paid by the State was estimated to be 81.2% for active employees and 56.1% for State retirees. Using approved subsidization rates and projected enrollment for Plan Year 2013, the percentage of cost paid by the State subsidy is estimated to be 79.8% for active employees and 53.7% for retirees. Based on the recommended subsidization

rates, the percentage of cost paid by the State subsidy for Plan Year 2013 is estimated to be 81.8% for active employees and 56.7% for retirees.

Domestic Partner Subsidization

PEBP currently allows participants to cover their domestic partners and the children of those domestic partners but only provides subsidization to the participant. Due to available reserves, it is possible for the Board to approve providing the same level of subsidization to domestic partners as it provides to spouses. Because domestic partners are not tax dependents, it will not change the post-tax treatment of domestic partner payroll deductions.

There are 28 domestic partners currently enrolled in PEBP plans. It would have cost approximately $131,000 to subsidize those domestic partners in the same manner as spouses for Plan Year 2012. It will cost approximately $135,000 to subsidize existing domestic partners in the same manner as spouses in Plan Year 2013 using the base rate tables. It is likely however, additional domestic partners will join if the subsidy is increased. The average cost per domestic partner is $4,821 for Plan Year 2013.

Health Savings Account and Health Reimbursement Arrangement Contributions

PEBP currently contributes $700 to either a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) for each primary participant and $200 per eligible dependent to a maximum of three dependents.

Based on the projected enrollment in the CD PPO HDHP plan, the cost to provide an additional $100 per primary participant is approximately $1,975,000. The cost to provide an additional $50 per dependent is approximately $671,000.

Alternatively, the Board may decide to provide additional HSA/HRA contributions to participants based on specific participant criteria such as retirees only, participants over a certain age, participants with more than a set number of years of service (potentially including active employees with more than the set number of years of service), some combination of the criteria above or some different criteria.

Proposed Rates and Contributions

Attachment A provides comparisons of total rates, State subsidies and participant contributions in all tiers for the four scenarios listed below.

Scenario 1 (Base Rates) contains the rates, subsidies and contributions that would be required if the Board were to approve the base rates provided by the actuaries and the HMOs using Appendix A of the current Board Duties, Policies and Procedures. This scenario is provided to show the amount of expenditures projected by the actuaries,

HMOs and staff given the projected enrollment in the various plans under the current plan design. The total revenue resulting from multiplying these rates by the projected enrollment represents the amount needed to cover PEBP costs for Plan Year 2013 and to fully fund the IBNR liability as of June 30, 2013. The total revenue derived from multiplying these rates by the projected enrollment is $325.3 million and would maintain the $29.4 million in "Excess Reserves". The approval of rates by the Board that generate less total revenue than this amount will reduce the $29.4 million in "Excess Reserves" noted earlier.

If the Plan Year 2013 rates were set to be identical to the Plan Year 2012 rates, the amount of revenue generated would be $290.9 utilizing all of the "Excess Reserves" and $5.0 million from the Catastrophic Reserve. Further, the rates would continue subsidizing HMO participants based on the variance in blending created by actual versus projected enrollment.

The "Excess Reserves" will keep rates artificially low for Plan Year 2013. Without the "Excess Reserves", total rates would increase:

- Between 5.32% and 20.83% for State active employees;
- Between 3.61% and 18.84% for State non-Medicare retirees;
- Between 21.34% and 34.23% for non-State active employees; and
- Between 19.95% and 25.97% for non-State non-Medicare retirees.

Scenarios 2 through 4 keep the base rates provided by AonHewitt and the HMOs the same as those provided for Plan Year 2012. Setting Non-State base rates equal to Plan Year 2012 reduces "Excess Reserves" by $4.7 million. Setting State rates equal to Plan Year 2012 reduces "Excess Reserves" by $9.1 million. Setting both State and Non-State base rates equal to Plan Year 2012 reduces "Excess Reserves" by $13.8 million. Total Rates, especially the Non-State rates, are very likely to increase significantly in Plan Year 2014 if the "Excess Reserves" are completely reduced during Plan Year 2013. The rates would increase by the percentages above plus inflation and experience that will normally occur. The Board should consider this impact when setting rates for Plan Year 2013.

Scenario 2 contains rates using the base rates provided by AonHewitt and the HMOs for Plan Year 2012. Scenario 2 also includes revisions to the State subsidy percentage noted above (93% for active employee only; 64% for retiree only) and uses $14,498,000 in "Excess Reserves" (out of the $17,630,107 estimated to be available during the second year of the biennium as approved by the Legislature in PEBP's budget). The total revenue derived from Scenario 2 is $296.9 million, using all but $1.0 million of the "Excess Reserves".

Scenario 3 includes the Scenario 2 changes but decreases the subsidy percentage differential for HMO participants from 15% less than CD PPO HDHP Plan to 13% less than the CD PPO HDHP Plan. The total revenue derived from Scenario 3 is $296.9 million, using all but $1.0 million of the "Excess Reserves".

Scenario 4 is similar to Scenario 2 using the base rates provided by AonHewitt and the HMOs for Plan Year 2012 but only uses $8.5 million in "Excess Reserves". The total revenue derived from Scenario 4 is $302.9 million leaving $7.0 million in "Excess Reserves". Adding $300 for each primary HSA/HRA participant and $100 for each dependent would utilize all of the "Excess Reserves" as well as $266,000 from the Catastrophic Reserve.

The amount provided by State agencies for each employee increases from $644.81 in Fiscal Year 2012 to $733.64 in Fiscal Year 2013. There is also an increase in the base retiree contribution from $418.41 in Fiscal Year 2012 to $472.64 in Fiscal Year 2013. Any extra funds generated by these increases not used to pay the increase in State subsidies for Plan Year 2013 will be used to maintain the State subsidization percentages at 93% for active employees and 64% for retirees which will lessen the impact of rate increases to State participants in Plan Year 2014.

The total rate comparison (Attachment A page 1) reflects the change in the total monthly cost for each tier before any subsidy or participant share is applied.

The participant contribution (Attachment A page 3) is derived by subtracting the employer subsidy from the total rate. All retiree contributions are shown at the base subsidization rate (pre-1994 or 15 years of service if post-1994). Retiree contributions will vary depending upon each individual's years of service (See Attachment A page 4). Retirees who are enrolled in Medicare Part B on the PEBP CD PPO HDHP or HMO plan will receive a premium credit of $99.90 per month.

Non-state employee contribution comparisons are not shown because subsidization of employees is at the discretion of the individual employer.

The spreadsheets used to create the scenarios above utilize the following changeable components:

- Plan Year base rates (2012 or 2013) (amounts to cover claims for CD PPO HDHP or premium for HMO);
- The amount of "Excess Reserves" utilized to decrease rates and whether the decrease is for CD PPO HDHP only or both the CD PPO HDHP and HMO plans;
- The HMO blending adjustment for prior years based on actual enrollment which increases HMO rates and decreases CD PPO HDHP rates;
- HSA/HRA contributions;
- The base plan participant subsidization percentage;
- The percent differential from the base plan (CD PPO HDHP) to non-base plans (HMOs); and
- The percent differential from primary participant to dependents.

Staff recommends the Board provide direction to staff on the scenarios above to determine the final rate and subsidy structure. The Board can approve one of the three scenarios discussed earlier to reduce the "Excess Reserves" or create its own scenario by changing the different components listed above that drive the final rates. Staff will provide rates after the Board has determined the individual elements for its final approval.

Recommendations

1. Amend Appendix A of the Duties Policies and Procedures approved under Agenda Item VII at the January 13, 2011 Board Meeting by increasing the State base subsidy percentage for the primary insured in the base plan from:
    a. 91.0% to 93.0% for active employees; and
    b. 61.0% to 64.0% for retirees.
2. Provide direction to staff on providing subsidies to domestic partners in the same manner as provided to spouses.
3. Provide direction to staff on additional HSA/HRA contributions.
4. Provide direction to staff regarding any change to the State subsidy percentage differential for non-base plans in Appendix A of the Duties Policies and Procedures.
5. Provide direction to staff on usage of "Excess Reserves".
6. Approve the proposed rates for Plan Year 2013. In conformance with Federal rules, COBRA participants will be assessed 102% of the normal rates.

State of Nevada
Public Employees' Benefits Program

Plan Year 2013 Rates
Effective July 1, 2012

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Plan Year 2013 State Rates - Active Employees

State Active Employees	Statewide PPO				Statewide HMO			
	PPO Consumer Driven High Deductible Health Plan				Hometown Health Plan & Health Plan of Nevada			
	Rate	Base Subsidy	Supp Subsidy	Participant Premium	Rate	Base Subsidy	Supp Subsidy	Participant Premium
Employee Only	641.79	596.86	-	44.93	612.48	477.73	-	134.75
Employee + Spouse	1,241.92	1,034.96	-	206.96	1,224.96	832.97	-	391.99
Employee + Child(ren)	832.10	735.79	-	96.31	878.77	632.18	-	246.59
Employee + Family	1,432.21	1,173.87	-	258.34	1,491.25	987.42	-	503.83

-- State employees on Leave Without Pay, active Legislators and employees on Military leave do not receive a subsidy. Refer to the Rate column to determine the premium.

Plan Year 2013 State Rates - Retirees

State Retirees Non-Medicare	Statewide PPO				Statewide HMO			
	PPO Consumer Driven High Deductible Health Plan				Hometown Health Plan & Health Plan of Nevada			
	Rate	Base Subsidy	Supp Subsidy	Participant Premium	Rate	Base Subsidy	Supp Subsidy	Participant Premium
Retiree only	631.32	404.04	-	227.28	602.01	294.98	-	307.03
Retiree + Spouse	1,220.98	663.49	-	557.49	1,204.02	469.57	-	734.45
Retiree + Child(ren)	813.12	484.04	-	329.08	863.79	370.90	-	492.89
Retiree + Family	1,408.34	745.93	-	662.41	1,465.80	545.48	-	920.32
Surviving/Unsubsidized Dependent	631.32	-	-	631.32	602.01	-	-	602.01
Surviving/Unsubsidized Spouse + Child(ren)	813.12	-	-	813.12	863.79	-	-	863.79

-- The state retiree rates listed on this page 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 Plan Year 2013 State and Non-State Retiree Years of Service Subsidy table on page 8. Locate your years of service and add or subtract the corresponding subsidy to or from the participant premium. Do not add more than the base subsidy published above.
-- 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 by their last employer on or after January 1, 2012 do not receive a Years of Service Subsidy or Base Subsidy.
-- For those retirees on the PEBP PPO or HMO plan who are enrolled in Medicare Part B, subtract an additional $99.90 from the participant premium.

Plan Year 2013 Non-State Rates - Active Employees

Non-State Active Employees	Statewide PPO			Statewide HMO		
	PPO Consumer Driven High Deductible Health Plan			Hometown Health Plan & Health Plan of Nevada		
	Rate	Supp Subsidy	Participant Premium	Rate	Supp Subsidy	Participant Premium
Employee Only	846.62	-	846.62	623.98	-	623.98
Employee + Spouse/DP	1,651.57	-	1,651.57	1,247.96	-	1,247.96
Employee + Child(ren)	1,229.01	-	1,229.01	930.55	-	930.55
Employee + Family	2,033.96	-	2,033.96	1,554.53	-	1,554.53

-- Subsidies for non-state active employees are determined by the employer and are not published here.

Plan Year 2013 Non-State Rates - Retirees

Non-State Retirees Non-Medicare	Statewide PPO			Statewide HMO		
	PPO Consumer Driven High Deductible Health Plan			Hometown Health Plan & Health Plan of Nevada		
	Rate	Supp Subsidy	Participant Premium	Rate	Supp Subsidy	Participant Premium
Retiree only	836.15	-	836.15	602.01	-	602.01
Retiree + Spouse/DP	1,630.63	-	1,630.63	1,204.02	-	1,204.02
Retiree + Child(ren)	1,213.83	-	1,213.83	864.69	-	864.69
Retiree + Family	2,008.31	-	2,008.31	1,466.70	-	1,466.70
Surviving/Unsubsidized Dependent	836.15	-	836.15	602.01	-	602.01
Surviving/Unsubsidized Spouse/DP + Child(ren)	1,213.83	-	1,213.83	864.69	-	864.69

-- The non-state retiree rates listed above are unsubsidized rates.
-- For those who retired prior to January 1, 1994, subtract $472.64.
-- For those who retired on or after January 1, 1994, refer to the Plan Year 2013 State and Non-State Retiree Years of Service Subsidy table on page 8. Locate your years of service and subtract the corresponding subsidy from the participant premium.
-- 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 by their last employer on or after January 1, 2012 do not receive a Years of Service Subsidy or Base Subsidy.
-- For those retirees on the PEBP PPO or HMO plan who are enrolled in Medicare Part B, subtract an additional $99.90 from the participant premium.

Plan Year 2013 State Domestic Partner Rates - Active Employees

State Active Employees	Statewide PPO					
	PPO Consumer Driven High Deductible Health Plan					
	Rate	Base Subsidy	Taxable Subsidy	Participant Premium	Pre Tax Deduction	Post Tax Deduction
Employee + DP	1,241.92	596.86	438.10	206.96	44.93	162.03
Employee + DP's Child(ren)	832.10	596.86	138.93	96.31	44.93	51.38
Employee + Children of both	832.10	735.79	-	96.31	96.31	-
Employee + DP + EE's Child(ren)	1,432.21	735.79	438.08	258.34	96.31	162.04
Employee + DP + DP's Child(ren)	1,432.21	596.86	577.01	258.34	44.93	213.42
Employee + DP + Children of both	1,432.21	735.79	438.08	258.34	96.31	162.04

State Active Employees	Statewide HMO					
	Hometown Health Plan & Health Plan of Nevada					
	Rate	Base Subsidy	Taxable Subsidy	Participant Premium	Pre Tax Deduction	Post Tax Deduction
Employee + DP	1,224.96	477.73	355.24	391.99	134.75	257.24
Employee + DP's Child(ren)	878.77	477.73	154.45	246.59	134.75	111.84
Employee + Children of both	878.77	632.18	-	246.59	246.59	-
Employee + DP + EE's Child(ren)	1,491.25	632.18	355.24	503.83	246.59	257.24
Employee + DP + DP's Child(ren)	1,491.25	477.73	509.69	503.83	134.75	369.08
Employee + DP + Children of both	1,491.25	632.18	355.24	503.83	246.59	257.24

-- State employees on Leave Without Pay, active Legislators and employees on Military leave do not receive a subsidy. Refer to the Rate column to determine the premium.
-- Pursuant to the Board's decision on Agenda Item V of the November 5, 2009 Board meeting, participants with domestic partners will pay part of their premium through a pre-tax deduction and part of their premium through a post-tax deduction.

Plan Year 2013 State Domestic Partner Rates - Retirees

State Retirees Non-Medicare	Statewide PPO				Statewide HMO			
	PPO Consumer Driven High Deductible Health Plan				Hometown Health Plan & Health Plan of Nevada			
	Rate	Base Subsidy	Taxable Subsidy	Participant Premium	Rate	Base Subsidy	Taxable Subsidy	Participant Premium
Retiree + DP	1,220.98	404.04	259.45	557.49	1,204.02	294.98	174.59	734.45
Retiree + DP's Child(ren)	813.12	404.04	80.00	329.08	863.79	294.98	75.92	492.89
Retiree + Children of both	813.12	484.04	-	329.08	863.79	370.90	-	492.89
Retiree + DP + Ret's Child(ren)	1,408.34	484.04	261.89	662.41	1,465.80	370.90	174.58	920.32
Retiree + DP + DP's Child(ren)	1,408.34	404.04	341.89	662.41	1,465.80	294.98	250.50	920.32
Retiree + DP + Children of both	1,408.34	484.04	261.89	662.41	1,465.80	370.90	174.58	920.32

-- The state retiree rates listed on this page 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 Plan Year 2013 State and Non-State Retiree Years of Service Subsidy table on page 8. Locate your years of service and add or subtract the corresponding subsidy to or from the participant premium.
-- 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 by their last employer on or after January 1, 2012 do not receive a Years of Service Subsidy or Base Subsidy.
-- For those retirees on the PEBP PPO or HMO plan who are enrolled in Medicare Part B, subtract an additional $99.90 from the participant premium.

Plan Year 2013 State and Non-State Retiree Years of Service Subsidy

YOS	State	Non-State
5	+354.48	-118.16
6	+319.03	-153.61
7	+283.58	-189.06
8	+248.14	-224.50
9	+212.69	-259.95
10	+177.24	-295.40
11	+141.79	-330.85
12	+106.34	-366.30
13	+70.90	-401.74
14	+35.45	-437.19
15	-	-472.64
16	-35.45	-508.09
17	-70.90	-543.54
18	-106.34	-578.98
19	-141.79	-614.43
20	-177.24	-649.88

-- For participants who retired before January 1, 1994, subtract the 15 year (base) subsidy from the participant premium in the selected plan and tier.
-- For participants who retired on or after January 1, 1994, add or subtract the appropriate subsidy above to the participant premium in the selected plan and tier. Do not add more than the base subsidy in the selected plan and tier.
-- 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 by their last employer on or after January 1, 2012 do not receive a Years of Service Subsidy or Base Subsidy.

Plan Year 2013 Exchange Retiree HRA Contributions and Dental Rates

YOS	Contri bution
5	+50.00
6	+60.00
7	+70.00
8	+80.00
9	+90.00
10	+100.00
11	+110.00
12	+120.00
13	+130.00
14	+140.00
15	+150.00
16	+160.00
17	+170.00
18	+180.00
19	+190.00
20	+200.00

-- Exchange participants who retired before January 1, 1994 receive the base 15 year HRA contribution.
-- Exchange participants who retired on or after January 1, 1994, receive the HRA contribution that corresponds to the number of years the retiree worked for a Nevada public entity.
-- 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 an HRA contribution.
-- Those retirees who were hired by their last employer on or after January 1, 2012 do not receive an HRA contribution.

Voluntary Dental Coverage	State Rate	Non-State Rate
Retiree only	38.87	30.63
Retiree + Spouse/DP	77.73	61.27
Surviving/Unsubsidized Spouse/DP	38.87	30.63

Plan Year 2013 COBRA Rates

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

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

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Plan Year 2012 Communication Activities

Communication Activities

PEBP provided the following communications to participants in Plan Year 2012 (July 2011 – June 2012)

Date	Type	Description	Number of Participants
Jul 2011 – Jun 2012			
Jul 2011 – Jun 2012	Introduction to Employee Benefits	The *Introduction to Employee Benefits* guide is mailed to all new hire, rehire and reinstated employees. The guide contains detailed information on the following: • Medical plan options • Health Savings Account • Health Reimbursement Arrangement • Dental Insurance • Basic Life and Accidental Death & Dismemberment Insurance • Long-Term Disability • Eligibility • Premium rates and subsidy • Voluntary products • Initial COBRA Notice • HIPAA Privacy Notice • Enrollment form	Quantity mailed: 3,561

Date	Type	Description	Number of Participants
Jul 2011 – Jun 2012	Retiree Guide	The *Retiree Guide* is mailed to all retiring employees. The guide contains detailed information on the following: • Medical plan options • PPO Health Reimbursement Arrangement • Exchange Health Reimbursement Arrangement • Dental Insurance • Basic Life and Accidental Death & Dismemberment Insurance • Eligibility • Retiree premium rates and subsidy • Voluntary products • Initial COBRA Notice • Medicare Part D Notice • HIPAA Privacy Notice • Enrollment form • Years of Service Certification Form	580
Jul 2011 – Jun 2012	PEBP and Medicare Guide	The *Retiree Guide* is mailed to all retiring employees. The guide contains detailed information on the following: • PEBP Medicare enrollment requirements • Enrollment timeframe • Plan options	580
July 2011 - June 2012	Plan Year 2013Master Plan Document	Plan document containing: • Eligibility • PPO Plan medical benefit • PPO dental benefit • PPO Plan pharmacy • PPO vision benefit • Long-term Disability • Basic Life insurance • COBRA • Premium rates/subsidy for all plan options • Vendor contact information	PEBP website and hardcopy available by request

Date	Type	Description	Number of Participants
May 2012	Face-to-face Open Enrollment Meetings	• Las Vegas • Carson City • Reno • Winnemucca • Tonopah • Ely • Elko	6 sessions 6 sessions 6 sessions 2 sessions 2 sessions 2 sessions 2 sessions
May 2012	Recorded audio/visual Power Point presentations	• Open Enrollment • Maximize Your PPO Benefits • Maximize Your Benefits for Medicare Retirees • Navigating Changes to Your Benefits	PEBP website and hardcopy available by request
May 2012	Plan Document	Medical Dependent Care Flexible Spending Accounts	PEBP website and hardcopy available by request
May 2012	Plan Document	Medicare Exchange Plan Document	PEBP website and hardcopy available by request
Mar 2012	Frequently Asked Questions	Frequently asked questions and answers	PEBP website and hardcopy available by request
Apr 2012	Open Enrollment Guide	Informational guide containing plan changes for Plan Year 2012. The guides are available on the PEBP website and hardcopies through the mail by request. • Open Enrollment form • Medicare creditable coverage letter • Medical Plan options • Dental benefits • Contact information	PEBP website and hardcopy available by request
Apr 2012	Open Enrollment Letter	Open Enrollment letter to retirees enrolled in the Medicare exchange regarding dental option and premium rates	9,268

Date	Type	Description	Number of Participants
Apr 2012	Open Enrollment meeting schedule	Schedule of Open Enrollment meetings face-to-face meetings	PEBP website and hardcopy available by request
Apr 2012	Creditable Coverage letter	Notice of Creditable Coverage for prescription drug benefits available under the CDHP and HMO plans	33,261
Mar 2012	PEBP Customer Satisfaction Survey	Customer satisfaction survey to all HMO and PPO participants	24,000
Feb 2012	Winter newsletter	Newsletter describing expanded benefits for the PPO diabetes care and obesity care management programs and disease management program offered by the HMO plans; Board meeting information	8,143
Feb 2012	Customer Satisfaction survey/cover letter	Cover letter and customer satisfaction survey specific to members with diabetes whether or not they participated in the diabetes care management program	2,025
Jan 2012	Customer Satisfaction Survey and cover letter	Cover letter and member survey to Medicare retirees enrolled in the Medicare Exchange	9,065
Dec 2011	Postcard	Action required notice to earn premium incentive for participating in the wellness program	13,600
Dec 2011	Letter	Reinstatement notification to non-state retirees and survivors	4,334
Nov 2011	Postcard	Announcement to Medicare retirees regarding auto-reimbursement for PEBP dental	3,900
Nov 2011	Benefits flyer	Maximize Your Benefits seminar announcement to Medicare retirees	9,000
Nov 2011	Benefits flyer	Maximize Your Benefits seminar announcement to PPO participants	20,500
Nov 2011	Postcard to certain HSA account holders	Reminder notice to HSA account holders requesting identity verification by deadline	200
Oct 2011	Informational letter	Description of expanded diabetes benefits for eligible individuals diagnosed with diabetes	2,095

Date	Type	Description	Number of Participants
Oct 2011	Informational letter	Reminder to participants to complete registration, obtain blood test and complete health assessment questionnaire before the deadline	13,168
Oct 2011	Wellness program reminder letter	Reminder to participants to obtain their blood test and complete health assessment questionnaire before the deadline	5,418
Oct 2011	Wellness program reminder letter	Reminder to participants to obtain their blood test before the deadline	2,537
Oct 2011	Automated telephonic messages	Telephonic reminder messages to participants to enroll in the wellness program	21, 157
Oct 2011	Creditable Coverage letter	Notice of Creditable Coverage for prescription drug benefits available under the CDHP and HMO plans	32,000
Oct 2011	Medicare retiree Newsletter	Extend Health newsletter mailed to Medicare retirees	8,916
Oct 2011	Press release	Press release regarding wellness program incentive	Statewide email to active employees and PEBP website
Sept 2011	Default Coverage Letter	Notice to participants who failed to make an open enrollment election which resulted in default coverage	300
Aug 2011	Flyer	Flyer regarding available flu shot clinics for HMO and PPO participants	Statewide email to active employees and PEBP website
Apr 2011	Healthcare expense planning tools	• Fair consumer price look-up and cost estimator for various health care services, • Prescription drug pricing tool	PEBP website

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E.

NRS 287.0245 Section (2)

An independent biennial certified actuarial valuation and report of the State's health and welfare benefits for current and future state retirees, which are provided for the purpose of developing the annual required contribution pursuant to the statements issues by the Governmental Accounting Standards Board.

State of Nevada

Nevada Public Employees' Benefits Program's Retiree Health and Life Insurance Plans

Actuarial Report for GASB OPEB Valuation - Final

Valuation Date:	*July 1, 2010*
Fiscal Year Ending:	*June 30, 2011*
Date of Report:	*September 21, 2011*

AON Hewitt

September, 2011

This report contains the results of the Fiscal Year 2011 actuarial valuation of the State of Nevada Public Employees' Benefits Program's Retiree Health and Life Insurance Plans (the Plan). The accounting results are prepared in accordance with GASB Statement No. 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans* (GASB 43) and GASB Statement No. 45, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions* (GASB 45). The purposes of the accounting results are to:

- Develop the Annual Required Contribution (ARC) and the Annual OPEB Cost (AOC) for the fiscal year ending June 30, 2011.
- Provide information needed by the Plan's auditors for financial statement entries and footnote disclosures to conform to the disclosure requirements under GASB 43 and GASB 45.

This report is prepared for the sole use of the Nevada Public Employees' Benefits Program's (PEBP) and supplies information consistent with the stated purposes of the report. It may not be appropriate to use this report for other business applications.

Aon Hewitt is pleased to present this report, and we look forward to discussing it with you.

Respectfully submitted,

Deborah L. Donaldson, FSA, MAAA
Vice President
Aon Hewitt

Table of Contents

Executive Summary

GASB 43 and GASB 45 require government entities that sponsor Other Postemployment Benefits (OPEB) to account for these benefits on an accrual basis. PEBP adopted GASB 43 and GASB 45 for the fiscal year beginning July 1, 2007.

The benefits considered under this valuation were medical, prescription drug, dental, and life insurance coverage. PEBP provides these benefits to participating retirees, spouses, and survivors. In addition, participants on long-term disability and their spouses can qualify for retiree health insurance benefits. PEBP contributes a portion of the coverage. *Summary of Plan Provisions* section of this report provides the monthly participant contributions.

It is expected that approximately 90% of all of the active employees who retire directly from PEBP and meet the eligibility criteria, including receipt of a pension benefit provided by the Public Employees' Retirement System (PERS), the Legislative Retirement System (LRS), the Judges Retirement System (JRS), or the Retirement Plan Alternative Program (RPA), will participate in the PEBP Plan.

The table below summarizes the valuation results. Please see *Principal Valuation Results* and *Accounting Information* for additional details. The results have been calculated based upon the actuarial assumptions including, but not limited to, current claim cost, projected increases in health insurance costs, mortality, turnover, retirement, disability and discount rate. Please see *Valuation Methods and Assumptions* for details of the actuarial assumptions.

As of July 1, 2011, PEBP significantly changed the medical plan design for both current and future retirees. The pre-Medicare self-insured group now receives benefits under a High Deductible Health Plan arrangement with an accompanying Health Reimbursement Account (HRA). The Medicare eligible retirees now receive benefits through the individual market with PEBP subsidizing the cost by contributing to an HRA. For specific details of these plans, please see the *Plan Provisions* section. The plan design changes had a significant impact to reduce liabilities, please see the experience section of the report for details.

In addition to the plan design changes, Aon Hewitt reviewed all assumptions this year and recommended a number of assumption changes to align with the new plan design and updates to reflect current behavior patterns. Lastly, the valuation method was changed from Entry Age Normal to Projected Unit Credit.

This summary illustrates the OPEB value of benefits for Fiscal Year 2010 and 2011 based upon a 4% discount rate and the Projected Unit Cost Method.

	Fiscal Year 2010	Fiscal Year 2011
Present Value of Benefits (PVB)	$3,263,363,000	$1,768,710,000
Actuarial Accrued Liability (AAL)	$1,874,005,000	$977,045,000
Annual Required Contribution (ARC)	$220,709,000	$119,959,000
Annual OPEB Cost (AOC)	$213,537,000	$109,802,000

The balance of this report provides greater detail of the above results.

Actuarial Certification

This report presents the results of the actuarial valuation for the Nevada Public Employees' Benefits Program's Retiree Health and Life Insurance Plans for Fiscal Year 2011 for development of the Annual Required Contribution (ARC), Annual OPEB Cost (AOC), and other disclosure items under Governmental Accounting Standards Board (GASB) Statements No. 43 and No. 45. This report was prepared using generally accepted actuarial practices and methods. The actuarial assumptions used in the calculations are individually reasonable and reasonable in aggregate.

The employee data and financial and claims information used in this valuation were submitted to Aon Hewitt by the plan sponsor, or at the plan sponsor's direction. Aon Hewitt did not audit the employee data and financial information used in this valuation but did review it for reasonableness and consistency. On the basis of this review, we believe the information is sufficiently complete and reliable, and is appropriate for the purposes intended.

Actuarial computations under GASB 43 and 45 are for purposes of fulfilling Plan and PEBP accounting requirements, respectively. The calculations reported herein were made on a basis consistent with our understanding of these accounting standards. Determinations for purposes other than meeting Plan or PEBP financial accounting or disclosure requirements may be different from these results. As required by GASB 43 and 45, this valuation assumes the Plan will be an ongoing plan. However, this assumption does not imply any obligation by PEBP to continue the plan.

This report is intended for the sole use of the Nevada Public Employees' Benefits Program. It is intended only to supply information for the Nevada Public Employees' Benefits Program to comply with the stated purpose of the report and may not be appropriate for other business purposes. Reliance on information contained in this report by anyone for other than the intended purposes, puts the relying entity at risk of being misled because of confusion or failure to understand applicable assumptions, methodologies, or limitations of the report's conclusions. Accordingly, no person or entity, including the Nevada Public Employees' Benefits Program should base any representations or warranties in any business agreement on any statements or conclusions contained in this report without the written consent of Aon Hewitt.

The actuaries whose signatures appear below are Members of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. The actuaries are available to answer any questions with regard to the matters enumerated in this report.

Aon Hewitt's relationship with the Plan and the Plan Sponsor is strictly professional. There are no aspects of the relationship that may impair or appear to impair the objectivity of our work.

Justin M. Kindy, FSA, MAAA Vice President	Timothy N. Nimmer, FSA, MAAA Senior Vice President	Deborah L. Donaldson, FSA, MAAA Vice President
		
Date: 9/21/11	Date: 9/21/11	Date: 9/21/11

Principal Valuation Results

This section presents detailed valuation results for PEBP's retiree health and life insurance benefits program.

- The Present Value of Benefits (PVB) is the total present value of all expected future benefits, based upon certain actuarial assumptions. Benefits are defined as paid claims and expenses from the plan, net of retiree contributions. The PVB is a measure of total liability or obligation. It is the value (on the valuation date) of the benefits, as described in this report, for retirees, both currently retired and currently active. The plan's PVB is $1,768,710,000. Of this PVB, 70% is for the currently active employees (future retirees).
- The Actuarial Accrued Liability (AAL) is the liability or obligation for benefits earned through the valuation date, based on certain actuarial methods and assumptions. The Plan's AAL is $977,045,000.
- Normal Cost is the value of benefits expected to be earned during the year, again based on certain actuarial methods and assumptions. The fiscal year 2011 Normal Cost is $65,185,000.
- The Annual Required Contribution (ARC) of $119,959,000 is a combination of the Normal Cost and an amortization payment of the Unfunded AAL (UAAL), both with interest to the end of the Fiscal Year, June 30, 2011. The (UAAL) is equal to the AAL less assets. For the method change which resulted in a reduction in AAL, PEBP utilizes the minimum amortization period allowed by GASB 45 which is ten years. For all other purposes, PEBP utilizes the maximum amortization period allowed under GASB 45 which is 30 years.

AON Hewitt

Summary of Principle Valuation Results

State of Nevada Public Employees Benefit Plan (PEBP)

GASB 43/45 Valuation Results for Fiscal Year Ending June 30, 2011

As of July 1, 2010

Disount Rate = 4%

	7/1/2009	7/1/10 Pre Plan Chg	7/1/10 Post Plan Chg	7/1/10 Assumptions/ Method Change
Present Value of Benefits				
Retirees	$863,386,000	$1,075,605,000	$468,803,000	$493,453,000
Terminated Vesteds	25,022,000	34,670,000	981,000	34,639,000
Actives	2,374,955,000	2,496,046,000	959,774,000	1,240,618,000
Total	***$3,263,363,000***	***$3,606,321,000***	***$1,429,558,000***	***$1,768,710,000***
---$ change			***($2,176,763,000)***	***339,152,000***
---Total $ change				***($1,494,653,000)***
Actuarial Accrued Liability				
Retirees	$863,386,000	$1,075,605,000	$468,803,000	$493,453,000
Terminated Vesteds	25,022,000	34,670,000	981,000	34,639,000
Actives	985,597,000	1,124,250,000	420,549,000	448,953,000
Total	***$1,874,005,000***	***$2,234,525,000***	***$890,333,000***	***$977,045,000***
Assets	$24,209,000	$29,895,000	$29,895,000	$29,895,000
Unfunded AAL	**$1,849,796,000**	**$2,204,630,000**	**$860,438,000**	**$947,150,000**
---$ change			***($1,344,192,000)***	***$86,712,000***
---Total $ change				***($902,646,000)***
Annual Required Contribution				
Normal Cost	$113,736,000	$114,818,000	$43,441,000	$65,185,000
Amortization of UAL-30 Years	106,974,000	127,494,000	49,759,215	58,707,000
Amortization of UAL-10 Years	0	0	0	-3,933,000
Total ARC	***$220,710,000***	***$242,312,000***	***$93,200,215***	***$119,959,000***
---$ change			***($149,111,785)***	***$26,758,785***
---Total $ change				***($100,751,000)***
Expected Benefit Payments	**$46,104,000**	**$52,574,000**	**$42,721,000**	**$47,209,000**
Participants				
Actives	27,068	26,085	26,085	26,085
Terminated Vested	1,311	1,688	1,688	1,688
Retirees and disableds	8,211	8,569	4,036	4,036
Total	36,590	36,342	31,809	31,809

Experience

Overall, the plan experienced an $896,960,000 gain from the previous valuation. The components of this gain are shown below:

Expected AAL, 6/30/09		$1,874,005,000
Changes during Fiscal Year 2011 Due to:		
Benefit Accrual	$163,679,000	
Assumption/Method Changes	40,178,000	
Plan Changes	(1,297,658,000)	
Experience	196,841,000	
Total Change		($896,960,000)
Actuarial Accrued Liability (AAL), 7/1/10		$977,045,000

Of the $896,960,000 gain, $1,297,658,000 is due to plan changes. Of the $40,178,000 loss due to assumption changes, a $68,008,000 gain is associated with the change in funding method from the Entry Age Normal to the Projected Unit Credit Cost Method. The offsetting loss of $108,186,000 is primarily due to the assumption change for the number of Terminated Vesteds who would participate in the PEBP program upon reaching retirement eligibility. The assumption was changed from 25% to 50%. The experience loss of $196,841,000 represents experience changes such as demographic, turnover, retirement, claim, contribution and subsidy trend, and other experience which occurred differently than expected.

Accounting Information

This page illustrates the Annual OPEB Cost (AOC), Net OPEB Obligation (NOO), funding status, and required supplementary information for PEBP as of Fiscal Year 2010 and 2011 using a 4% discount rate. Note that the AOC and NOO are estimated based upon expected benefit payments.

Annual OPEB Cost (AOC)

Annual OPEB Cost (AOC)	Fiscal Year Ending June 30, 2010	Fiscal Year Ending June 30, 2011
Annual Required Contribuiton (ARC)	$220,709,000	$119,959,000
Interest on NOO	16,089,000	22,787,000
Adjustment to ARC	(23,261,000)	(32,944,000)
Total	$213,537,000	$109,802,000

Net OPEB Obligation (NOO)

Net OPEB Obligation (NOO)	Fiscal Year Ending June 30, 2010	Fiscal Year Ending June 30, 2011
Annual OPEB Cost (AOC)	$213,537,000	$109,802,000
Expected Benefit Payments	(46,104,000)	(47,209,000)
Additional Contributions	0	0
Increase in NOO	$167,433,000	$62,593,000
Estimated NOO – beginning of year	402,233,000	569,666,000
Estimated NOO – end of year	$569,666,000	$632,259,000

Schedule of Employer Contributions

Fiscal Year Ended	Annual OPEB Cost	Percentage of Annual OPEB Cost Contributed	Net OPEB Obligation
6/30/2009	$235,264,000	21.60%	$402,233,000
6/30/2010	$213,537,000	21.59%	$569,666,000
6/30/2011	$109,802,000	42.99%	$632,259,000

Funded Status

PEBP must show the funding status at the end of each year. The funded status as of June 30, 2010 and 2011 are shown below:

	June 30, 2010	June 30, 2011
Actuarial Accrued Liability (AAL)	$1,706,543,000	$1,071,800,000
Actuarial Value of Plan Assets	$29,895,000	TBD
Unfunded AAL (UAAL)	$1,676,648,000	TBD
Funded Ratio (Assets/AAL)	1.8%	TBD
Covered Payroll	$1,556,892,493	$1,398,962,830
UAAL as a % of Covered Payroll	107.7%	TBD
Normal Cost	$113,735,000	$65,185,000

Required Supplementary Information

A schedule of funding progress for the three years prior to the valuation date must be provided.

Actuarial Valuation Date	(a) Actuarial Value of Assets	(b) Actuarial Accrued Liability (AAL)	(b)-(a) Unfunded AAL (UAAL)	(a/b) Funded Ratio	(c) Covered Payroll	(b - a) / (c) UAAL as a Percentage of Covered Payroll
07/01/08	$25,665,000	$1,815,501,000	$1,789,836,000	1.4%	$1,488,847,000	120.2%
07/01/09	$24,209,000	$1,874,005,000	$1,849,796,000	1.3%	$1,556,892,000	118.8%
07/01/10	$29,895,000	$977,045,000	$947,150,000	3.1%	$1,398,963,000	67.7%

Demographic Information

The following pages illustrate the demographic information for the retiree health insurance plan.

Number of Lives		
	7/1/2009	7/1/2010
Actives	27,068	26,085
Inactives		
Terminated Vesteds	1,311	1,688
Retiree	8,206	8,075
Disabled	5	471
Total Inactives	9,522	10,234
Total	36,590	36,319

The following charts provide detailed active demographic characteristics of the data used to perform the July 1, 2010 valuation.

HPN Actives

	Completed Years of Service									
Age	0-4	5 - 9	10 - 14	15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40+	Total
15 - 19	7	-	-	-	-	-	-	-	-	7
20 - 24	127	8	-	-	-	-	-	-	-	135
25 - 29	347	86	6	-	-	-	-	-	-	439
30 - 34	317	160	40	1	-	-	-	-	-	518
35 - 39	311	187	109	31	7	-	-	-	-	645
40 - 44	254	191	139	66	29	5	-	-	-	684
45 - 49	195	157	123	72	45	19	1	-	-	612
50 - 54	163	147	126	83	57	14	5	-	-	595
55 - 59	120	135	115	82	52	21	3	1	-	529
60 - 64	71	99	50	55	21	15	2	-	-	313
65 - 69	15	26	22	15	8	1	-	-	-	87
70+	5	7	4	6	1	-	-	-	-	23
Total	1,932	1,203	734	411	220	75	11	1	0	4,587
Average Age	44.31			Average Service:		7.98				

AON Hewitt

Demographics (cont.)

HTH Actives

Age	Completed Years of Service									Total
	0-4	5 - 9	10 - 14	15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40+	
15 - 19	5	-	-	-	-	-	-	-	-	5
20 - 24	88	9	-	-	-	-	-	-	-	97
25 - 29	191	78	1	-	-	-	-	-	-	270
30 - 34	189	140	44	5	-	-	-	-	-	378
35 - 39	187	170	115	33	8	-	-	-	-	513
40 - 44	171	181	130	93	40	9	-	-	-	624
45 - 49	156	171	151	108	69	24	5	-	-	684
50 - 54	153	168	156	103	78	37	6	1	-	702
55 - 59	112	124	130	88	75	36	2	-	-	567
60 - 64	72	100	67	50	40	18	4	1	-	352
65 - 69	13	15	28	10	15	3	-	-	-	84
70+	1	2	7	1	3	2	1	1	-	18
Total	1,338	1,158	829	491	328	129	18	3	-	4,294

Average Age 46.3 Average Service: 9.72

HDHP Actives

Age	Completed Years of Service									Total
	0-4	5 - 9	10 - 14	15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40+	
15 - 19	32	-	-	-	-	-	-	-	-	32
20 - 24	513	19	-	-	-	-	-	-	-	532
25 - 29	1,101	243	7	-	-	-	-	-	-	1,351
30 - 34	1,054	473	143	8	-	-	-	-	-	1,678
35 - 39	952	533	360	116	21	1	-	-	-	1,983
40 - 44	771	545	412	264	145	30	-	1	-	2,168
45 - 49	828	582	484	306	255	110	6	-	-	2,571
50 - 54	666	536	465	367	263	123	32	-	1	2,453
55 - 59	515	490	453	366	256	145	40	5	-	2,270
60 - 64	313	359	282	257	158	54	34	9	4	1,470
65 - 69	84	104	82	92	58	22	23	12	10	487
70+	46	53	28	30	15	10	9	5	13	209
Total	6,875	3,937	2,716	1,806	1,171	495	144	32	28	17,204

Average Age: 46.05 Average Service: 8.94

The following chart provides demographic information on the inactive population used to value liabilities as of July 1, 2009 and July 1, 2010.

Inactives				
	7/1/2009		7/1/2010	
	Count	Average Age	Count	Average Age
Retirees & Survivors Under Age 65	3,970	59.1	3,211	59.6
Retirees & Survivors Age 65 and Older	4,236	73.6	4,887	73.7
Terminated Vesteds	1,311	54.9	1,688	56.5
Disableds	5	57.9	471	60.1
Total Inactive	9,522		10,257	

Summary of Plan Provisions

Plan

This valuation reflects plan design changes made as of July 1, 2011 since they were communicated to plan participants during fiscal year 2011.

Eligibility

For a retiree to participate in the PEBP program, the participant must be receiving a PERS, LRS, JRS, or RPA benefit. PERS eligibility requirements vary by employee group and benefit type.

Normal Retirement - Regular Employees
Minimum age of 65 with 5+ years of service
Minimum age of 60 with 10+ years of service
Minimum 30 years of service, regardless of age

Normal Retirement – Police & Fire
Minimum age 65 and 5+ years of service
Minimum age 55 and 10+ years of service
Minimum age 50 and 20+ years of service
Minimum 25 years of service, regardless of age

Disability Benefit
Minimum 5 years of service, regardless of age

Reduced Benefit
Minimum 5 years of service, regardless of age

For this valuation, Regular Employees were considered eligible for retirement at a minimum age of 50 with 5 years of service and Police & Fire Employees were considered eligible for retirement at a minimum age of 45 with 5 years of service

State Retiree Medical Expense Coverage Plan Features

The following plan features are effective as of July 1, 2011:

Non-Medicare Retirees

Plan Features	Self-Funded PPO Plan (In-Network)	Self-Funded PPO Plan (Out- Of-Network)	Hometown Health Plan (Northern HMO)	Health Plan of Nevada (Southern HMO)
Plan Deductible *(per calendar year)*			None	None
Individual*	$1,900	$1,900		
Family*	$3,800	$3,800		
Out-of-Pocket Maximum				$6,800 per person
Individual	$3,900	$10,600	$6,200	
Family	$7,800	$21,200	$12,400	
Lifetime Maximum *(per covered person)*	Unlimited		Unlimited	Unlimited
HRA Account Contributions			NA	NA
Individual	$700			
Family	$700 + $200/dependant (max 3)			
Physician Services *(except Mental Health/Alc/Drug)*	$75% after deductible	50% U&C after plan year deductible	$25 copay	$15 copay
Office Visits				
Routine Physical	100% no deductible	Not Covered	No charge	No charge
Routine OB/GYN Exam				
Well Child exams and immunizations				
Mammography/Pap Test				
Prostate Screening				
Specialist (office visits)	75% after deductible	50% U&C after plan year deductible	$45 copay	$15 copay
Diagnostic X-ray & Laboratory *(other than physician's office)*	75% PPO after plan year deductible	50% after deductible, U&C applies	CT, MRI, & Nuc. Med. -$250 Pet Scan - $350 Diagnostic Mammogram - $45 All other X-ray - $75 PCP or specialist – included in office visit copay	No charge
Ambulance	75% PPO after plan year deductible	75% U&C after plan year deductible	$150/$200 copay	$0

Plan Features	Self-Funded PPO Plan		Hometown Health Plan	Health Plan of Nevada
	(In-Network)	(Out- Of-Network)	(Northern HMO)	(Southern HMO)
Hospital Services	75% after deductible	50% U&C after deductible	$1,500 per admission	$200 copay per admission
Inpatient Coverage				
Outpatient Coverage	75% after deductible	50% U&C after plan year deductible	$1,000 copay per admit	$50 per admission
Emergency Room	75% after deductible U&C applies	75% after deductible U&C applies	$300 copay unless admitted	$50 copay; $25 physician copay
Physician In-Hospital Services	75% after plan year deductible	50% U&C after plan year deductible	No charge	No charge
Urgent Care Facility	75% after deductible	50% U&C after plan year deductible	$50 copay	$15 copay
Skilled Nursing Facility	75% after plan year deductible (60 days per plan year)	50% U&C after plan year deductible (60 days per plan year)	$1,500 copay (30 days per calendar year)	$200 per admission (100 days per calendar year)
Home Health Care	75% PPO after deductible	50% of U&C or 110% of the Medi Span AWP; after plan year deductible	$25/visit	-
Rehabilitation Services	75% PPO after plan year deductible (Occupational, physical, speech therapy)	50% U&C after plan year deductible (Occupational, physical, speech therapy)	Rehabilitation facility: $1,500 copay (30 days per calendar year)	-
Durable Medical Equipment	75% after plan year deductible	50% U&C after plan year deductible	No charge ($3,500 limit per calendar year.)	$100 or 50% of EME of purchase or rental, whichever is less
Corrective Appliances	Hearing aids: 50% after plan year deductible; all other corrective appliances: 75% after plan year deductible	Hearing aids: 50% after plan year deductible; all other corrective appliances: 50% after plan year deductible	-	-
Vision Care	One exam per rolling 12 months; 75% U&C.		$15 exam copay	$10 exam copay
	Hardware not covered		15%-20% discount on eye wear	$10 lens copay, $100 eye wear allowance

	(In-Network)	(Out- Of-Network)	(Northern HMO)	(Southern HMO)
Pre-certification	Required for genetic testing		N/A	N/A
Medical Claim Submission	Provider initiated	Member initiated	Provider initiated	Provider initiated
Prescription Drugs				
Retail	75% after deductible	75% after deductible on eligible prescriptions based on allowable in-Network cost	$7 Formulary generic	$7 Preferred generic
	Participant responsible for 100% of non-preferred non-generic brands		$40 Formulary Brand	$35 Preferred Brand
			Greater of $75 or 40%	$55 Non-preferred
Mail			$14 Formulary Generic	The Member pays two of the applicable copayments as outlined above for up to a 90-day Maintenance Supply for Preferred Maintenance Covered Drugs
	75% after deductible	75% after deductible on eligible prescriptions	$80 Formulary Brand	
	Participant responsible for 100% of non-preferred non-generic brands		Greater of $150 or 40%	

For the July 1, 2010 – June 30, 2011, plan year, the following provisions apply:

State Retiree Medical Expense Coverage Plan Features

The following plan features are effective July 1, 2010:

All Retirees

Plan Features	Self-Funded PPO Plan		Hometown Health Plan	Health Plan of Nevada
	(In-Network)	(Out- Of-Network)	(Northern HMO)	(Southern HMO)
Plan Deductible *(per calendar year)*			$250	$750
Individual*	$800	$800		
Family*	$1,600	$1,600		
Out-of-Pocket Maximum				$6,200 per person
Individual	$3,700	$10,000	$6,200	
Family	$7,400	$21,000	$12,400	
Lifetime Maximum *(per covered person)*	$2,000,000		$400,000 for transplant services	$1,000,000 for transplant services
Physician Services *(except Mental Health/Alc/Drug)*	$20 copay PCP/$30 copay specialist then 100%	50% U&C after plan year deductible	$25 copay	$15 copay
Office Visits				
Routine Physical	100% up to plan year maximum of $2,500, no ded.	Not Covered	$25 copay PCP/$45 specialist	$15 copay
Routine OB/GYN Exam				
Well Child exams and immunizations				
Mammography/Pap Test				
Prostate Screening				
Specialist (office visits)	$30 copay then 100%	50% U&C after plan year deductible	$45 copay	$15 copay
Diagnostic X-ray & Laboratory *(other than physician's office)*	80% after plan year deductible; 100% for pre-admission testing, no ded.	50% U&C after plan year deductible; 100% for pre-admission testing, no ded.	$0 copay	$0 copay
Ambulance	80% after plan year deductible	80% U&C after plan year deductible	$150/$200 copay	$0
Maternity	80% after plan year deductible	50% U&C after plan year deductible	$25 copay	$15 copay

Plan Features	Self-Funded PPO Plan		Hometown Health Plan	Health Plan of Nevada
	(In-Network)	(Out- Of-Network)	(Northern HMO)	(Southern HMO)
Hospital Services	$105 copay per admission; 80% after plan year deductible	$600 copay per admission; 50% U&C after plan year deductible	$1,500 per admit, subject to deductible	$200 per admission
Inpatient Coverage				
Outpatient Coverage	80% after plan year deductible	50% U&C after plan year deductible	$1,000 per admit and subject to deductible	$50 per admission
Emergency Room	$70 copay then 80% U&C after plan year deductible	$70 copay then 80% U&C after plan year deductible	$300 copay unless admitted and subject to deductible	$50 copay; $25 physician copay
Physician In-Hospital Services	80% after plan year deductible	50% U&C after plan year deductible	100%	100%
Urgent Care Facility	$45 copay then 100%	50% U&C after plan year deductible	$50 copay and subject to deductible	$15 copay
Skilled Nursing Facility	80% after plan year deductible (60 days per plan year)	50% U&C after plan year deductible (60 days per plan year)	$1500 copay per admit (30 days per calendar year) and subject to deductible	$200 per admission (100 days per calendar year)
Home Health Care	80% after plan year deductible (60 visits per plan year)	50% U&C after plan year deductible (60 visits per plan year)	$20/visit (Limited to $5,000 per calendar year)	-
Rehabilitation Services	80% after plan year deductible (Occupational, physical, speech therapy)	50% U&C after plan year deductible (Occupational, physical, speech therapy)	Rehabilitation facility: $150 per admission (30 days per calendar year) and subject to deductible	-
Durable Medical Equipment	80% after plan year deductible	50% U&C after plan year deductible	100% ($3,500 limit per calendar year.)	$100 or 50% of EME of purchase or rental, whichever is less
Corrective Appliances	Hearing aids: 50% after plan year deductible; all other corrective appliances: 80% after plan year deductible	Hearing aids: 50% after plan year deductible; all other corrective appliances: 80% after plan year deductible	100% ($3,500 limit per calendar year.)	-
Vision Care	One exam per rolling 12 months; 80% U&C.		$15 exam copay	$10 exam copay
	$125 hardware allowance per rolling 2-year period.		15%-20% discount on eye wear	$10 lens copay, $100 eye wear allowance

Plan Features	Self-Funded PPO Plan		Hometown Health Plan	Health Plan of Nevada
	(In-Network)	(Out- Of-Network)	(Northern HMO)	(Southern HMO)
Pre-certification	Required for genetic testing		N/A	N/A
Medical Claim Submission	Provider initiated	Member initiated	Provider initiated	Provider initiated
Prescription Drugs	$50 annual deductible			
Retail	$5 Generic (no deductible)		$7 Formulary generic	$7 Formulary generic
	$40 Preferred brand		$40 Formulary Brand	$35 Formulary Brand
	100% Copay Non-preferred brand		Greater of $70 Non-formulary or 40%	$55 Non-formulary
Mail	$15 Generic (no deductible)		$14 Formulary Generic	$14 Formulary generic
	$120 Preferred brand		$80 Formulary Brand	$70 Formulary Brand
	100% Copay Non-preferred brand		Greater of $150 or 40% Non-Formulary	N/A

For Medicare retirees, the standard coordination of Benefits applies.

Medicare Eligible retirees will participate in the individual market. PEBP will contribute to a Health Reimbursement Arrangement Plan (Exchange HRA Plan).

HRA Benefit

The following monthly amount with be credited on behalf of Medicare Eligible Retirees

(1) For those who retired prior to January 1, 1994, the dollar amount is equal to $150.

(2) For those who retired on or after January 1, 1994, the dollar amount is equal to the base amount ($10) multiplied by the years of service credit up to a maximum of 20 years of service.

State Retiree Dental Expense Plan Features

Funding

PEBP shall credit Exchange HRA Accounts of Eligible Retirees with Benefit Credits on the first business day of each calendar month.

Plan Features	Dental PPO Plan	
	(In-Network)	(Out-of-Network)
Annual Deductible Individual	$100	$100
Family	$300	$300
Annual Maximum	$1,000	$1,000
Preventive Services	100%; No deductible	80% U&C; No deductible
Basic Services	75% after deductible	50% U&C after deductible
Major Services	50% after deductible	50% U&C after deductible

State Retiree Life Insurance Plan Features

The following plan features are effective July 1, 2011.

If you participate in a PEBP medical plan, your benefits include $5,000 life insurance.

State Retire Life Insurance Plan Contributions

Retirees contribute $6.24 per month for retiree life insurance/ADD coverage. This contribution is included in the monthly medical premium

State Retiree Medical Expense Coverage Plan Retiree Contributions

The following retiree contributions are effective July 1, 2011.

FY 2012 Coverage	State Non-Medicare Retirees and Survivor Rates (Based on 15 Years of Service)	
	Self-Funded PPO HDHP	Hometown Health Plan & Health Plan of Nevada
Retiree	$220.70	$268.85
Retiree + Spouse	$539.93	$642.72
Surviving Spouse	$609.68	$525.10

FY 2012 Coverage	Non-State Non-Medicare Retiree and Survivor Rates	
	Self-Funded PPO HDHP	Hometown Health Plan & Health Plan of Nevada
Retiree	$750.65	$495.37
Retiree + Spouse/DP	$1,459.63	$990.74
Surviving Spouse/DP	$750.65	$495.37

State Retiree Medical Expense Coverage Plan Retiree Contributions (cont)

FY 2012 Coverage	Voluntary Dental Insurance Rates for Medicare Exchange Retirees	
	State Retiree Rate	Non-State Retiree Rate
Retiree	$33.09	$29.27
Retiree + Spouse/DP	$66.17	$58.54
Surviving Spouse/DP	$33.09	$29.27

HRA Contribution for Retirees Enrolled in an Extend Health Plan	
Years of Service	Contribution
5	$50
6	$60
7	$70
8	$80
9	$90
10	$100
11	$110
12	$120
13	$130
14	$140
15 (Base)	$150
16	$160
17	$170
18	$180
19	$190
20+	$200

Summary of Plan Provisions (cont.)

State Retiree Medical Expense Coverage Plan Retiree Subsidy

Years of Service	7/1/2010	7/1/2011
5	+$258.23	+313.81
6	+232.40	+282.43
7	+206.58	+251.05
8	+180.76	+219.67
9	+154.94	+188.28
10	+129.11	+156.90
11	+103.29	+125.52
12	+77.47	+94.14
13	+51.65	+62.76
14	+25.82	+31.38
15	$0.00	$0.00
16	-$25.82	-31.38
17	-51.65	-62.76
18	-77.47	-94.14
19	-103.29	-125.52
20	-129.11	-156.90

Non-State Retiree Medical Expense Coverage Plan Retiree Subsidy

Years of Service	7/1/2010	7/1/2011
5	-86.08	-104.60
6	-111.90	-135.98
7	-137.72	-167.36
8	-163.54	-198.74
9	-189.37	-230.13
10	-215.19	-261.51
11	-241.01	-292.89
12	-266.83	-324.27
13	-292.66	-355.65
14	-318.48	-387.03
15	-344.30	-418.41
16	-370.12	-449.79
17	-395.95	-481.17
18	-421.77	-512.55
19	-447.59	-543.93
20	-473.41	-573.31

Valuation Methods and Assumptions

Actuarial Cost Method: Projected Unit Cost Method

Valuation Date: Data was provided June 30, 2011. The liabilities are calculated as of June 30, 2011 and discounted back to July 1, 2010

Funding Method: Projected Unit Credit

Discount Rate: 4%

Trends:

Year	Medical/ Subsidy/ HMOs	Rx
7/1/2010	9.75%	11.0%
7/1/2011	9.5%	10.0%
7/1/2012	9.0%	9.0%
7/1/2013	8.5%	8.5%
7/1/2014	8.0%	8.0%
7/1/2015	7.5%	7.5%
7/1/2016	7.0%	7.0%
7/1/2017	6.5%	6.5%
7/1/2018	6.0%	6.0%
7/1/2019	5.5%	5.5%
7/1/2020 and beyond	5.0%	5.0%

HRA Account:	0.0%
Dental:	4.5%
Administrative:	3.0%

Mortality:

Healthy Lives

Regular Employees

RP-2000 Combined Health Table, set forward one year for females

Police & Fire

RP-2000 combined Healthy Table, set forward one year

Disabled Members

Regular Employees

Males: RP-2000 Disabled Retiree Table, set back three years

Females: RP-2000 Disabled Retiree Table, set forward eight years

Police & Fire

Males: RP-2000 Combined Healthy Table, set forward ten years

Females: RP-2000 Disabled Retiree Table, set forward eight years

Retirement Retirement rates vary by employee group and are shown below.

Rates:

Regular Employees				
Years of Service				
Age	**5-19**	**20-24**	**25-29**	**30 or more**
45-49	0%	1%	8%	0%
50-54	2%	2%	10%	25%
55-59	4%	7%	15%	30%
60-61	13%	20%	25%	30%
62-64	15%	20%	25%	30%
65-69	22%	25%	30%	30%
70 & Older	100%	100%	100%	100%

Police & Fire					
Years of Service					
Age	**5-9**	**10-19**	**20-24**	**25-29**	**30 or more**
40-44	0%	1%	1%	0%	0%
45-49	0%	1%	3%	15%	15%
50-54	1%	5%	12%	15%	25%
55-59	5%	12%	20%	25%	35%
60-64	10%	20%	25%	25%	35%
65 & Older	100%	100%	100%	100%	100%

Withdrawal Rates: Withdrawal rates vary by employee group and are shown below.

Regular Employees	
Years of Service	**Rate**
0	18.25%
1	13.00%
2	9.80%
3	7.75%
4	6.50%
5	6.00%
6	5.00%
7	4.65%
8	3.90%
9	3.70%
10	3.30%
11 or more	2.00%

Police & Fire	
Years of Service	**Rate**
0	13.00%
1	6.50%
2	5.50%
3	4.00%
4	3.90%
5	3.75%
6 or more	2.00%

Disability Rates: Disability rates vary by employee group and are shown below.

Age	Regular Employees	Police & Fire
22	0.01%	0.05%
27	0.02%	0.05%
32	0.06%	0.06%
37	0.09%	0.09%
42	0.18%	0.37%
47	0.31%	0.53%
52	0.50%	0.66%
57	0.69%	0.60%
62	0.50%	0.60%

PERS Assumptions: The mortality, retirement, withdrawal and disability are the same as those used for the June 30, 2010 actuarial valuation for the Public Employees Retirement system (PERS) for the State of Nevada.

Participation Rate: 90% of current eligible actives and 50% of current terminated vested employees will elect retiree plan coverage. In addition, 50% of actives decrement to withdrawal from the plan with at least five years of service will elect retiree medical and dental coverage.

Spouse Coverage: 30% of active males and 15% of active females will elect retiree spouse coverage. This assumption was determined using PEBP census. Actual spousal data was used for the current retirees.

Age Difference: Male participants are assumed to be four years older than spouses: female participants are assumed to be two years younger than spouses.

Employees Covered: *Medical, Dental, Rx:* All actives, terminated vesteds, current retirees and survivors electing healthcare coverage;
Life Insurance: All active employees and current retirees that elected healthcare coverage. Reinstated retirees and survivors are not eligible to receive the life insurance benefit

Non-State Employees: Non-State employees with State service credit of 5 years or more were valued assuming a pro rata distribution of the state subsidy adjustment.

Medical Plans:

Pre-Medicare Retirees: For retirees with younger spouses, retirees and spouses will move to the exchange once the spouse becomes Medicare eligible (age 65). For retires with older spouse, retirees and souses will each move to the Exchange when Medicare eligible.

Terminated Vesteds: If service is less than 10 years, Terminated Vested (TVs) participants are assumed to retire at age 65 and go directly to the Exchange. If service is ten years or more, TVs are assumed to retire at age 60 and move to the exchange in the same manner as actives outlines above.

Current Actives: Actives enrolled in the HDHP are assumed to participate in this plan upon retirement. It is assumed 5% of actives enrolled in the HPN Plan will participate in the HDHP upon retirement. Likewise, it is assumed 20% of actives enrolled in the HTH Plan will participate in the HDHP upon retirement. The balance of the HMO populations will remain in the HMO plan as early retirees. These assumptions were based upon actual PEBP census. For all plans, when actives retire and then reach age 65, it is assumed they become Medicare eligible and participate in the Exchange.

Dental Plan:

Pre-Medicare retirees will participate in PEBP's Dental Plan. Those enrolled in the EHPD plan will assume to enroll in PEBP's dental plan. For those future Exchange retirees, we assume 41% will participate in PEBP's Dental program/

Medicare Eligibility:

Certain retirees over age 65 are not eligible for Medicare Part A as indicated on the data. For these participants, we have assumed they will not become eligible for Medicare Part A at any time in the future. Current active employees are assumed to be eligible for Medicare Part A. Medicare eligible retirees will go to the Exchange.

Health Care Reform

The impact of the Patient Protection and Affordable Care Ace (PPACA) was reflected in this valuation, including the impact of the Excise Tax which was estimated to be no increase in liability.

Missing/Incomplete Data:

Missing or incomplete data (e.g., salary, hire date, retirement date, class, relationship, eligibility) will be substituted by averages determined from complete records.

Health Care Claims Costs:

Annual per capita medical and prescription drug claims costs are shown on the following pages. The costs represent estimated claims based on the plan design in effect on July 1, 2010. Expenses are shown separately. The retiree costs for active employees currently enrolled in an HMO plan are a blend of their current HMO plan and the PPO plan, using the blending percentages stated above.

Admin Fees

Admin Fees		
HDHP	$430	
HMO	$138	
Dental	Male	Female
	$374	$440

Health Care Claims Cost – After Plan Changes

	PPO Medical							
	State				Non-State			
	Male		Female		Male		Female	
Age	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
30	$2,541	$2,541	$3,228	$3,228	$2,755	$2,755	$2,699	$2,699
31	$2,584	$2,584	$3,248	$3,248	$2,802	$2,802	$2,716	$2,716
32	$2,628	$2,628	$3,269	$3,269	$2,849	$2,849	$2,733	$2,733
33	$2,673	$2,673	$3,290	$3,290	$2,898	$2,898	$2,751	$2,751
34	$2,718	$2,718	$3,311	$3,311	$2,947	$2,947	$2,769	$2,769
35	$2,764	$2,764	$3,333	$3,333	$2,997	$2,997	$2,786	$2,786
36	$2,825	$2,825	$3,369	$3,369	$3,063	$3,063	$2,817	$2,817
37	$2,886	$2,886	$3,406	$3,406	$3,129	$3,129	$2,847	$2,847
38	$2,949	$2,949	$3,443	$3,443	$3,198	$3,198	$2,878	$2,878
39	$3,014	$3,014	$3,480	$3,480	$3,268	$3,268	$2,910	$2,910
40	$3,080	$3,080	$3,518	$3,518	$3,339	$3,339	$2,941	$2,941
41	$3,185	$3,185	$3,615	$3,615	$3,453	$3,453	$3,023	$3,023
42	$3,294	$3,294	$3,715	$3,715	$3,572	$3,572	$3,106	$3,106
43	$3,407	$3,407	$3,817	$3,817	$3,694	$3,694	$3,192	$3,192
44	$3,523	$3,523	$3,923	$3,923	$3,820	$3,820	$3,280	$3,280
45	$3,644	$3,644	$4,031	$4,031	$3,951	$3,951	$3,370	$3,370
46	$3,788	$3,788	$4,168	$4,168	$4,107	$4,107	$3,485	$3,485
47	$3,938	$3,938	$4,310	$4,310	$4,269	$4,269	$3,603	$3,603
48	$4,093	$4,093	$4,457	$4,457	$4,438	$4,438	$3,726	$3,726
49	$4,255	$4,255	$4,609	$4,609	$4,613	$4,613	$3,853	$3,853
50	$4,423	$4,423	$4,766	$4,766	$4,796	$4,796	$3,984	$3,984
51	$4,569	$4,569	$4,923	$4,923	$4,954	$4,954	$4,116	$4,116
52	$4,720	$4,720	$5,085	$5,085	$5,118	$5,118	$4,252	$4,252
53	$4,876	$4,876	$5,253	$5,253	$5,286	$5,286	$4,392	$4,392
54	$5,037	$5,037	$5,427	$5,427	$5,461	$5,461	$4,537	$4,537
55	$5,203	$5,203	$5,606	$5,606	$5,641	$5,641	$4,687	$4,687
56	$5,390	$5,390	$5,808	$5,808	$5,844	$5,844	$4,856	$4,856
57	$5,584	$5,584	$6,017	$6,017	$6,055	$6,055	$5,030	$5,030
58	$5,785	$5,785	$6,233	$6,233	$6,273	$6,273	$5,211	$5,211
59	$5,993	$5,993	$6,458	$6,458	$6,498	$6,498	$5,399	$5,399
60	$6,209	$6,209	$6,690	$6,690	$6,732	$6,732	$5,593	$5,593
61	$6,470	$6,470	$6,971	$6,971	$7,015	$7,015	$5,828	$5,828
62	$6,742	$6,742	$7,264	$7,264	$7,310	$7,310	$6,073	$6,073
63	$7,025	$7,025	$7,569	$7,569	$7,617	$7,617	$6,328	$6,328
64	$7,320	$7,320	$7,887	$7,887	$7,937	$7,937	$6,594	$6,594
65	$7,627	-	$8,218	-	$8,270	-	$6,871	-
66	$7,856	-	$8,465	-	$8,518	-	$7,077	-
67	$8,092	-	$8,719	-	$8,774	-	$7,289	-
68	$8,335	-	$8,980	-	$9,037	-	$7,508	-
69	$8,585	-	$9,250	-	$9,308	-	$7,733	-
70	$8,842	-	$9,527	-	$9,587	-	$7,965	-
71	$9,063	-	$9,765	-	$9,827	-	$8,164	-
72	$9,290	-	$10,009	-	$10,072	-	$8,368	-
73	$9,522	-	$10,260	-	$10,324	-	$8,578	-
74	$9,760	-	$10,516	-	$10,582	-	$8,792	-
75	$10,004	-	$10,779	-	$10,847	-	$9,012	-

Health Care Claims Cost (cont)

	PPO Rx							
	State				Non-State			
	Male		Female		Male		Female	
Age	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
30	$518	$518	$883	$883	$507	$507	$753	$753
31	$527	$527	$889	$889	$516	$516	$758	$758
32	$536	$536	$895	$895	$525	$525	$763	$763
33	$545	$545	$900	$900	$534	$534	$768	$768
34	$554	$554	$906	$906	$543	$543	$773	$773
35	$563	$563	$912	$912	$552	$552	$777	$777
36	$576	$576	$922	$922	$564	$564	$786	$786
37	$588	$588	$932	$932	$576	$576	$795	$795
38	$601	$601	$942	$942	$589	$589	$803	$803
39	$614	$614	$952	$952	$602	$602	$812	$812
40	$628	$628	$963	$963	$615	$615	$821	$821
41	$649	$649	$989	$989	$636	$636	$843	$843
42	$671	$671	$1,017	$1,017	$658	$658	$867	$867
43	$694	$694	$1,045	$1,045	$680	$680	$891	$891
44	$718	$718	$1,073	$1,073	$704	$704	$915	$915
45	$743	$743	$1,103	$1,103	$728	$728	$940	$940
46	$772	$772	$1,141	$1,141	$757	$757	$972	$972
47	$803	$803	$1,179	$1,179	$786	$786	$1,005	$1,005
48	$834	$834	$1,220	$1,220	$818	$818	$1,040	$1,040
49	$867	$867	$1,261	$1,261	$850	$850	$1,075	$1,075
50	$901	$901	$1,304	$1,304	$883	$883	$1,112	$1,112
51	$931	$931	$1,347	$1,347	$913	$913	$1,149	$1,149
52	$962	$962	$1,392	$1,392	$943	$943	$1,186	$1,186
53	$994	$994	$1,438	$1,438	$974	$974	$1,226	$1,226
54	$1,026	$1,026	$1,485	$1,485	$1,006	$1,006	$1,266	$1,266
55	$1,060	$1,060	$1,534	$1,534	$1,039	$1,039	$1,308	$1,308
56	$1,099	$1,099	$1,589	$1,589	$1,077	$1,077	$1,355	$1,355
57	$1,138	$1,138	$1,646	$1,646	$1,115	$1,115	$1,404	$1,404
58	$1,179	$1,179	$1,706	$1,706	$1,155	$1,155	$1,454	$1,454
59	$1,221	$1,221	$1,767	$1,767	$1,197	$1,197	$1,507	$1,507
60	$1,265	$1,265	$1,831	$1,831	$1,240	$1,240	$1,561	$1,561
61	$1,319	$1,319	$1,908	$1,908	$1,292	$1,292	$1,626	$1,626
62	$1,374	$1,374	$1,988	$1,988	$1,347	$1,347	$1,695	$1,695
63	$1,432	$1,432	$2,071	$2,071	$1,403	$1,403	$1,766	$1,766
64	$1,492	$1,492	$2,158	$2,158	$1,462	$1,462	$1,840	$1,840
65	$1,554	-	$2,249	-	$1,523	-	$1,917	-
66	$1,601	-	$2,316	-	$1,569	-	$1,975	-
67	$1,649	-	$2,386	-	$1,616	-	$2,034	-
68	$1,699	-	$2,457	-	$1,665	-	$2,095	-
69	$1,750	-	$2,531	-	$1,715	-	$2,158	-
70	$1,802	-	$2,607	-	$1,766	-	$2,223	-
71	$1,847	-	$2,672	-	$1,810	-	$2,278	-
72	$1,893	-	$2,739	-	$1,855	-	$2,335	-
73	$1,941	-	$2,807	-	$1,902	-	$2,393	-
74	$1,989	-	$2,878	-	$1,949	-	$2,453	-
75	$2,039	-	$2,950	-	$1,998	-	$2,515	-

Health Care Claims Cost (cont)

HMO		
	Medical	
Age	Non-Medicare	Medicare
30	$3,555	$3,555
31	$3,578	$3,578
32	$3,601	$3,601
33	$3,624	$3,624
34	$3,647	$3,647
35	$3,670	$3,670
36	$3,710	$3,710
37	$3,751	$3,751
38	$3,792	$3,792
39	$3,833	$3,833
40	$3,875	$3,875
41	$3,982	$3,982
42	$4,091	$4,091
43	$4,204	$4,204
44	$4,320	$4,320
45	$4,439	$4,439
46	$4,590	$4,590
47	$4,747	$4,747
48	$4,909	$4,909
49	$5,076	$5,076
50	$5,249	$5,249
51	$5,422	$5,422
52	$5,601	$5,601
53	$5,786	$5,786
54	$5,977	$5,977
55	$6,174	$6,174
56	$6,396	$6,396
57	$6,626	$6,626
58	$6,865	$6,865
59	$7,112	$7,112
60	$7,368	$7,368
61	$7,678	$7,678
62	$8,000	$8,000
63	$8,336	$8,336
64	$8,686	$8,686
65	$9,051	-
66	$9,322	-
67	$9,602	-
68	$9,890	-
69	$10,187	-
70	$10,493	-
71	$10,755	-
72	$11,024	-
73	$11,299	-
74	$11,582	-
75	$11,871	-

Glossary

The Government Accounting Standards Board (GASB) has issued Statements No. 43 and 45 for the recognition and disclosure for public entities sponsoring other (than pensions) post-retirement benefit plans.

This Exhibit summarizes pertinent issues from the above statements and includes comments about GASB's OPEB standard.

Allocating Costs (Attribution)

The attribution period is the period over which the total postretirement benefit is earned. Unless the plan states that post-retirement benefits are not earned until a later date, the attribution period is from the employee's hire date until the employee is first eligible for the benefit. The GASB statements do not restrict entities to a single attribution method, but instead allows sponsors (and actuaries) to choose from several acceptable methods (similar to GASB 27). GASB allows all six funding methods shown in the statement. GASB allows attribution to the expected retirement age rather than the earliest eligibility age.

Defining the Plan

The substantive plan may differ from the written plan in that it reflects the employer's cost sharing policy based on past practice or communication of intended changes, or a past practice of cost increases in monetary benefits. GASB requires entities to recognize the underlying promise, not just the written plan. GASB also requires the plan sponsor to recognize any implied subsidy when retirees participate in the active healthcare plan, but are charged a rate based on composite active and retiree experience.

Actuarial Assumptions

Generally, GASB requires explicit assumptions.

In the statement GASB requires that the discount rate be based on the source of funds used to pay the benefits. This means the underlying expected long-term rate of return on plan assets for funded plans. However, since the source of funds for unfunded plans is usually the agency's general fund, and agencies are usually restricted by State law as to what investments they can have in their general fund, unfunded plans will need to use a relatively low discount rate. For PEBP, we have examined historical returns in the portfolio of funds from which benefits are currently being paid to set the discount rate assumption.

Transition Issues

Because historical annual required contribution information will rarely be available, GASB is taking a prospective approach on transition issues. This means there will be no requirement for any initial transition obligation.

Effective Dates

The new standard will have staggered effective dates as follows:

		Effective for Fiscal Years Beginning After	
	Annual Revenue	**GASB 43**	**GASB 45**
Phase I	≥ $100 million	December 15, 2005	December 15, 2006
Phase II	≥ $10 million, but < $100 million	December 15, 2006	December 15, 2007
Phase III	< $10 million	December 15, 2007	December 15, 2008

Actuarial Accrued Liability (AAL)

As determined by a particular Actuarial Cost Method, the portion of the Actuarial Present Value of plan benefits and expenses which is attributable to past service, and thus not provided for by future Normal Costs.

Actuarial Assumptions

Assumptions as to the occurrence of future events affecting benefit costs, such as: mortality, withdrawal, disablement and retirement; changes in compensation and employer provided benefits; rates of investment earnings and asset appreciation or depreciation; procedures used to determine the Actuarial Value of Assets; and other relevant items. The Actuarial Assumptions are used in connection with the Actuarial Cost Method to allocate plan costs over the working lifetime of plan participants.

Actuarial Cost Method

A procedure for determining the Actuarial Present Value of plan benefits and expenses and for developing an actuarially equivalent allocation of such value to time periods (e.g., past service, future service), usually in the form of a Normal Cost and an Actuarial Accrued Liability.

Actuarial Experience Gain or Loss

A measure of the difference between actual experience and that expected based upon a set of Actuarial Assumptions, during the period between two Actuarial Valuation Dates, as determined in accordance with a particular Actuarial Cost Method.

Actuarial Present Value

The value of an amount or series of amounts payable or receivable at various times, determined as of a given date by the application of a particular set of Actuarial Assumptions. For purposes of this standard, each such amount or series of amounts is:

a. adjusted for the probable financial effect of certain intervening events (such as changes in compensation levels, Social Security, marital status, etc.).
b. multiplied by the probability of the occurrence of an event (such as survival, death disability, termination of employment, etc.) on which the payment is conditioned, and
c. discounted according to an assumed rate (or rates) of return to reflect the time value of money.

Actuarial Present Value of Total Projected Benefits or Present Value of Benefits (PVB)

Total projected benefits include all benefits estimated to be payable to plan members (retirees and beneficiaries, terminated employees entitled to benefits but not yet receiving them, and current active members) as a result of their service through the valuation date and their expected future service. The actuarial present value of total projected benefits as of the valuation date is the present value of the cost to finance benefits payable in the future, discounted to reflect the expected effects of the time value (present value) of money and the probabilities of payment. Expressed another way, it is the amount that would have to be invested on the valuation date so that the amount invested plus investment earnings will provide sufficient assets to pay total projected benefits when due.

Actuarial Valuation

The determination, as of a Valuation Date, of the Normal Cost, Actuarial Accrued Liability, Actuarial Value of Assets, and related Actuarial Present Values for a benefit plan.

Actuarial Valuation Date

The date as of which an actuarial valuation is performed.

Actuarial Value of Assets

The value of cash, investments, and other property belonging to a benefit plan, as used by the actuary for the purpose of an Actuarial Valuation.

Amortization (of Unfunded Actuarial Accrued Liability)

The portion of benefit plan costs or contributions which is designed to pay off principal and interest on the Unfunded Actuarial Accrued Liability.

Annual OPEB Cost (AOC)

An accrual-basis measure of the periodic cost of an employer's participation in a defined benefit OPEB plan.

Annual Required Contributions of the Employer (ARC)

The employer's periodic required contributions to a Defined Benefit OPEB Plan, which is the basis for determining an employer's Annual OPEB Cost.

Covered Group

Plan members included in an actuarial valuation.

Deferred Inactives

Former employees, not yet receiving retirement benefits, who are eligible for plan benefits in the future.

Defined Benefit OPEB Plan

An OPEB plan having terms that specify the benefits to be provided at or after separation from employment. The benefits may be specified in dollars (for example, a flat dollar payment or an amount based on one or more factors such as age, years of service, and compensation), or as a type or level of coverage (for example, prescription drugs or a percentage of healthcare insurance premiums).

Discount Rate (Investment Return Assumption)

The rate used to adjust a series of future payments to determine the present value by reflecting the time value of money.

Employer Contributions

Contributions made in relation to the annual required contributions of the employer (ARC). An employer has made a contribution in relation to the ARC if the employer has (a) made payments of benefits directly to or on behalf of a retiree or beneficiary, (b) made premium payments to an insurer, or (c) irrevocably transferred assets to a trust, or equivalent arrangement, in which plan assets are dedicated to providing benefits to retirees and their beneficiaries in accordance with the terms of the plan and are legally protected from creditors of the employer(s) of plan administrator. Employer contributions generally do not necessarily equate to benefits paid.

Funded Ratio

The actuarial value of assets expressed as a percentage of the Actuarial Accrued Liability.

Funding Excess

The excess of the Actuarial Value of Assets over the Actuarial Accrued Liability.

Funding Policy

The program for the amounts and timing of contributions to be made by plan members, employer(s), and other contributing entities to provide the benefits specified by an OPEB plan.

Healthcare Cost Trend Rate

The rate of change in per capita health claims costs over time as a result of factors such as medical inflation, utilization of healthcare services, plan design, and technological developments.

Implicit Rate Subsidy

The differential between utilizing a blend of active and non-Medicare retiree experience for cost of benefits, and utilizing solely the expected retiree experience. Blending a lower cost active cohort with retirees results in an implicit rate subsidy for the retirees of the entire group.

Inactives

Certain former employees with a minimum amount of years of creditable service who have benefits payable from the retirement system.

Level Dollar Amortization Method

The dollar amount to be amortized is divided into equal dollar amounts to be paid over a given number of years; part of each payment is interest and part is principal (similar to a mortgage payment on a building). Because payroll can be expected to increase as a result of inflation, level dollar payments generally represent a decreasing percentage of payroll; in dollars adjusted for inflation, the payments can be expected to decrease over time.

Level Percentage of Projected Payroll Amortization Method

Amortization payments are calculated so that they are a constant percentage of the projected payroll of active plan members over a given number of years. The dollar amount of the payments generally will increase over time as payroll increases (e.g., due to inflation); in dollars adjusted for inflation, the payments can be expected to remain level.

Market-Related Value of Plan Assets

A term used with reference to the actuarial value of assets. A market related value may be fair value, market value (or estimated market value), or a calculated value that recognizes changes in fair or market value over a period of, for example, three to five years.

Net OPEB Obligation (NOO)

The cumulative difference since the effective date of this Statement between Annual OPEB Cost and the employer's contributions to the plan, including the OPEB liability (asset) at transition, if any, and excluding (a) short-term differences and (b) unpaid contributions that have been converted to OPEB-related debt.

Normal Cost

The portion of the Actuarial Present Value of plan benefits and expenses that is allocated to a valuation year by the Actuarial Cost Method.

OPEB Assets

The amount recognized by an employer for contributions to an OPEB plan greater than OPEB expense.

OPEB Expenditures

The amount recognized by an employer in each accounting period for contributions to an OPEB plan on the modified accrual basis of accounting.

OPEB Expense

The amount recognized by an employer in each accounting period for contributions to an OPEB plan on the accrual basis of accounting.

OPEB Liabilities

The amount recognized by an employer for contributions to an OPEB plan less than OPEB expense/expenditures.

Other Postemployment Benefits (OPEB)

Postemployment benefits other than pension benefits. Other postemployment benefits (OPEB) include postemployment healthcare benefits, regardless of the type of plan that provides them, and all postemployment benefits provided separately from a pension plan, excluding benefits defined as termination offers and benefits.

Pay-As-You-Go

A method of financing a plan under which the contributions to the plan are generally made at about the same time and in about the same amount as benefit payments and expenses becoming due.

Plan Assets

Resources, usually in the form of stocks, bonds, and other classes of investments, that have been segregated and restricted in a trust, or equivalent arrangement, in which (a) employer contributions to the plan are irrevocable, (b) assets are dedicated to providing benefits to retirees and their beneficiaries, (c) assets are legally protected from creditors of the employers or plan administrator, for the payment of benefits in accordance with the terms of the plan.

Plan Members

The individuals covered by the terms of an OPEB plan. The plan membership generally includes employees in active service, terminated employees who have accumulated benefits but are not yet receiving them, and retired employees and beneficiaries currently receiving benefits.

Postemployment

The period between termination of employment and retirement as well as the period after retirement.

Postemployment Healthcare Benefits

Medical, dental, vision, and other health-related benefits provided to terminated or retired employees and their dependents and beneficiaries.

Postretirement Benefit Increase

An increase in the benefits of retirees or beneficiaries granted to compensate for the effects of inflation (cost-of-living adjustment) or for other reasons. Ad hoc increases may be granted periodically by a decision of the board of trustees, legislature, or other authoritative body; both the decision to grant an increase and the amount of the increase are discretionary. Automatic increases are periodic increases specified in the terms of the plan; they are nondiscretionary except to the extent that the plan terms can be changed

Projected Benefits

Those plan benefit amounts which are expected to be paid at various future times under a particular set of Actuarial Assumptions, taking into account such items as the effect of advancement in age and past and anticipated future compensation and service credits. That portion of an individual's Projected Benefit allocated to service to date, determined in accordance with the terms of a plan and based on future compensation as projected to retirement, is called the Credited Projected Benefit.

Projected Unit Credit Actuarial Cost Method

A method under which the benefits (projected or unprojected) of each individual included in an Actuarial Valuation are allocated by a consistent formula to valuation years. The Actuarial Present Value of benefits allocated to a valuation year is called the Normal cost. The Actuarial Present Value of benefits allocated to all periods prior to a valuation year is called the Actuarial Accrued Liability.

Under this method, the Actuarial Gains (or Losses), as they occur, generally reduce (or increase) the Unfunded Actuarial Accrued Liability.

Under this method, benefits are projected to all future points in time under the terms of the Plan and actuarial assumptions (for example, health trends). Retirees are considered to be fully attributed in their benefits. For actives, attribution is to expected retirement age; thus, benefits at each future point in time are allocated to past service based on a proration of service-to-date over total projected service.

Required Supplementary Information (RSI)

Schedules, statistical data, and other information that are an essential part of financial reporting and should be presented with, but are not part of, the basic financial statements of a governmental entity.

Single-Employer Plan

A plan that covers the current and former employees, including beneficiaries, of only one employer.

Sponsor

The entity that established the plan. The sponsor generally is the employer or one of the employers that participate in the plan to provide benefits for their employees and employees of other employers.

Substantive Plan

The terms of an OPEB plan as understood by the employer(s) and plan members.

Transition Year

The fiscal year in which this Statement is first implemented.

Unfunded Actuarial Accrued Liability (Unfunded Actuarial Liability)

The excess of the Actuarial Accrued Liability over the Actuarial Value of Assets.

About Aon Hewitt

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F.

NRS 287.0245 Section 2 (b)

A biennial review of the Program to determine whether the Program complies with federal and state laws relating to taxes and employee benefits.

PREPARED FOR AND AT THE REQUEST OF PUBLIC EMPLOYEES' BENEFITS PROGRAM

Public Employees' Benefits Program

Biennial Compliance Review

Review Period September 2012

January 4, 2013

AON Hewitt

Report Contents

SECTION A: INTRODUCTION

This compliance review is being undertaken pursuant to Nevada Revised Statute ("NRS") Section 287.0425 (2)(b), which requires a biennial review of the Public Employees' Benefits Program ("PEBP") to determine whether the PEBP complies with federal and state laws relating to taxes and employee benefits. Accordingly, Aon Hewitt performed a review of certain plan documents provided by PEBP and administration processes to verify that procedures have been implemented to enable the PEBP to comply with applicable federal and state laws.

Our compliance review is based on documents received, statutes, and regulations as existing and in effect during September 2012 unless otherwise noted ("Review Period"). In this respect we requested from PEBP staff members, certain documents and answers to specific questions relevant to the PEBP during the Review Period. We did not attempt to verify actual administration of the PEBP through sampling techniques, discussions with third party vendors/administrators, or otherwise. In addition, we did not perform any claim audit related to PEBP, or consider issues related to payroll practices, workers' compensation, unemployment compensation, classification of employees or other non-benefits related aspects of any federal or state law.

This Report outlines the results of Aon Hewitt's review and summarizes our findings and recommendations to address certain document compliance issues that we have identified. Any consulting advice we provide is intended to assist PEBP in determining how best to comply with applicable requirements relating to the PEBP's compliance with federal and state laws. Nevertheless, Aon Hewitt does not engage in the practice of law, and the consulting advice we provide is not, and is not intended to be, legal advice.

Although we have identified certain issues pertaining to the PEBP, our Report should not be relied upon to identify all possible weaknesses in internal controls, errors, irregularities, or illegal acts, or to identify all possible violations of the NRS, Nevada Administrative Code ("NAC"), the Internal Revenue Code (the "Code"), the Employee Retirement Income Security Act of 1974 as amended ("ERISA"), Internal Revenue Service ("IRS") regulations, or other technical pronouncements as we did not perform a transactional operational compliance review of the PEBP. We interpreted compliance requirements in a manner we believe to be reasonable; however, we cannot guarantee that government agencies, courts, or participants will agree with our interpretation, or that the PEBP would be in compliance with all applicable laws, regulations, rules, or other governmental pronouncements if PEBP implemented all of our recommendations.

We would be pleased to discuss this Report and our recommendations with you in further detail. If you have any questions, please contact Kenneth Morgan at 732.302.5986, Jill Carson at 213.996.1771, or Richard Asensio at 213.996.1765.

SECTION B: EXECUTIVE SUMMARY

Overall, we found that PEBP has done an excellent job in ensuring that its documents and procedures comply with applicable federal and state laws. In particular, we found a significant improvement in addressing issues noted in previous reviews. In particular, we note that the 2012 Master Plan Document ("MPD") for the PEBP Self Funded Consumer Driven High Deductible PPO Plan has addressed the vast majority of suggestions identified in prior reviews. In bringing the MPD into compliance with the Patient Protection and Affordable Care Act of 2010 ("PPACA"), the necessary revisions to the claim and appeal procedures have been adopted.

However, as is typical with reviews of this magnitude, we did note a few areas that could be enhanced to better meet federal and/or state law requirements. The following summarizes our significant findings. Please refer to Sections E and F for a detailed description of the findings and the recommended courses of action to be taken.

Federal Law Issues- Current

- **HIPAA Privacy and Data Security Regulations**
  - HIPAA's Privacy and Security Rules, and the HITECH provisions, have the potential of exposing the PEBP to significant penalties in the event of a breach of unsecured protected health information (PHI) by PEBP staff or the personnel of one of its vendors.
  - We have suggested that certain language be added to plan documentation
  - We strongly recommend that PEBP consider the completion of a detailed HIPAA Privacy and Security Compliance Review/Risk Analysis. In this regard, specific attention needs to be directed to:
    - the presence of all required HIPAA privacy and data security language in the related plan documentation,
    - the satisfaction of HIPAA's Security Rule requirement (first of the forty-two implementation specifications contained in the regulation) that a data security risk assessment has been completed and documented relative to the transmission and storage of the PEBP's electronic PHI,
    - documentation of all HIPAA privacy and data security policies and procedures in a detailed policy and procedures manual, and
    - operational compliance with the HIPAA recordkeeping requirements such as training and disclosure logs and various data security logs/assessments.
- **Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA")**
  - We recommend that PEBP develop a "Notice of Unavailability of Continuation Coverage" to be provided to participants when applicable, in accordance with COBRA regulations.

SECTION B: EXECUTIVE SUMMARY (CONT'D)

Federal Law- Future Considerations

- **Patient Protection and Affordable Care Act of 2010 ("PPACA")**
  - PPACA provisions that are already in effect appear to have been adopted.
  - The MPD should be timely amended for upcoming PPACA requirements including:
    - Automatic enrollment
    - Limit of 90-day waiting period for coverage – we note that the first day of the month following 90 days may not satisfy proposed Department of Health and Human Services ("HHS")' rules based on current guidance
  - The PEBP Board should continue monitoring of changes to HHS/ Health Resources and Services Administration ("HRSA") preventive task force guidelines and make respective plan changes from time to time
  - The MPD should be timely amended for the addition of women's preventive health requirements to no cost sharing and coverage for certain in-network preventive health services
  - The PEBP should develop necessary forms and procedures to comply with these PPACA requirements as regulatory guidance becomes available:
    - Distribution of Summary of Benefits and Coverage to Participants
    - Payment of comparative effectiveness fee
    - Filing employer quality of care reports
    - Treatment of medical loss ratio rebates (insured plans only)
    - Reporting of health coverage on Form W-2
    - Notice to inform employees of coverage options in exchange
    - Employer reporting of health insurance information to government and participants
  - PEBP should develop a long-term strategy with respect to the excise tax on high-cost coverage

- **Code Sections 79, 105(h), 125(h), and 129**
  - PEBP has discussed the requirements of each Code Section with Aon Hewitt's subject matter expert in nondiscrimination testing to ascertain the extent to which the nondiscrimination tests imposed by Code Sections 105(h) (self-funded medical reimbursement plans- two tests), 125(h) (cafeteria plans-three tests), and/or 129 (dependent day care FSAs-four tests) are applicable. Accordingly, we recommend that testing be performed in conjunction with recommendations set forth by Aon Hewitt's testing team.

SECTION B: EXECUTIVE SUMMARY (CONT'D)

State Law Issues

- **Eligibility and Enrollment**
  - The Certification of Disabled Dependent Child should be revised to state that the declaration is being made under penalty of perjury
  - Certain changes to the NAC may be advisable to bring into compliance with PPACA and to reflect MPD provisions
  - Certain information about retiree eligibility contained in the Retiree Enrollment materials should be incorporated into the MPD
- **Miscellaneous**
  - Certain best practices concerning administrative procedures should be evaluated and implemented to the extent advisable

Transactional Testing

This is the fifth biennial review of the PEBP health and welfare plans to assess compliance with applicable federal and Nevada state statutes and regulations there under that Aon Hewitt has been engaged by the PEBP. These reviews have only focused on document compliance with applicable laws, statutes and regulations. We have previously recommended that an operational review, including in depth interviewing of PEBP staff members regarding plan operations and processes in conjunction with testing a limited sample of transactions to ensure that the PEBP is operating the health and welfare programs in compliance with various federal and Nevada state laws. We continue to recommend that such transactional testing be performed within the next year to ensure full compliance with the requirements of NRS Section 287.0425, and applicable federal and state laws.

SECTION C: FACTS AND ASSUMPTIONS

The following facts and assumptions were relied upon in performing our review and preparing this Report:

- All documents and data received (see Section D), as well as any information conveyed to us orally, are accurate and were in effect during the Review Period
- Generally, the PEBP sponsored health and welfare benefit plans that are subject to this review are those reflected in the Master Plan Document and the FSA SPD:
  - Self-funded Consumer Driven High Deductible PPO Medical Plan
  - Self-funded Prescription Drug Program
  - Self-funded PPO Dental Plan
  - Live Well, Be Well Program (Wellness Program)
  - Medical Flexible Spending Account
  - Dependent Care Flexible Spending Account.
- To the extent that the Federal and/or State of Nevada laws noted in the bullet points below are applicable, the following PEBP health and welfare benefit plans were also included:
  - Long-term Disability Plan
  - Life Insurance Plan
  - Hometown Health HMO Medical Plan
  - Health Plan of Nevada HMO Medical Plan
- The voluntary elective products/benefits offered under the PEBP (Long-term Care Plan, Short Term Disability Plan, and Supplemental Life Insurance Plan) were also outside the scope of our review.
- There were also documents that were provided during our previous review(s) that were still effective during this Review Period. To the extent that applicable statutes had not been subsequently amended, we relied on our prior findings for our current review, assuming they would be still applicable.
- The PEBP health and welfare benefit plans listed above were reviewed for compliance with the following federal laws:
  - Americans with Disability Act of 1990 and the Americans with Disability Act Amendments Act of 2008 (together "ADA")
  - Age Discrimination in Employment Act of 1967 ("ADEA")
  - Children's Health Insurance Program Reconciliation Act of 2009 ("CHIPRA")
  - COBRA (as made applicable through Section 300bb of the Public Health Service Act)
  - Executive Order 11246 (re: nondiscrimination on the basis of sex)

SECTION C: FACTS AND ASSUMPTIONS (CONT'D)

- Family and Medical Leave Act of 1993 ("FMLA")
- Genetic Information Nondiscrimination Act of 2008 ("GINA")
- Gulf Opportunity Zone Act of 2005 ("GO")
- Heroes Earnings Assistance and Relief Tax Act of 2008 ("HEART")
- Health Insurance Portability and Accountability Act of 1996 ("HIPAA") benefit provisions, including wellness program requirements
- HIPAA privacy and data security provisions , including HITECH (note that our review did not include a review for compliance with HIPAA's Electronic Data Interchange ("EDI") regulations)
- HMO Act
- Medicare Secondary Payer ("MSP") requirements
- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("Medicare Part D Requirements")
- Mental Health Parity Act ("MHPA") and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA")
- Michelle's Law of 2008
- National Defense Authorization Act of 2008 ("NDAA")
- Newborns' and Mothers' Protection Act of 1996 ("NMHPA")
- Patient Protection and Affordable Care Act of 2010 ("PPACA")
- Pregnancy Discrimination Act ("PDA")
- QMCSOs
- Rehabilitation Act of 1973
- Social Security Act Health Insurance ("Medicare"), including Medicare Part D
- Title VII of the Civil Rights Act of 1964
- Uniformed Services Employment and Reemployment Rights Act of 1964 ("USERRA")
- Women's Health & Cancer Rights Act of 1998 ("WHCRA")
- Code Sections 79, 105(h), 125(h), and 129

SECTION C: FACTS AND ASSUMPTIONS (CONT'D)

- The PEBP health and welfare plans listed above were reviewed for document compliance with the certain Nevada state law requirements in the following areas. This listing reflects the impact of several new and revised pieces of legislation subsequent to our previous review that may have impacted PEBP benefits and administration:
  - Eligibility and Participation (NAC Sections 287.035, 287.045, 287.085, 287.095, 287.135, 287.150, 287.310, 287.311, 287.312, 287.317, 287.3123, 287.3125, 287.313, 287.314, 287.320, 287.350 – 287.389, 287.500, 287.510, 287.515, 287.520, 287.530; NRS Sections 287.010, 287.017, 287.020, 287.021, 287.025, 287.040, 287.043, 287.04335, 287.045, 287.046, 287.0467, 287.0475, 287.0477, 287.0479, 689B.033)
  - Retiree (NAC Section 287.530, 287.542, 287.544, 287.546, 287.548; NRS Sections 287.0205, 287.023, 287.024, 287.043, 287.046, 287.047, 287.0475)
  - Benefit Coverage (NAC 287.100; NRS Sections 287.0205, 287.027, 287.0272, 287.0274, 287.0276, 287.04062, 287.0433, 287.04335, 287.0485, 689B.283, 689B.287, 695B.0306, 695G.160, 695G.164, 695G.170, 695G.173 and 295G.405)
  - Premium and Funding (NAC Sections 287.420-287.490, 287.760-287.792; NRS Sections 287.015, 287.017, 287.043, 287.0434, 287.0435, 287.0436, 287.04362, 287.04364, 287.04385, 287.0439, 287.044, 287.0445, 287.046)
  - Subrogation (NRS Section 287.0465)
  - Orientation Program (NAC Sections 287.314 and 287.317)
  - Agency Participation and Administration (NAC Sections 287.310, 287.320, and 287.350-287.389 NRS Sections 287.010, and 287.020)
  - Board Authority and Duties (NAC Sections 287.170-287.196; NRS Sections 287.0402, 287.04062, 287.0415, 287.0424, 287.0426, NRS 287.043, 287.041, 287.04335, 287.0434, 287.04366, and 287.0487)
  - Executive Branch Reporting Requirements (NRS 287.0425)
  - Claims and Appeals Procedures (NAC Sections 287.610-287.690, and 287.750; NRS Sections 287.043, 287.04335, 689B.255, 695G.200-695G.230, 695G.241-695G.300, and 695G.310)
  - Notice Requirements (NRS Sections 695G.210 and 695G.230)
  - Family and Medical Leave (NAC Sections 284.52345, 284.581, 284.5811, and 284.5813)
  - Leave of Absence for Military Duty (NAC Sections 281.145 and 284.359)
  - Audit Requirements (NRS Sections 287.0425 (1)(a), (b)).

SECTION D: DOCUMENTS RECEIVED

In performing our review of the PEBP health and welfare plans, we obtained the following documents during this review period:

- PEBP to Aon Work Order Request FY 2012
- PEBP Organizational Chart May 3, 2012
- Master Plan Document Plan Year 2012 (July 1, 2011 – June 30, 2012)
- Public Employees' Benefits Program Active Employee and Non-Medicare Retirees Open Enrollment guide for Plan Year 2012
- Public Employees' Benefits Program State Medicare Retirees Open Enrollment guide for Plan Year 2012
- Public Employees' Benefits Program – Open Enrollment Form Plan Year 2012
- Public Employees' Benefits Program – Open Enrollment Letter Plan Year 2012
- Public Employees' Benefits Program – Open Enrollment Form (Medicare Retirees) Plan Year 2012
- Public Employees' Benefits Program Introduction to Employee Benefits Plan Year 2012
- Flexible Spending Accounts ("FSA") Plan Year 2012 Summary Plan Description and Employee Enrollment
- Flexible Spending accounts – Enrollment Agreement Plan Year 2012
- Claim Form – Dependent Care Assistance (day care, babysitting, etc.) and Unreimbursed Medical Benefits
- State of Nevada Manager Handbook (undated)
- State of Nevada Employee Handbook (undated)
- PEBP Administrator Manual (Printed on July 13, 2012)
- Standard Insurance Company documents:
  - Certificate Group Life Insurance, effective July 1, 2003 – Policy Numbers 642682-A (Revised 03/14/11)
  - Certificate Group Life Insurance, effective July 1, 2003 – Policy Numbers 642682-C (Revised 03/14/11)
  - Certificate Group Long Term Disability Insurance, effective July 1, 2003 – Policy Number 642682-D
  - Certificate Short Term Disability Insurance, effective July 1, 2007 – Policy Number 642682-E (Revised 09/19/08)
- ExtendHealth documents:
  - Overview of Enrollment and HRA Reimbursement Process (Revised 11.2011)

SECTION D: DOCUMENTS RECEIVED (CONT'D)

- Health Plan of Nevada, Inc. documents:
  - Summary of Benefits -- Sierra Nevada Spectrum (Regional PPO) 2011
  - Vision Benefit Plan Summary Option 6: 12/12/24/10-10-100
  - $7/$35/$55 Outpatient Group Prescription Drug Benefit Summary
  - Plan Benefit Information State of Nevada – 10000330 – 7/1/2011
  - State of Nevada HPN 15-0 Medical Plan
  - State of Nevada HPN 15-0 Medical Plan – Attachment A Benefit Schedule
- HealthSCOPE documents:
  - Accident Questionnaire Form Acknowledgement
  - Non Specific Accident Questionnaire
  - Benefits Subrogation Letter
  - Maximizing Your PPO Plan Benefits Presentation – Carson City, Nevada (November 2011)
  - Maximizing Your PPO Plan Benefits Presentation – Reno, Nevada (November 2011)
  - Maximizing Your PPO Plan Benefits Presentation – Las Vegas, Nevada (November 2011)
- Hometown Health Plan, Inc. documents:
  - Hometown Health Plan, Inc. (HMO) 2010 Evidence of Coverage Autism Spectrum Disorders Addendum Effective January 1, 2011
  - Summary of Benefits Table – State of Nevada Benefit Plan: HMO 25-1500 A D0000 2010
  - HMO Prescription Drug Rider Benefit Providers: RX $7-$40-$75/$40% 2011
  - Value Exam Plus Plan (12 month exam frequency)
- UNUM Life Insurance Company of America – Group Master Policy/Certificate – Form Number 584040
- COBRA related documents, including:
  - Initial COBRA notice, including COBRA address notification form (June 2012)
- Other Notices:
  - Worker's Compensation
  - Certificate of Disabled Dependent Child (Disabled Dependent 022011)
  - Qualified Medical Child Support Order Notification
  - Declination of Benefits Notification

SECTION D: DOCUMENTS RECEIVED (CONT'D)

  - Notification of Retiree Turning 65
  - FMLA Notice
  - Confidentiality and Security Statement of Understanding (Revised 8.2008)
  - Military Leave
  - Release of Information Authorization Form (Revised 03.2010)
  - Certificate of Group Health Plan Coverage
- Local Government Entity Application Instructions for Coverage under Public Employees' Benefits Program (Health Insurance) (Revised 04.2011)
- HIPAA Privacy and Security Related Documents:
  - HIPAA Privacy Notice
  - HIPAA Security Policy
  - Department HIPAA Policy Guideline (Revised 2008)
  - HIPAA Policies and Procedures – Date Originated 09/17/03, Last Updated 07/09/12
  - HIPAA Privacy Policy and Procedures (Revised 2008)
  - HIPAA Training -- Board Presentation
  - HIPAA Training – Staff Presentation
  - Public Employees' Benefits Program Business Associate Agreement – In Force
  - Public Employees' Benefits Program Business Associate Agreement – Template 2010
  - HIPAA Training Sign In 10.2011
  - HIPAA Training Sign In 5.2012
  - HIPAA Training Board Member Sign In 5.2012
- Independent audited financial statements as of June 30, 2010 and June 30, 2011 for the Public Employees' Benefits Fund and the State Retirees' Health and Welfare Benefit Fund
- Governmental Accounting Standards Board 43/45 actuarial valuation as of June 30, 2011
- Self-funded plan utilization report for the year ended June 30, 2011
- Public Employees' Benefits Program Policies and Procedures – Quality Control, Date Originated 09/03/03, Last Updated 07/03/2012
- Public Employees' Benefits Program – Board and Agency Duties, Policies and Procedures, January 2012
- Plan Year 2012 Rates – Effective July 1, 2011
- Adopted Regulation of the Board of the Public Employees' Benefits Program LCB File No. R002-12 (Effective June 29, 2012)

SECTION E: SUMMARY OF FINDINGS – FEDERAL LAW REQUIREMENTS

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SECTION E: SUMMARY OF FINDINGS – FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Americans with Disabilities Act of 1990 ("ADA") **Americans with Disability Amendments Act of 2008 ("ADA")**	• Reviewed Master Plan Document ("MPD") and Flexible Spending Account Summary Plan Description ("FSA SPD"). • Reviewed Employee's Handbook. • Reviewed Manager's Handbook.	• No exceptions noted.	• None.		
Age Discrimination in Employment Act of 1967	• Reviewed MPD and FSA SPD. • Reviewed Employee's Handbook. • Reviewed Manager's Handbook. • Reviewed Group Life Insurance Certificates. • Reviewed Group Long Term Disability Insurance Certificates. • Reviewed HMO's Evidence of Coverage.	• No exceptions noted.	• None.		

SECTION E: SUMMARY OF FINDINGS – FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Children's Health Insurance Program Reconciliation Act of 2009 ("CHIPRA")	• Reviewed MPD and FSA SPD. • Reviewed Employee's Handbook. • Reviewed Manager's Handbook.	• No exceptions noted.	• None.		
Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA")	• Reviewed MPD and FSA SPD. • Reviewed COBRA notices received for compliance with regulations effective January 1, 2005.	• The 2012 FSA SPD appropriately reflects the availability of COBRA.		• No Action needed.	• Not Applicable.
		• However, neither the COBRA General (Initial) Notice nor the Election Notice reflects the availability of COBRA coverage to Medical FSA participants.	• PEBP had indicated that an Election Notice for the Medical FSA would be developed. We did not find it among the documents provided for review.	• PEBP will add the recommended language to the Election Notice.	• January 1, 2013
		• A Notice of Unavailability of Continuation Coverage is required when an individual is not entitled to COBRA continuation coverage.	• PEBP had indicated that a Notice of Unavailability of Continuation Coverage would be developed. We did not find it among the documents provided for review.	• PEBP currently has a Notice of Unavailability of Continuation Coverage, however, this was not provided to Aon upon initial submittal. PEBP has included the Notice in this response. Please refer to Attachment A.	• Complete.

SECTION E: SUMMARY OF FINDINGS – FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Executive Order 11246	• Reviewed MPD and FSA SPD. • Reviewed Group Life Insurance Certificates. • Reviewed Group Long Term Disability Insurance Certificates. • Reviewed HMO's Evidence of Coverage.	• No exceptions noted	• None.		
Family and Medical Leave Act of 1993 ("FMLA")	• Reviewed MPD and FSA SPD. • Reviewed Manager's Handbook. • Reviewed Employee's Handbook. • FMLA Notice.	• No exception noted	• None.		
Genetic Information Nondiscrimination Act of 2008 ("GINA")	• Reviewed MPD. • Revised Manager's Handbook.	• No exception noted.	• None.		
Gulf Opportunity Zone Act of 2005 ("GO Act")	• Reviewed MPD. • Reviewed HMO's Evidence of Coverage.	• No exception noted	• None		

SECTION E: SUMMARY OF FINDINGS – FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Heroes Earnings Assistance and Relief Tax Act of 2008 ("HEART")	• Reviewed FSA SPD. • Reviewed FSA Enrollment Agreement. • Reviewed Employee's Handbook.	• No exceptions noted.	• None.		
HIPAA Benefit Provisions (including wellness program requirements)	• Reviewed MPD and FSA SPD.	• No exceptions noted.	• None.		

SECTION E: SUMMARY OF FINDINGS – FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
HIPAA Privacy and Data Security Provisions	• Aon Hewitt conducted HIPAA Privacy and Data Security Training for PEBP staff and the Board in May 2012. • Reviewed MPD and FSA SPD. • Reviewed HIPAA Privacy Notices. • Reviewed HIPAA Security Policy. • Reviewed Business Associate (BA) Agreements.	• Training. PEBP staff has a good understanding of the HIPAA rules and regulations and are very sensitive to the privacy and security of PEBP health information. • Documentation. It appears that the 2012 health plans have not been amended as required by HIPAA to permit plan sponsors (PEBP Board) to have access to PHI. - Plan documents should include procedures necessary to permit access, and list titles of those inside the HIPAA firewall to receive, use or disclose PHI. - Plan sponsor (PEBP Board) must certify compliance with the HIPAA health plan amendment requirements. • MPD and FSA SPD should identify titles of individuals inside the HIPAA firewall. • MPD should identify the title of the HIPAA data security official.	• Training: None. • Documentation: Consider an independent review of its compliance with the requirements of HIPAA's Privacy and Security Rules, with particular focus on the ensuring that: - All required plan amendments have been made and adopted - Required notices reflect those amendments. • HIPAA privacy and data security policies and procedures should be updated for the HITECH Act. • Define the respective health plans as "hybrid entities" to avoid HIPAA mandated privacy and data security requirements being imposed on	• The purpose of the Biennial Legal Compliance Review that is completed by Aon Hewitt is to identify areas which may require PEBP to take action in regards to federal and state mandates. • PEBP may consider performing an independent review of its compliance with the requirements of HIPAA's Privacy and Security Rules. • PEBP may consider amending the MPD subject to the adoption of final federal regulations. • PEBP will update its internal HIPAA Policies and Procedures to reflect the HITECH data security requirements. • PEBP will amend its internal HIPAA Policies and Procedures to reflect "hybrid entities"." affiliated covered entities", and "organized health care arrangements" as recommended.	• To be determined. • To be determined. • July 1, 2013 • July 1, 2013

SECTION E: SUMMARY OF FINDINGS – FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
		• FSA SPD should identify the title of the HIPAA privacy and data security officials and reflect HIPAA data security provisions.	benefits that would not normally be subject to HIPAA's requirements (e.g., life, disability, etc., dependent care FSA). - A hybrid entity is a single covered entity whose business activities include both covered functions and non-covered functions (i.e., benefits subject to HIPAA and those that are not). A hybrid entity also designates health care components (in accordance with 45 CFR Section 164.104(a)(2)(iii)(C)) for purposes of fulfilling the hybrid entity requirements of HIPAA as defined in 45 C.F.R. Section 164.103. • Declare the respective health plans as "affiliated covered entities" so that a single Notice of Privacy Practices could be used for all of the health care components. - Affiliated Covered Entities are legally		

SECTION E: SUMMARY OF FINDINGS – FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
			separate Covered Entities that are all under common control or common ownership and are designated as an affiliated group of covered entities in accordance with 45 CFR Section 164.103. For purposes of this definition, "common control" exists if an entity has the power, directly or indirectly, significantly to influence or direct the actions or policies of another entity; and "common ownership" exists if an entity or entities possess an ownership or equity interest of five (5) percent or more of another entity. • Declare the respective plans as "organized health care arrangements" so that PHI can be shared between the health care components. - An "organized health care arrangement" is defined as 45 CFR Section 160.103 and		

SECTION E: SUMMARY OF FINDINGS – FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
			includes: (i) A group health plan (within the meaning of 45 CFR Section 160.103) and a Health Insurance Issuer or HMO with respect to such group health plan, but only with respect to Protected Health Information created or received by such Health Insurance Issuer or HMO that relates to Individuals who are or who have been participants or beneficiaries in such group health plan; (ii) A group health plan and one (1) or more other group health plans each of which are maintained by the same Plan Sponsor; or (iii) The group health plans described in paragraph (ii) of this definition and Health Insurance Issuers or HMOs		

SECTION E: SUMMARY OF FINDINGS – FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
			with respect to such group health plans, but only with respect to Protected Health Information created or received by such Health Insurance Issuers or HMOs that relates to Individuals who are or have been participants or beneficiaries in any of such group health plans.		
		• HIPAA Data Security Compliance. PEBP's Health Plan Auditor completed a security review in 2010. - Audit demonstrates operational compliance and improvement in certain areas. - Review included some of the areas required by the HIPAA data security regulations.	• HIPAA Data Security Compliance: - HIPAA Data Security Policy does not address all security data requirements. Consider a focused HIPAA data-security gap assessment to confirm full compliance with HIPAA's data security regulations. HIPAA requires that the Plan, as a "covered entity", comply with the new security requirements. Generally, these	• PEBP's Health Plan Auditor is scheduled to perform an operations review of PEBP the week of January 7, 2013. The review will include PEBP's compliance with the 18 HIPAA security standards.	• July 2013

SECTION E: SUMMARY OF FINDINGS – FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
			require covered entities to: ensure the confidentiality, integrity, and availability of electronic PHI ("ePHI") that the Plan creates, receives, maintains, or transmits; protect against reasonably anticipated threats or hazards to the security or integrity of ePHI; protect against reasonably anticipated uses or disclosures of ePHI that are not permitted; and ensure compliance by its workforce. To implement these general requirements, the regulations lay out a series of specific measures that covered entities must take to comply. – 18 Security standards must be implemented through "Required" specifications and "Addressable" specifications		

SECTION E: SUMMARY OF FINDINGS – FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
		• Business Associate Agreements ("BAA"). - We received 15 executed BAA executed in 2010 - 2011. - PEBP has asserted that all vendors who receive PHI have been identified. - PEBP has asserted that its Health Plan Auditor includes BAAs as part of the review of PEBP's internal policies and procedures. - We are unable to independently confirm that every business associate of PEBP has been identified.	– 3 categories of safeguards (administrative, physical and technical) • BAAs: Confirm that BAAs are in place with all vendors of all of PEBP plans, in which PHI is exchanged. - PEBP previously identified a vendor, Beechstreet/Viant that had not returned a signed BAA. - This vendor was not included among the BAAs provided. - Please confirm the status of this vendor.	• PEBP has current BAAs with all vendors that PEBP exchanges PHI with. – The Beechstreet/Viant contract was terminated on June 30, 2012. – Beechstreet/Viant did not return a signed BAA to PEBP.	

SECTION E: SUMMARY OF FINDINGS – FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Code Sections 79, 105(h), 125(h), and 129	• Reviewed results of prior assessment.	• Nondiscrimination testing has not been performed on the PEBP plans. - PEBP asserts that more than 70% of all active full time employees are covered under PEBP. - Plan provisions apply uniformly regardless of compensation. - PEBP benefits are not designed to be discriminatory. - To comply with Code requirements, plans must be tested for discrimination in operation. - Documentation does not address other Code nondiscrimination testing requirements that apply, including those under Code Sections 125 and 129.	• PEBP has discussed nondiscrimination testing requirements with Aon Hewitt's subject matter experts. • We recommend the PEBP perform nondiscrimination testing in conjunction with recommendations set forth by Aon Hewitt's testing team.	• PEBP will continue to work closely with Aon Hewitt's legal staff to schedule Section 125 non-discrimination testing as required after final regulations regarding the non-discrimination testing are published by the IRS. • It is PEBP's intent to work with Aon Hewitt's legal staff to complete Section 129 non-discrimination testing as required.	• To be determined • June 30, 2013
Medicare Secondary Payer Requirements	• Reviewed MPD.	• No exceptions noted.	• None.		
Medicare Part D Requirements	• Reviewed Medicare Part D Notice.	• No exceptions noted.	• None.		

SECTION E: SUMMARY OF FINDINGS – FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Mental Health Parity and Addiction Equity Act ("MHPAEA")	• Reviewed MPD. • Reviewed HMO's Evidence of Coverage.	• No exceptions noted with the change to the CDHD PPO design.	• None.		
Michelle's Law	• Reviewed MPD.	• No exceptions noted.	• None.		
National Defense Authorization Act of 2008 ("NDAA")	• Reviewed MPD. • Reviewed Manager's Handbook. • Reviewed Employee's Handbook.	• No exceptions noted.	• None.		
Newborns' and Mothers' Health Protection Act of 1996 ("NMHPA")	• Reviewed MPD and FSA SPD language. • Reviewed HMO's Evidence of Coverage.	• No exceptions noted.	• None.		

SECTION E: SUMMARY OF FINDINGS – FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Patient Protection and Affordable Care Act of 2010 ("PPACA")	• Reviewed MPD and FSA SPD language. • Reviewed HMO's Evidence of Coverage.	• The Health FSA does not reimburse over-the-counter medicines without a prescription, except insulin • We note that the 2013 SPD also limits Health FSA contributions to $2,500 in accordance with PPACA. • The MPD covers adult children to Age 26. • The MPD no longer contains lifetime dollar limits on essential health benefits. • The MPD does not appear to contain overly restrictive annual dollar limits on essential health benefits. • The MPD does not appear to have any preexisting condition exclusions.	• The MPD should be timely amended for upcoming PPACA requirements including: - Limit of 90-day waiting period for coverage – based on current guidance, we note that the first day of the month following 90 days may not satisfy proposed HHS rules.	• PEBP will update the MPD, NRS, NAC and other relevant documents to ensure compliance with the Waiting Periods described by PPACA.	• When final regulations are determined by the Department of Labor (expected to take effect in 2014)

SECTION E: SUMMARY OF FINDINGS – FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
		• The MPD appears to provide no cost sharing and coverage for certain in-network preventive health services in accordance with HHS guidelines. • The MPD claim and appeals processes appear to satisfy the PPACA requirements. • The MPD's prohibition on rescissions satisfies PPACA.	• Continued monitoring of changes to HHS/HRSA preventive task force guidelines and make respective plan changes from time to time. • The MPD should be timely amended for the addition of women's preventive health requirements to no cost sharing and coverage for certain in-network preventive health services.	• PEBP continually monitors HHS/HRSA guidelines that relate to preventive services and will update the MPD as required. • The MPD will be updated to include information regarding coverage for certain female reproductive services at no cost to the participant or their covered dependent.	• As needed • July 1, 2013

SECTION E: SUMMARY OF FINDINGS – FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
			• PEBP should develop necessary forms and procedures to comply with these PPACA requirements as regulatory guidance becomes available: a) Distribution of Summary of Benefits and Coverage to Participants. b) Payment of comparative effectiveness fee. c) Filing employer quality of care reports. d) Treatment of medical loss ratio rebates (insured plans only). e) Reporting of health coverage on Form W-2. f) Notice to inform employees of coverage options in exchange. g) Employer reporting of health insurance information to government and participants. • PEBP should work with Aon Hewitt team to develop a long-term strategy with respect to the excise tax on high-cost coverage.	a) PEBP has completed the draft Summary of Benefits and Coverage document in accordance with PPACA. b) PEBP is in the process of developing a method to reimburse the federal government as required. This process will be documented in Internal Policies and Procedures. c) Until HHS publishes the applicable regulations, this item remains outstanding. d) PEBP will create a process for passing MLR rebates to participants enrolled in fully-insured plan(s) for the year to which the rebate applies. This process will be documented in Internal Policies and Procedures. e) Health coverage information was reported to employers in January 2012. Some employers added the information to W-2's while others are waiting until 2013. f) PEBP is awaiting final regulations regarding notice to employees of coverage options in the Exchange. g) PEBP is awaiting final regulations regarding employer reporting of health insurance information to the Federal government and participants. • PEBP continues to work with Aon Hewitt on a long-term strategy for coverage subject to "Cadillac Tax".	a) Final document to be distributed during Open Enrollment in April 2013 b) July 1, 2013 c) Awaiting final regulation publication d) Both HMO's passed the MLR test in 2012. PEBP will review the federal regulations and document the process by December 2013 e) Completed f) Awaiting final regulation publication, not prior to September 30, 2013 g) To be determined upon receipt and review of final regulations • Awaiting final regulation publication

SECTION E: SUMMARY OF FINDINGS – FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Pregnancy Discrimination Act ("PDA")	• Reviewed MPD. • Reviewed HMO's Evidence of Coverage.	• No exceptions noted.	• None.		
QMCSOs	• Reviewed MPD and FSA SPD.	• No exceptions noted.	• None.		
Rehabilitation Act of 1973	• Reviewed MPD and FSA SPD. • Reviewed Employee's Handbook.	• No exceptions noted.	• None.		
Social Security Act Health Insurance ("Medicare")	• Reviewed Medicare Part D Notice.	• No exceptions noted.	• None.		
Title VII of the Civil Rights Act of 1964	• Reviewed MPD and FSA SPD. • Reviewed Employee Handbook.	• No exceptions noted.	• None.		
Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")	• Reviewed MPD and FSA SPD. • Reviewed Employee's Handbook. • Reviewed Manager's Handbook	• No exceptions noted.	• None.		
Women's Health & Cancer Rights Act of 1998 ("WHCRA")	• Reviewed MPD and FSA SPD. • Reviewed HMO Evidence of Coverage.	• No exceptions noted.	• None.		

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS

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SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Eligibility and Participation: Definition of "dependent" NAC 287.035 NAC 287.311 NAC 287.312 NAC 287.3125 NAC 287.313	• Reviewed Master Plan Document ("MPD") • Reviewed Certification of Disabled Dependent Child. • Reviewed Full-time Student Verifications.	• The requirement under NAC 287.311 that the declaration of enrollment must be made under penalty of perjury has been added to the MPD. • While the Certification of Disabled Dependent Child describes the NRS penalties for insurance fraud, the certification does not indicate that the declaration is made under penalty of perjury.	• Recommendation: Consider updating the Certification Form to state that the declaration is being made under penalty of perjury.	• The Certification of Disabled Dependent Child Form will be revised to include recommended language.	• March 1, 2013
		• We note that the MPD has been updated to reflect the PPACA provisions concerning coverage of adult children. While NAC 287.312 has been recently amended, it does not appear to fully reflect the MPD provisions/ PPACA requirements (e.g., adult children being covered to age 26). • The reference to NAC 287.312 reflects the requirements applicable during the review period. We note that the language has been removed from the 2013 MPD to reflect the amendments to NAC 287.312.	• Recommendation: NAC 287.312 should be reviewed and updated as necessary to reflect the PPACA requirements.	• PEBP revised NAC 287.312 in LCB file R002-12 (effective June 29, 2012) to remove conflicting information regarding coverage of adult children. Please refer to Attachment D.	• Completed

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Eligibility and Participation: Definition of "Domestic Partner" NAC 287.035 NAC 287-038	• Reviewed MPD.	• NAC 287.035 amended the definition of "dependent" to include "domestic partner". • We note that the MPD has been updated to include domestic partner eligibility provisions.	• None.		
Eligibility and Participation: Definition of "participant" NAC 287.095 NAC 287.135 NAC 287.150 NAC 287.313 NAC 287.500	• Reviewed MPD.	• No exceptions in MPD noted. • We note that the MPD has been updated to include former school board members as noted in the prior review. • The requirement under NAC 287.135 concerning retired officers and employees noted in the prior review has been added to the MPD.	• None.		
Eligibility and Participation: Definition of "full-time employment" and eligibility waiting periods NRS 287.045 NAC 287.150 NAC 287.313	• Reviewed MPD. • Reviewed Employee and Retiree Open Enrollment Guides.	• No exceptions in MPD noted. • No exceptions noted in Employee and Retiree Open Enrollment Guides.	• None.		

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Eligibility and Participation: Retirees NAC 287.440 NAC 287.530 NAC 287.540 NAC 287.542 NAC 287.544 NAC 287.546 NAC 287.548 NRS 287.0406 NRS 287.0436 NRS 287.046 NRS 287.023 NRS 287.047 NRS 287.043	• Reviewed MPD. • Reviewed PEBP Board and Agency Duties, Policies and Procedures ("Board Procedures"). • Reviewed Retiree Enrollment Guide.	• Employees and officers of participating local government agencies may also continue PEBP coverage at retirement under certain conditions. • The requirement under NRS 287.047 concerning retired legislators noted in the prior review has been added to the MPD.	• These provisions are described in the Retiree Enrollment Guide. • Recommendation. A reference to the relevant provisions should be included in the "NAC and NRS Regarding the PEBP Plan and Your Coverage" section of the MPD.	• PEBP will include references to stated NAC and NRS in the Plan Year 2014 MPD.	• July 1, 2013
Eligibility and Participation: Seasonal employees and employees on a biennial plan NAC 287.095 NAC 287.150 NAC 287.500 NRS 287.0467	• Reviewed MPD. • Reviewed Open Enrollment Guide.	• No exceptions noted.	• None.		
Eligibility and Participation: Rehired employees NAC 287.510 NAC 287.515 NRS 287.043	• Reviewed MPD.	• No exceptions noted.	• None.		

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Eligibility and Participation: Individual as both employee and dependent NAC 287.520 NRS 287.043	• Reviewed MPD.	• No exceptions noted.	• None.		
Eligibility and Participation: Surviving spouse/ dependents NAC 287.530 NRS 287.021 NRS 287.0475 NRS 287.0477	• Reviewed MPD. • Reviewed Open Enrollment Guide.	• No exceptions noted. • We note that a reference to NRS 287.0477 noted in the prior review has been added to the MPD.	• None.		
Eligibility and Participation: Pre-existing condition limitations for retirees NRS 287.0475	• Reviewed MPD.	• No exceptions noted. • We note that the MPD reflects that the Legislature eliminated Reinstatement Late Enrollment.	• None.	.	

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Eligibility and Participation: Surviving spouse/child of a police officer, firemen or volunteer firemen killed in the line of duty NRS 287.0477	• Reviewed MPD. • Reviewed Employee Open Enrollment Guide.	• No exceptions noted. • During the prior review, we recommended that procedures should exist to ensure that the PEBP properly informs a surviving spouse/child of his or her requirements to notify the PEPB within 60 days following the death of the insured policeman/ fireman. • PEBP indicated that the condolence letter would be updated to specifically address policeman/ fireman.	• Please confirm the status of the changes to the condolence letter.	• PEBP is in the process of revising the condolence letter as recommended.	• March 1, 2013
Eligibility and Participation: Coverage of newly born and adopted children NRS 689B.033 NRS 287.04335	• Reviewed MPD.	• No exceptions noted. • We note that the MPD has been updated to reflect the NRS 689B.033 requirement for coverage for medically necessary care of newborns, including transportation related costs, as noted in the prior review.	• None		

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Eligibility and Participation: Applications for participation in PEBP by local government agencies NAC 287.310 NRS 287.010 NRS 287.017 NRS 287.025.1.(a) NRS 287.040	• Reviewed "Local Government Entity Application Instructions for Coverage under Public Employees' Benefits Program (Health Insurance)" Application Instructions. • Reviewed MPD.	• The application instructions (Step 1, #2) omitted the requirement in NAC 287.310 (1)(d)(2) that local governmental agencies must also provide the current selection of coverage for its members that are currently enrolled in the local governmental agencies group health plan (it only requires for the agency to provide the plan options that it offers its employees).	• We note that the Application Instructions were amended in 2011, but could not locate the information required by NAC 287.310 (1)(d)(2). We recommend further discussion with PEBP to confirm.	• PEBP will revise the application instruction form to include this recommendation.	• July 2013
		• Procedures should exist to reflect responsibilities of Executive Officer/ PEBP regarding administration of the application process and responsibilities to the local government agencies, including the requirements of NAC 287.310(3), regarding providing a claims history report upon request.	• Further discussion with PEBP is recommended to obtain verification that the appropriate procedures have been updated.	• PEBP will revise the procedures to more clearly reflect the responsibilities of PEBP and the local government.	• July 1, 2013

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Eligibility and Participation: Orientation program NAC 287.314 NAC 287.317	• Reviewed MPD.	• No exceptions noted. • We note that issues identified in the prior review have been addressed.	• None.		
Eligibility and Participation: Terminating interlocal contract and withdrawing from program NAC 287.320 NAC 287.350 (repealed) NAC 287.355 NAC 287.357 NAC 287.359 NAC 287.361 NAC 287.363 NAC 287.367 NAC 287.369 NRS 287.0479	• Reviewed Local Government Agency Application Instructions. • Reviewed MPD.	• NAC 287.357(8) requires a business associate agreement or certification that each opt-out plan is a covered entity under HIPAA's privacy regulations on file for each opt-out plan.	• Further discussion with PEBP to obtain confirmation there are no opt-out plans recommended.	• There are currently no opt-out plans.	• Not Applicable

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Eligibility and Participation: Opt-out plan administration NAC 287.371 NAC 287.373 NAC 287.375 NAC 287.377 (repealed) NAC 287.379 NAC 287.381 NAC 287.383 NAC 287.385 NAC 287.387 NAC 287.389 NRS 287.010	• Reviewed MPD.	• Under NAC 287.375, PEBP is responsible for administering eligibility requirements for participants in opt-out plans. – In addition, PEBP is responsible for processing child support orders, workers' compensation leave, military leave, family and medical leave and other leaves of absence that affect coverage. – It does not appear procedures unique to opt-out plan administration, exist at PEBP.	• Further discussion with PEBP to obtain confirmation there are no opt-out plans recommended.	• There are not and have never been any opt-out plans. If a group does opt-out of PEBP, PEBP will comply with these requirements through its current administration process. A unique process should not be required to administer these requirements.	• Complete
		• NRS 287.010(3)-(6) permit employees of legal org. contracted with a participating local agency can be eligible for benefits under a participating local agency plan, including the PEBP. – However, formal procedures do not appear to exist.		• NRS 287.010 (3)-(6) does not apply to PEBP as we are not a legal services organization.	• Not Applicable

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Eligibility and Participation: Definition of "Open Enrollment" NAC 287.085	• Reviewed MPD.	• This definition relates to opt-out plan administration and the ability to switch opt-out plans or join an opt-out plan that the employees are eligible for.	• None.	• The rules for opt-out eligibility and participation were changed in the 2011 Legislative session and the corresponding regulations were amended in LCB file R002-12 regarding the ability of the participants to switch plans. Please refer to Attachment D.	• Not Applicable
Benefits Coverage: Definition of "Plan Year" NAC 287.100	• Reviewed MPD.	• No exceptions noted. • We note that the PEPB modified the definition of "plan year" in the MPD and the FSA SPD as noted in the prior review.	• None.		
Benefits Coverage NRS 287.0433 NRS 287.04062 NRS 695G.160 NRS 287.0485	• Reviewed MPD. • Reviewed State of Nevada Employee Handbook.	• We noted an apparent conflict between the statutes and the applicability of NRS 689B and 695G provisions to self-insured health plans. Under NRS 287.04335, these provisions are made applicable to self-insured health plans. • We note that the PEPB modified the MPD to comply with NRS 287.0485 as noted in the prior review.	• NRS 695G.160 requires specific written criteria concerning coverage of health care services and standards for quality of health care services. The PEBP has previously indicated that the statute is not intended to apply to its self-insured plan, which conflicts with the requirement under NRS 287.04335. – The conflicts between the statutes should be resolved and corrective action taken if necessary, including amending NRS 287.04335.	• PEBP will revise language in the MPD to address the criteria of NRS 695G.160.	• July 1, 2013

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Benefits Coverage: Restatement of coverage by retired public officer, employee or surviving spouse NRS 287.0205	• Reviewed MPD.	• This provision relates to self-insured opt-out plans maintained by local governmental agencies.	• None (outside scope of review).		
Benefits Coverage: Human papillomavirus vaccination, screening for colorectal cancer, prostate cancer and autism NRS 287.0272 NRS 287.027 NRS 287.0274 NRS 287.0276	• Reviewed MPD.	• Relates to self-insured opt-out plans maintained by local governmental agencies.	• None (outside scope of review).		

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Benefits: Coverage: Continued medical treatment NRS 695G.164 NRS 287.04335	• Reviewed MPD.	• Under NRS 287.04335, NRS 695G.164 (re: required provisions concerning coverage for continued medical treatment) is applicable to self-insured health plans. However, it is our understanding that PEBP staff has determined that this is not intended to be applicable to the self-insured PPO plans offered under the PEBP.	• Note that the PEBP has previously indicated that it is in the process of addressing the discrepancies between the statutes that make certain provisions applicable to HMOs (subject to the requirements of the Department of Managed Care) also applicable to self-insured plans. - The conflicts between the statutes should be resolved and corrective action taken if necessary, including amending NRS 287.04335.	• PEBP will revise language in the MPD to address the criteria of NRS 695G.164.	• July 1, 2013
Benefits Coverage: Medically necessary emergency services NRS 695G.170 NRS 287.04335	• Reviewed MPD.	• No exceptions noted. • Under NRS 287.04335, NRS 695G.170 is made applicable to self-insured health plans. However, it is our understanding that PEBP staff has determined that this is not intended to be applicable to the self-insured PPO plans offered under the PEBP.	• Note that he PEBP has previously indicated that it is in the process of addressing the discrepancies between the statutes that make certain provisions applicable to HMOs (subject to the requirements of the Department of Managed Care) also applicable to self-insured plans. - The conflicts between the statutes should be resolved and corrective action taken if necessary, including amending NRS 287.04335.	• PEBP will revise language in the MPD to address the criteria of NRS 695G.170.	• July 1, 2013

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Benefits Coverage: Treatment received as part of a clinical trial or study NRS 695G.173 NRS 689B.0306 NRS 287.04335	• Reviewed MPD.	• No exceptions noted.	• None.		
Benefits Coverage: Conversion health plan NRS 689B.283	• Reviewed MPD. • Interviewed PEBP staff.	• N/A- the self-insured medical plan does not offer a conversion plan.	• None.		
Benefits Coverage: Claims Involving Intoxication NRS 689B.287 NRS 695G.405	• Reviewed MPD.	• No exceptions noted.	• None.		

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Funding Requirements: Non-retiree plans NRS 287.0435 NRS 287.0434 NRS 287.043 NRS 287.046	• Reviewed MPD. • Reviewed Board Procedures.	• NRS 287.0435(3) has been amended since last review to indicate that disbursements made from the PEBP must be only for the benefit of PEBP participants.	• As a best practice, we recommend that the MPD contain a statement to the effect that payments from the PEBP may only be made for only the benefit of the participants in the PEBP. a. We could not determine where this language was added to the MPD.	• PEBP will review the MPD and add appropriate language.	• July 1, 2013
		• NRS 287.0435(1) indicates that the PEBP fund must be accounted for as an internal service fund. We have been told previously by PEBP staff that is how the fund is being administered.	• None.		

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Funding Requirements: Retiree Plans NAC 287.485 NAC 287.490 NRS 287.017 NRS 287.043 NRS 287.0434 NRS 287.0436 NRS 287.04362 NRS 287.04364 NRS 287.046	• Reviewed Board Procedures • Reviewed "Nevada Public Employees' Benefits Programs Retiree Health and Life Insurance Plans Actuarial Report for GASB OPEB Valuation-Final" for fiscal year ending June 30, 2010 -2011 ("GASB Report").	• Under NRS 287.0436, an irrevocable trust fund must be created to account for the financial assets designated to offset a portion of the current and future costs of providing health care to retirees. The GASB Report indicates that there is an irrevocable trust. PEBP staff members have also indicated that an irrevocable trust has been established.			
		• Funds remaining in the trust at the end of a fiscal year are retained in the trust and not reverted to the State's general fund. Also, retiree fund assets must be invested to obtain highest return possible in accordance with Nevada state law.	• None.		
		• NAC 287.045 requires an audit from the local governmental agency employer certifying the hire date of the retiree in all cases. The Board Procedures and other documents reviewed do not address this.	• Best Practice. Document Procedures to reflect audit requirement and develop procedures for monitoring process. • PEBP staff has indicated that: – PEBP Board procedures do not address the day to day operations of PEBP and are not designed for this type of procedure.	• PEBP will review the procedures and add additional language to reflect what entity is responsible for the audits (NSHE or PERS) if appropriate.	• July 1, 2013

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Funding Requirements: Retiree Plans- cont'd.			– PEBP staff currently requests audits from the appropriate certifying agency (PERS or NSHE) for all new retirees. These audits contain information regarding Years of Service and initial hire dates.		
		• Per the requirements of NRS 287.017, local government agencies must establish irrevocable trusts for their retiree health benefit plans. • PEBP staff members previously have indicated that – PEBP does not monitor compliance of the operations of local governmental agencies and that NRS 287.017 does not apply to PEBP. – It is unnecessary procedures to ensure that irrevocable trusts have been established.	• Assuming that NRS 287.017 is outside the scope of PEBP's purview, none. • Best Practice. Document in PEBP procedures who has responsibility for monitoring compliance with NRS 287.017.	• NRS 287.017 is outside the scope of PEBPS's oversight responsibility. Any monitoring or oversight would be performed by the Committee on Local Government Finance.	• Not Applicable

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Funding Requirements: Payment of Premiums Due date of premiums billed by PEBP and owed by public employers. Legislator payment of premiums. Responsibility for dependent coverage. NAC 287.420 NRS 287.04385 NRS 287.043 NRS 287.044	• Reviewed MPD. • Reviewed Board Procedures. • Reviewed Local Government Agency Application Instructions.	• NAC 287.420 provides penalties to be assessed in the event of nonpayment by the participating public agency. • In previous reviews, we were told that specific procedures exist regarding the billing and payment of premiums by participating employers to the PEBP.	• Confirm that procedures exist for billing/monitoring invoicing of local governmental entities. • Confirm who is responsible for payment of invoices. Billing due dates are included on each months bill.	• Existing Accounting Policies and Procedures are under review and billing/monitoring invoicing of local government entities will be reviewed and updated as needed. • The Local Government is responsible for providing a contact person for payment of invoices from PEBP. These are updated as changes are received.	• July 1, 2013
Funding Requirements: Direct payment of premiums for retirees, LOAs without pay and LOAs due to work injury NAC 287.430 NAC 287.440 NAC 287.450 NAC 287.460 NRS 287.043 NRS 287.046 NRS 287.0439 NRS 287.0445	• Reviewed MPD. • Reviewed Flexible Spending Accounts Summary Plan Description for the 2012 Plan Year ("FSA SPD"). • Reviewed State Employee Handbook.	• No exceptions in the MPD noted. • We note that the Termination for Non-payment section reflects the new requirements of NAC 287.430.	• None. • None. .		

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Funding Requirements: Procedures regarding handling over/ underpayments of premiums NAC 287.470 NRS 287.043	• Reviewed MPD and FSA SPD.	• NAC 287.470 generally indicates that certain over/under payments of premiums may be adjusted in the premiums for the following month. – However, we could not find administrative procedures in the documents reviewed. – MPD indicates that premium overpayments due to lack of proper notification by the participant will not be refunded if over 30 days.	• Best Practice. Administrative procedures should be developed for treatment of over/under payments including necessary approvals.	• Existing Accounting Policies and Procedures are under review and over/underpayment of premiums will be reviewed and updated as needed.	• July 1, 2013
Subrogation to rights of officer, employee or dependent NRS 287.0465	• Reviewed MPD. • Reviewed subrogation notice.	• No exceptions noted. • We note that NRS 287.0465, the MPD and the HealthScope subrogation language has been amended.	• None.		

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Claims and Appeals Procedures NAC 287.610 NAC 287.620 NAC 287.660 NAC 287.670 NAC 287.680 NAC 287.690 NRS 287.043 NRS 287.04335 NRS 689B.255	• Reviewed MPD. • Reviewed FSA SPD. • Reviewed PEBP Quality Control Claims Appeals Policies and Procedures (claims policies and procedures).	• No exceptions noted. • We note that the PEBP substantially revised its current appeal process to reflect the requirements in the PPACA.	• Consider amending NRS 287.04335 if the requirements in NRS 689B.255 are not intended to apply to self-insured plans.	• PEBP will revise language in the MPD to address the criteria of NRS 689B.255.	• July 1, 2013
Claims and Appeals Procedures: Complaint system; notice requirements to insured NAC 287.750 NRS 695G.200 NRS 695G.220 NRS 695G.230 NRS 287.04335	• Reviewed MPD.	• No exceptions noted. • We note that the PEBP substantially revised its current appeal process to reflect the requirements in the PPACA.	• None.		

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Claims and Appeals Procedures: Notice to insured; expedited review process NRS 695G.210 NRS 695G.230 NRS 287.04335	• Reviewed MPD. • Reviewed PEBP appeals procedures.	• NRS 695G.210 requires notification to insured to be made in writing within 72 hours. MPD requires oral notification immediately, followed by written notification. However, MPD language (p. 136 is vague as to timeframe for providing the written notification. • We note that the PEBP substantially revised its current appeal process to reflect the requirements in the PPACA.	• Confirm that MPD language regarding notification requirements complies with NRS 695G.210; amend MPD if necessary.	• PEBP will revise language in the MPD to address the criteria of NRS 695G.210.	• July 1, 2013
Claims and Appeals Procedures: External review process NRS 695G.241 NRS 695G.300 NRS 695G.310 NRS 287.04335	• Reviewed MPD.	• No exceptions noted. • We note that the PEBP substantially revised its current appeal process to reflect the requirements in the PPACA.	• None.		
Family Medical Leave Provisions NAC 284.52345 NAC 284.581 NAC 284.5811 NAC 284.5813	• Reviewed MPD. • Reviewed FMLA procedures. • Reviewed State Employee Handbook. • Reviewed Manager's Handbook.	• No exceptions noted.	• None.		

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
Leave of Absence for Military Duty NAC 281.145	• Reviewed MPD. • Reviewed State Employee Handbook.	• No exceptions noted.	• None.		
Audit Requirements NRS 287.0425(1)(a),(b)	• Confirmed State of Nevada Self-Insurance Trust Fund, Public Employees' Benefits Program, June 30, 2012 and 2011 issued. • Confirmed State Retirees" Health & Welfare Benefits Fund, Public Employees' Benefits Program, June 30, 2012 and 2011 issued.	• No exceptions noted.	• None.	• These documents are being provided with this update. Please refer to Attachments B and C.	• Complete
Additional Reporting Requirements NRS 287.0425(2)(a)	• Confirmed biennial GASB Report was issued (independent biennial certified actuarial valuation and report of the State's health and welfare benefits for current and future state retirees).	• GASB valuation last performed as of June 30, 2011. Since there haven't been significant design changes for 2012, PEBP has decided to forgo a GASB valuation as of June 30, 2012 plan (GASB allows entities to perform a valuation every other year when there hasn't been significant plan design changes).	• None.		

SECTION F: SUMMARY OF FINDINGS – STATE LAW REQUIREMENTS (CONT'D.)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION NEEDED	PEBP ACTION	ACTION TIMELINE
PEBP Board Authority and Duties NRS 287.04062 NRS 287.0415 NRS 287.0424 NRS 287.0426 NRS 287.043 NRS 287.0487 NRS 287.04335 NRS 287.0402 NRS 287.041 NRS 287.0434	• Reviewed Board Procedures.	• No exceptions noted.	• None.		
Miscellaneous NAC 287.005, NAC 287.145	• Reviewed MPD.	• No exceptions noted.	• None.		