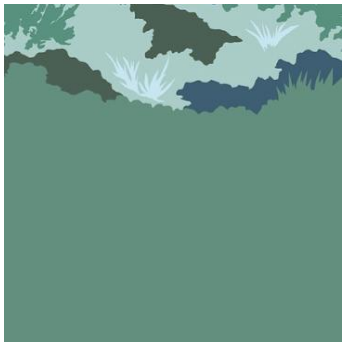
ENROLLMENT AND ELIGIBILITY POLICY

(Updated March 2026)








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Public Employees' Benefits Program Enrollment and Eligibility Policy

The Enrollment and Eligibility Policy describes the enrollment and eligibility provisions for state and non-state employees and retirees. It also includes information regarding initial enrollment requirements, qualifying life status events and applicable notification timeframes, COBRA, military, FMLA and other types of leave.

PEBP plans are governed by the State of Nevada.

This policy is intended to comply with Chapter 287 of the Nevada Revised Statutes (NRS), Chapter 287 of the Nevada Administrative Code (NAC), and all other applicable provisions of Nevada law. Additionally, PEBP intends to incorporate herein by reference and to comply with all applicable provisions of the Health Insurance Portability and Accountability Act (HIPAA).

The provisions and information described in this policy were updated in May of 2025**.**

This policy describes the process and timeframes for submitting new hire or retiree enrollment elections, qualifying life status changes, and supporting document requirements.

Per NRS 287.0485 no officer, employee, or retiree of the State has any inherent right to benefits provided under the PEBP.

Rescission of Coverage

The Plan Administrator is prohibited from rescinding or retroactively terminating the coverage of a covered person under a benefit option that is a group health plan that is not excepted or exempt under Section 2712 of the Public Health Service Act, unless 30 days' advance written notice is provided and such covered person commits an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; provided however, that the foregoing prohibition shall not prohibit retroactive termination in the event: (i) a Participant fails to timely pay premiums towards the cost of coverage; or (ii) any other circumstance under which retroactive termination would not violate the Patient Protection and Affordable Care Act. The covered person may appeal against the rescission of coverage as a denial of a post-service claim under Article 7 in the Health and Welfare Wrap Document available at https://www.pebp.nv.gov.In the event the Plan Administrator rescinds a Covered Person's coverage on account of an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent, such rescission shall not cause the individual to incur a "qualifying event" as provided under COBRA.

Summary of Benefit Options

	Full-Time Employees			Active Legislator	Retirees (non-Medicare)			Survivors of Retirees (non-Medicare)	
	State	Non-State	NSHE		State	Non-State	Reinstated (State or Non-State)	Spouse	Dependent Child
Medical Options									
Consumer Driven Health Plan (CDHP)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Exclusive Provider Organization Plan (EPO)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Low Deductible PPO Plan (LD PPO)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health Plan of Nevada (HPN) HMO	✓	✓	✓	✓	✓	✓	✓	✓	✓
Other Options									
Self-funded PPO Dental	✓	✓	✓	✓	✓	✓	✓	✓	✓
Basic Life	✓	✓	✓	✓	✓	✓			
					Retirees eligible for Medicare Parts A and B			**Survivors of Retirees**	
Medicare Exchange for Medicare eligible retirees and their covered Medicare eligible dependents					✓	✓	✓	✓	

Summary of Voluntary Product Options

	Full-Time Employees			Active Legislator	Retirees			Survivors of Retirees	
	State	Non-State	NSHE		State	Non-State	Reinstated (State or Non-State)	Spouse	Dependent Child
Summary of Voluntary Product Options									
VSP Voluntary Vision	X	X	X	X	X	X	X		
MetLIfe Employee Critical Illness	X	X	X	X					
MetLIfe Spouse Critical Illness	X	X	X	X					
MetLIfe Hospital Indemnity	X	X	X	X					
MetLIfe Accident Insurance	X	X	X	X					
MetLIfe Employee Voluntary Life and AD&D	X	X	X	X					
MetLIfe Spouse Voluntary Life	X	X	X	X					
MetLIfe Child Voluntary Life	X	X	X	X					
LegalEASE – Legal Services	X	X	X	X	X	X	X		
ID Theft Protection – ID Watchdog	X	X	X	X	X	X	X		
MetLIfe Retiree Voluntary Life				X	X	X	X		
MetLIfe Retiree Critical Illness				X	X	X	X		
MetLIfe Retiree Accident Insurance				X	X	X	X		

Auto, Home, Renters' Insurance (Liberty Mutual)	X	X	X	X	X	X	X		
Pet Insurance (Nationwide Pet Health)	X	X	X	X	X	X	X		
MetLIfe Short-Term and Long-Term Disability Insurance	X	X	X	X					

Enrollment Processes

Enrollment

Most enrollment events may be completed online and will eliminate having to complete a paper enrollment form. If the participant is enrolling in the Consumer Driven Health Plan (CDHP) they may also establish a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) online.

Enrollment must include without limitation:

- The name, address and social security number of the participant who is enrolling in the Plan; and
- The name and social security number of any dependent the participant chooses to cover under the Plan and any required supporting documents.

A participant who desires to enroll or add a dependent to the Plan must agree to the authorization section of the enrollment form by signing (submittal of the online enrollment is considered a digital signature) and dating the enrollment.

Initial Enrollment

Initial Enrollment for Active Employees

Benefit eligibility is reported to PEBP by the employer. A new benefits-eligible employee must enroll or decline coverage online at https://www.pebp.nv.gov and upload any required supporting documents (if adding dependents) to their E-PEBP portal no later than the last day of the month their coverage is scheduled to become effective. This is the initial enrollment that is also considered a "new hire" event.

Enrollment Requirement Example:

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

If a member's initial enrollment occurs during Open Enrollment, the initial enrollment must be completed before Open Enrollment elections.

Default Coverage – Failure to Enroll When Eligible

PEBP requires eligible employees to enroll in a medical Plan or decline benefits no later than the last day of the month coverage is scheduled to become effective. If an employee fails to enroll or decline coverage as specified above, the employee will be automatically enrolled in the Consumer Driven Health Plan (CDHP) with a Health Reimbursement Arrangement (HRA), in the "employee-only" tier without coverage for dependents.

Initial Enrollment for Retirees

Retirees who wish to enroll in retiree coverage must complete the required paper enrollment documents and submit to the PEBP office within 60 days of the date of retirement. Required forms include the Retiree Benefit Enrollment and Change Form (RBECF) and the Years of Service Certification Form (YOSCF) and are available upon request by contacting the PEBP office. Eligible dependents must be enrolled at the same time as the retiree.

Initial Enrollment for Survivors

Eligible surviving dependent(s) who wish to be covered under PEBP must complete an enrollment election within 60 days of the date of death of the employee or retiree.

Initial Enrollment for COBRA

Qualified beneficiaries who wish to elect COBRA continuation coverage must submit their COBRA enrollment election within 60 days of the qualifying event date. Coverage will not be processed until payment is received.

Open Enrollment

Open enrollment is typically held May 1 - May 31 and any changes made during open enrollment become effective on July 1st, immediately following the open enrollment period.

During this time active employees and retirees may:

- Enroll in a medical Plan or change Plan options; or
- Add or delete eligible dependents to/from medical coverage; or
- Decline coverage.
- Retirees covered under the Medicare Exchange may:
  - Opt-in/out of PEBP dental coverage (must be covered under a PEBP sponsored medical Plan)
  - Add or delete eligible dependents

During a positive enrollment period or if a medical Plan option is discontinued, the covered participant must submit a new plan election within the required timeframe as determined by PEBP. Failure to make a new enrollment election will cause the participant and any covered dependents to be defaulted to the CDHP Plan (default Plan).

Retiree Late Enrollment

Per NRS 287.0475, a retired public officer or employee of the State, NSHE, a participating local government, or the surviving spouse thereof, may reinstate insurance during the open enrollment period if the retired public officer or employee did not have more than one period during which he or she was not covered under the PEBP Plan on or after October 1, 2011, or on or after the date of his or her retirement, whichever is later. Meaning, the above individuals will only have one opportunity to rejoin a PEBP Plan following retirement.

In accordance with NRS 287.0475, a retired public officer or employee or the surviving spouse thereof, may reinstate insurance through the Medicare Exchange, except life insurance, under the Public Employees' Benefits Program, if the retired public officer or employee (1) did not have more than one period during which he or she was not covered by insurance under the Program on or after October 1, 2011; (2) retired from a nonparticipating local governmental agency; (3) was enrolled in the Program as a retiree on November 30, 2008; and (4) is enrolled in Medicare Parts A and B at the time of the request for reinstatement.

To enroll as a late enrollee, an eligible individual must contact PEBP between April 15th and May 15th to request the retiree late enrollment form. Approved enrollment for reinstated retirees will become effective July 1st. Reinstated retirees are not eligible for basic life insurance coverage through the PEBP. Requests for reinstatement must be completed through the submission of the required forms to the PEBP office not later than 31 days before the commencement of the plan year.

HIPAA Special Enrollment Notice

If a participant is declining medical benefits for themselves or their eligible dependents (including their eligible spouse or domestic partner) because of other health insurance or group health plan coverage, they may be able to enroll themselves and their eligible dependents in medical benefits provided under a PEBP-sponsored plan if the participant or their dependents lose eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, the participant must request enrollment within 60 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if the participant has a new dependent because of marriage, birth, adoption, or placement for adoption, they may be able to enroll themselves and their dependents. However, the participant must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

If the participant requests a change due to a special enrollment event within the 60-day timeframe, coverage will be effective the date of birth, adoption, or placement for adoption. For other events, coverage may be effective the first day of the month following the receipt of a completed request for enrollment. A completed request for enrollment means required supporting documentation such as a marriage certificate, birth certificate, proof of coverages, etc. For a list of supporting documents, see "Summary of Supporting Eligibility Documents," below.

HIPAA Special Enrollment Rights [26 CFR §1.125-4(b)] allow a "special enrollee" to change his or her existing enrollment after:

- A loss of eligibility for group health coverage, health insurance coverage, Medicare Part A, CHIP, or Medicaid.
- Becoming eligible for state premium assistance, Medicaid, or CHIP subsidies; and
- Obtaining a new spouse or dependent by marriage, domestic partnership, legal guardianship, birth, adoption, or placement for adoption.

Change in Status applies to marital status (marriage, divorce), number of dependents (includes birth, adoption, placement for adoption, registration/termination of domestic partnership, and death, employment status, dependent satisfies or ceases to satisfy eligibility requirements, change in residence [26 CFR §1.125-4(c)(1)(i)].

Special enrollment rights are subject to certain circumstances. If the participant is a State or non-State retiree, special enrollment does not apply, but it does apply to their dependents if the primary participant and the dependent are covered under the Plan. If the participant is a surviving spouse or surviving domestic partner not covered under a plan, special enrollment does not apply to them or their dependents.

Retroactive Premiums

Deductions for elections and/or tier changes may take several pay cycles to be applied. This may result in "catch-up" for retroactive premiums. Some members may see larger than anticipated pay deductions.

Address Changes

To protect the participant and their family's rights, the participant is responsible for notifying the Plan Administrator about any changes in the addresses of family members.

Eligibility for Coverage

Summary of PEBP Eligibility and Enrollment Requirements

This chapter outlines the enrollment processes and eligibility requirements for individuals eligible for coverage under the Public Employees' Benefits Program (PEBP). Information regarding the enrollment process, coverage termination procedures, timeframes for completing enrollment and submitting supporting documents and premium payments are detailed in this document.

- Any spouse or domestic partner that is eligible for coverage as both a primary participant and a dependent shall be enrolled as a primary participant.
- A child that is eligible as both a primary participant and a dependent may enroll as a primary participant or continue coverage as a dependent of a PEBP participant until age 26 years.

Eligibility Determinations

Eligibility for PEBP coverage is determined in accordance with the NRS Chapter 287, NAC Chapter 287, and the provisions outlined in this policy. Individuals have the right to appeal an eligibility decision and request information as to why a determination was made; however, unless evidence supports that an eligibility determination fails to comply with the eligibility terms in this document, the original determination will not be reversed.

Note: A retroactive rescission of coverage may be appealed except when the coverage termination is due to non-payment of premium.

Eligibility for Active Employees

The following full-time employees are eligible to participate in PEBP after satisfying their respective waiting period:

- Employees of a State and participating non-State agency.
- Employees of the Nevada Senate or Assembly.
- NSHE employees under a letter of appointment with benefits.
- NSHE classified employees.
- NSHE professional employees under annual contract.

Eligibility for Member of the Senate or Assembly

Members of the Nevada Senate or Assembly are eligible to enroll for coverage as provided in NRS 287.045.

Pursuant to NRS 287.045(4), a member of the Senate or Assembly is eligible on a) the first day of the initial term of office of the member, if that date is the first day of the month; or b) the first day of the month immediately following the first day of the initial term of office of the member.

If a member of the Senate or Assembly becomes an employee of the state, or vice versa, the basis for the member's eligibility will correspond to the member's current status, that is, the basis for eligibility will change accordingly. Upon such a change, the member is entitled to initial enrollment benefits.

Eligibility for Retirees

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

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

Eligibility for Dependents

Participant's Spouse

For the purposes of this Plan, the participant's lawful spouse is eligible for coverage under the PEBP Plan. Spouses that are eligible for health coverage through their current employer group health plan are typically not eligible for coverage under the PEBP Plan. If the primary participant's spouse's employer group health plan satisfies PEBP's definition of "Significantly Inferior Coverage" and the participant complies with the items listed in the Exception paragraph below, they may be able to enroll or continue their spouse's coverage under PEBP. The definition of "Significantly Inferior Coverage" is provided in the *definition section* of this document.

The Plan requires proof of the legal marital relationship and completion of the enrollment online declaring that the spouse is not eligible for an employer group health plan. A spouse is not an eligible dependent after divorce.

Participant's Domestic Partner

The participant's domestic partner, as recognized by the laws of the State of Nevada, is eligible for coverage under the PEBP Plan. Domestic partners that are eligible for group health insurance through their current employer are typically not eligible for coverage under the PEBP Plan. If the participant's domestic partner's employer sponsored health coverage satisfies PEBP's definition of "Significantly Inferior Coverage" and the participant complies with the items listed in the Exception paragraph listed below, they may be able to enroll or continue their domestic partners coverage under PEBP. The definition of "Significantly Inferior Coverage" is provided in the *definition section* of this document.

The Plan requires a copy of the domestic partnership certification, and completion of the online enrollment or through the submission of a paper enrollment form declaring that the domestic partner is not eligible for an employer group health plan. By completing an enrollment election, the participant acknowledges their responsibility for any federal income tax consequences resulting from the enrollment of the domestic partner in the Plan. A domestic partner is not an eligible dependent after dissolution of the domestic partnership. Participants who have a legal

union or domestic partnership validly formed in another jurisdiction which is substantially equivalent to a domestic partnership in Nevada, are not required to file with, or provide a certification from the Nevada Secretary of State.

PEBP requires the participant to provide an official summary of the coverage details from the employer of their spouse/domestic partner outlining all health insurance coverage plans available to their employees. PEBP has the authority to determine if the spouse's/domestic partner's employer sponsored health plan meets the definition of "Significantly Inferior Coverage."

Participant's Children/Stepchildren

A participant's children, stepchildren, or children of their domestic partner, under age 26 years, are eligible for coverage on:

- The day the participant becomes eligible for coverage, or
- The day the participant acquires the eligible dependent by birth, adoption, or placement for adoption, or
- The first day of the month concurrent with or following the date of the participant's marriage or certification of domestic partnership, or
- The first day of the month concurrent with or following the loss of coverage through an employer group health plan.

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

To enroll a dependent child(ren), the participant must submit an enrollment election online or paper form.

In the case of a stepchild or domestic partner's child, a certified marriage certificate or certification of domestic partnership will also be required. Participants who have a legal union or domestic partnership validly formed in another jurisdiction which is substantially equivalent to a domestic partnership in Nevada, are not required to file with, or provide a certification from the Nevada Secretary of State.

Dependent children are terminated from coverage on:

- The date of termination of the participant's coverage.
- The end of the month in which a dependent child under permanent legal guardianship turns age 19 years.
- The end of the month in which the dependent child reaches age 26 unless proof of disabled dependent child status has been provided to and approved by PEBP.
- For stepchildren, the end of the month for the date of dissolution of marriage or domestic partnership.

A dependent child under the age of 26 years who is covered as a dependent on his or her parent's PEBP Plan, and who later becomes eligible for their own PEBP coverage as a primary PEBP participant, may decline primary coverage as an active employee and retain coverage as a dependent on his or her parent's plan; or the newly eligible employee (dependent) may enroll in their own coverage as a primary PEBP participant.

A child who enrolls as a primary participant or who is defaulted as a primary participant will be removed as a dependent from their parent's PEBP coverage.

For more information, refer to the applicable sections in this document.

Participant's Newborn Child(ren)

The newborn dependent child(ren) of a PEBP participant will automatically be covered under a PEBP medical Plan option from the date of birth to 31 days following the date of birth (referred to as the initial coverage period) per NRS 689B.033. If the newborn is covered under more than one health insurance plan, the PEBP Plan reserves the right to coordinate benefits as stated in the Coordination of Benefits section of the PEBP Consumer Driven Health Plan, Low Deductible PPO Plan, and EPO Plan Master Plan Documents or HMO Evidence of Coverage Certificate (as applicable).

When the participant has Employee-Only coverage, the newborn will be covered under the member's plan for the first 31 days (NRS 689B.033). Individual deductible, copay, coinsurance, and out of pocket limitations, where applicable, will apply during the initial coverage period.

To continue coverage beyond the initial coverage period, enrollment must be completed within 60 days of the newborn's date of birth. A copy of the child's hospital birth confirmation will be required within the first 60 days to add the child, followed by a copy of the child's certified birth certificate and social security number within 120 days following the date of birth. A newborn dependent child may not be enrolled for coverage unless the participant is also enrolled for coverage. If newborn enrollment is not completed within 60 days of the date of birth, coverage of the newborn will end 31 days after the child's date of birth. If all supporting documentation for the newborn is not received within the required timeframe(s) the dependent newborn coverage will terminate at the end of the month the documents were due. Under no circumstances shall a newborn child have dual coverage under two PEBP plans. If the mother and father of the newborn are both primary participants under PEBP, the participant who elects to continue coverage for the newborn after the initial 31-day period shall be deemed to have covered the newborn since the date of birth.

Participant's Adopted Dependent Children

Pursuant to NRS 689B.033, PEBP includes coverage for a participant's adopted children and children placed with a member for purpose of adoption.

A newborn child who is adopted or placed for adoption may be covered the effective date of 1) adoption, or 2) placement for adoption, if the employee enrolls in coverage and enrolls the newborn within 60 days of the date of the adoption or placement for adoption and submits any

required supporting documents, (e.g., legal adoption or placement for adoption papers as certified by the public/private adoption agency, copy of the certified birth certificate, and the child's social security number). PEBP will also require a copy of the court order for adoption, signed by a judge within 6 months of the adoption date.

A dependent child who is adopted or placed for adoption more than 60 days after the child's date of birth will be covered from the 1st day of the same month that the child is adopted or placed for adoption, whichever is earlier. To add the dependent, PEBP will require the enrollment request within 60 days of the adoption or placement for adoption and any required supporting documents (e.g., legal adoption or placement for adoption papers as certified by the public/private adoption agency, copy of the certified birth certificate, and the child's social security number).

A child is placed for adoption on the date the participant first becomes legally obligated to provide full or partial support of the child. However, if a child is placed for adoption and the adoption does not become final, coverage of that child will terminate on the last day of the month that the participant no longer has a legal obligation to support the child. PEBP must be notified of the ineligibility for dependent coverage.

Legal Guardianship

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

- Is eligible to be claimed as a dependent on the federal income tax return of the participant or his spouse/domestic partner for the preceding calendar year; and
- Dependent is a grandchild, brother, sister, stepbrother, step-sister, or descendent of such relative.
- Children covered under legal guardianship are not eligible to continue benefits under the provision of a disabled dependent.

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

Children under a temporary guardianship are **not** eligible for coverage as a dependent under the PEBP Plan.

Disabled Dependent Child

To cover a dependent child with a disability and who is 26 years old or older requires that the dependent has maintained continuous medical coverage with no break in service and the completion of the *Certification of Disabled Dependent Child Form* by the participant and the child's physician. To be eligible for coverage, the physician must diagnose the child as having a mental or physical impairment causing incapability of self-sustaining employment and depending chiefly on the participant and/or participant's spouse for support and maintenance. Evidence of disability must be provided within 30 days after the child reaches age 26 years (NAC 287.312(1)(d)). The Plan will require proof of support and maintenance through the submission of a copy of the preceding year's income tax return showing the child was or could have been claimed as a tax dependent in compliance with the IRS Code 152 (a) without regard to the gross income test.

If the dependent is not deemed permanently disabled, PEBP will require proof of continuing disability once each year. PEBP reserves the right to have the child examined by a physician of PEBP's choice and at the Plan's expense to determine that the child meets the definition of a dependent child with a disability.

Children covered under legal guardianship are not eligible to continue benefits under this provision.

Grandchildren

Grandchildren are not eligible for coverage unless they are adopted or qualify under permanent legal guardianship. Please refer to the *Guardianship* section of this policy for more information.

Foster children

Foster children are not eligible for dependent coverage.

Survivors

Surviving dependents include a participant's spouse or domestic partner and dependent children to age 26 years (or to age 19 years for child(ren) under permanent legal guardianship) who are covered under the participant's medical Plan on the date of the participant's death.

Coverage for a surviving dependent(s) will end on the last day of the month of the participant's death. Surviving dependent(s) who meet the eligibility provisions to re-enroll as a surviving dependent(s) have the option to continue coverage as a surviving dependent(s). To re-enroll as an eligible surviving dependent(s), the surviving dependent(s) must re-enroll by submitting an enrollment election within 60 days of the date of death of the employee or retiree.

Surviving dependents are not eligible for a years of service premium subsidy or years of service Medicare Exchange HRA contribution or basic life insurance coverage.

Survivors of Active Employees

If an active employee dies with 10 or more years of service credit, the employee's covered dependent(s) are eligible to continue current PEBP Plan coverage as surviving dependent(s). Any

dependent not enrolled for coverage on the date of the participant's death, is not eligible to enroll for coverage as a survivor. A surviving spouse may not enroll dependent children who were not covered on the date of the participant's death. Surviving dependents include an employee's covered spouse or domestic partner and child(ren) to age 26 years (or to age 19 years for a child under permanent legal guardianship) on the date of the employee's death. If an active employee dies with less than 10 years of service credit, any covered dependents will be offered 36 months of COBRA coverage.

A surviving dependent child shall pay the surviving/unsubsidized spouse rate if there is no surviving spouse or the surviving spouse declines coverage.

Survivors of Retirees

Survivor dependent(s) of retirees who were covered on the date of the retiree's death have the option either to continue or cancel PEBP coverage. Any dependent that is not enrolled at the time of the retiree's death will not be eligible to enroll as a survivor. A surviving spouse may not enroll dependent children who were not covered on the date of the retiree's death.

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

Pursuant to NRS 287.0477, the surviving spouse and any surviving child of a police officer or firefighter who was employed by a participating public agency and who was killed in the line of duty may join or continue coverage under PEBP if the police officer or firefighter was eligible to participate on the date of the death of the police officer or firefighter. If the surviving dependent elects to join or discontinue coverage under the PEBP pursuant to this section, the dependent or legal guardian of the dependent must notify the participating public agency that employed the police officer or firefighter in writing within 60 days after the date of death of the police officer or firefighter.

The participating public agency that employed the police officer or firefighter shall pay the entire cost of the premiums or contributions to the Public Employees' Benefits Program for the surviving dependent who meets the requirements. The State will pay the entire cost of the premiums or contributions to the PEBP for the surviving dependent(s) of a police officer or firefighter.

A surviving spouse is eligible to receive coverage pursuant to this section for the duration of the life of the surviving spouse. A surviving child is eligible to receive coverage pursuant to this section until the child reaches age 26 years. (A surviving child under permanent guardianship of deceased police officer or firefighter killed in the line of duty is eligible for coverage to age 19 years.)

Unsubsidized Dependents Covered under a PEBP Plan

An unsubsidized dependent is an otherwise eligible spouse/domestic partner or dependent child who remains covered under PEBP while the primary Plan participant transitions medical coverage to the Medicare Exchange.

Termination of a retiree's coverage through the Medicare Exchange will result in the termination of any unsubsidized dependents. See *Survivors of Retirees* for exceptions to this provision.

Unsubsidized dependents enrolled in the CDHP, EPO Plan, LD PPO, or HMO Plan can decline their coverage at any time (coverage ends the last day of the month of notification).

Unsubsidized Dependents Covered under Medicare

An unsubsidized dependent is an otherwise eligible spouse/domestic partner who attains Medicare and elects PEBP dental coverage, while the primary Plan participant remains covered under a PEBP Plan. See *Survivors of Retirees* for exceptions to this provision.

Termination of a primary participant's coverage will result in termination of the unsubsidized dependent.

Unsubsidized dependents enrolled in Medicare and PEBP dental coverage can decline their coverage at any time (coverage ends the last day of the month of notification).

Retirees with Tricare for Life and Medicare Parts A and B

Retirees who are otherwise eligible for the Health Reimbursement Arrangement (HRA) and who have Tricare for Life and Medicare Parts A and B are not required to enroll in a medical plan through the Medicare Exchange. To receive the monthly HRA contribution, PEBP will require a copy of the Tricare for Life military ID card (front and back) and a copy of the retiree's Medicare Parts A and B card. The required documents must be submitted to PEBP within 60 days of the Medicare Parts A and B effective date, or within 60 days of the retirement date of the employee, whichever date is later. Retirees enrolled in Tricare for Life and Medicare Parts A and B and a medical plan through the Medicare Exchange may disenroll from the Medicare Exchange without experiencing a qualifying life status change or waiting for the Open Enrollment period.

If Tricare and Medicare cards are not received within this timeframe, the only other time to apply for Tricare coverage is during the open enrollment period with an effective date of July 1.

Dental Eligibility

When an eligible retiree is covered through Medicare, dependent children are not eligible for PEBP Dental coverage. Only primary retiree, spouse, domestic partners, surviving spouse or domestic partners, and unsubsidized spouse or domestic partners are eligible for PEBP Dental coverage and must be enrolled in Medicare A and B.

PEBP Open Enrollment is the only opportunity (besides initial enrollment) to enroll or decline PEBP's retiree dental-only coverage. If the participant would like to enroll or change their PEBP dental coverage, they must complete the Retiree Benefit and Enrollment Change Form and must submit it to PEBP no later than May 31st or the close of the open enrollment period.

When Coverage Begins

Active Employees

New Hire, Reinstated, and Rehired Employees

New Hire, Reinstated, and Rehired employees are eligible for coverage on the first day of the month concurrent with or following the date of hire.

Elected Officials Pursuant to NRS 287.045(4), a member of the Senate or Assembly is eligible on a) the first day of the initial term of office of the member, if that date is the first day of the month; or b) the first day of the month immediately following the first day of the initial term of office of the member.

Retirees

A retiree must enroll in a PEBP-sponsored medical Plan within 60 days of their retirement date as determined by the Public Employees' Retirement System (PERS) or NSHE.

Retiree Premium Subsidy or Exchange HRA Contribution for certain employees initially hired on or after January 1, 2010

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

Except for persons to whom NRS 287.043 applies, 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 Years of Service Premium Subsidy or Exchange HRA Contribution for Employees Initially Hired with a PEBP Participating Agency on or after January 1, 2012

- Employees of a State agency, judges, professional (contracted) employees of the Nevada System for Higher Education, legislators, and employees of participating local government entities with an initial date of hire on or after January 1, 2012, may participate in the program, but will not be eligible for a years of service premium subsidy or Medicare Exchange HRA contribution upon retirement.

- 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.

- Pursuant to NRS 287.046 (8), this section does not apply to a person who was employed by the State on or before January 1, 2012, who has a break in service and returns to work for the State at the same or another participating State agency after that date, regardless of the length of the break in service, so long as the person did not withdraw their retirement from PERS and was eligible to participate in the Public Employees' Retirement System (PERS) or the retirement plan alternative for the Nevada System of Higher Education (NSHE) before or during the break in service.

State Retirees

Retirees whose last employer is a State agency, NSHE, PERS, the Legislature, Legislative Counsel Bureau or a State Board or Commission are considered State retirees.

Non-State Retirees

Retirees whose last employer is a non-State public entity are considered non-State retirees. Non-State retirees are eligible to join PEBP only if their last employer is a participating local government entity (a local government that is contracted with PEBP to provide coverage to their active employees pursuant to NRS 287.025). If the participating local government entity leaves the PEBP Plan, the entity's retirees will also be dis-enrolled unless the retiree was covered under PEBP as a retiree continually since November 30, 2008. Retirees who were covered under PEBP as a retiree on November 30, 2008, and continually since then may remain covered under PEBP if they continue to pay their premiums.

Retiree Coverage Information

EXAMPLE

Termination Date	Retirement Date	Retiree Health Benefit Start Date	Benefit Impact
May 30th	May 31st	June 1st	**NO BREAK IN COVERAGE**
May 31st	June 1st	June 1st	
Because the retirement occurred immediately after the termination date, with no gap, there is no break in coverage.			
May 30th	June 3rd	July 1st	**BREAK IN COVERAGE**



Generally, when a termination/separation date and retirement date occur in different months with a gap, participants 1) will be offered COBRA coverage or 2) will have a break in coverage & loss of PEBP benefits.

Dependents

Benefit Coverage for any Eligible Dependent is effective on:

- The day an employee or retiree becomes eligible and enrolled for medical coverage,
- The day an employee or retiree acquires and enrolls eligible dependent by birth, adoption, placement for adoption, or
- The first day of the month following a request for enrollment due to a qualifying event.

Eligible Dependents may be Enrolled if:

- Benefit coverage is in effect for the active employee or retiree on that day;
- Any required supporting documents are received in the PEBP office:
  - within 60 days of the qualifying event date (for example: certified birth certificate, certified marriage certificate, etc.); or
  - Within 30 days following the last day of open enrollment; or

Covered dependents must be enrolled in the same medical plan option as the employee or retiree except as described in the *Coverage Options for Individuals with Medicare* section. Eligible dependents include a spouse, domestic partner, and/or dependent child(ren) (as defined in the *Definitions* section of this document). Anyone who does not qualify as a covered dependent has no right to any benefits or services under this Plan. Any retiree covered through the Medicare Exchange will have the option to enroll in the CDHP, Low Deductible, or EPO Plan, or HMO Plan when a non-Medicare eligible dependent is enrolled, subject to the rules described in the *Coverage Options for Individuals with Medicare* section and the rules of the Plan chosen through the Medicare Exchange.

When Coverage Ends

In Case of Death

In cases of death, coverage ends on the date of death of the employee, retiree, surviving spouse, or dependent. Dependent coverage ends on the last day of the month of the primary insured death.

Active Employees

For an active employee, coverage ends on the last day of the month in which:

- Employment ends.
- Employment contract ends.
- Employee is no longer eligible to participate in the Plan.
- The last day of the Plan Year if the employee declines coverage during open enrollment.
- Premium payment was last received (see *Termination for Non-Payment*); or
- The Plan is discontinued.

Elected Officials

Elected officials coverage ends on the last day of the month in which :

- They are no longer eligible to participate in the Plan.
- The last day of the Plan Year if they decline coverage during open enrollment.
- Premium payment was last received (see *Termination for Non-Payment*); or
- The Plan is discontinued.

Retirees

Retiree coverage ends on the last day of the month in which:

- The retiree no longer meets the definition of a retiree.
- PEBP received notification, generally in writing, of voluntary declination of coverage.
- Premium payment was last received (see *Termination for Non-Payment*).
- If a retiree is covered under a medical plan through the Medicare Exchange, coverage ends on the last day of the month preceding coverage through the Medicare Exchange; or
- The Plan is discontinued.

Dependents

Dependent coverage ends on the last day of the month in which:

- The active employee or retiree coverage ends.
- The covered spouse, domestic partner, or dependent child(ren) no longer meet the definition of spouse, domestic partner, or dependent child(ren) as provided in the *Definitions section* of this document.

- Premium payment was last received (see *Termination for Non-Payment*);
- Dependent is covered under a medical plan through the Medicare Exchange; or
- The Plan is discontinued.

Surviving Spouse/Domestic Partner of a Retiree

Coverage for a surviving spouse/domestic partner of a retiree ends on the last day of the month in which:

- PEBP received notification of voluntary declination of coverage;
- Premium payment was last received (see *Termination for Non-Payment*);
- If the surviving spouse/domestic partner is covered under a medical plan through the Medicare Exchange, coverage ends on the last day of the month preceding coverage through the Medicare Exchange; or
- The Plan is discontinued.

Unsubsidized Dependent

Coverage for an unsubsidized dependent will end on the last day of the month in which:

- The covered dependent no longer meets the definition of dependent as provided in the *Definitions section* of this document.
- Premium payment for the primary plan participant or the covered dependent was last received;
- PEBP received notification; or
- The Plan is discontinued.

Dependent Children of a Surviving Spouse or Domestic Partner of a Retiree

Coverage for dependent children of a surviving spouse or domestic partner of a retiree ends on the last day of the month in which:

- The covered dependent child(ren) no longer meets the definition of dependent child(ren) as provided in the *Definitions section* of this document.
- Premium payment was last received (see *Termination for Non-Payment*); or
- The Plan is discontinued.

Notice to the Plan When a Dependent Ceases to be Eligible for Coverage

An employee, spouse/domestic partner, or any dependent child(ren) must notify the Plan no later than 60 days after the date:

- Of a divorce or dissolution of a domestic partnership.
- On which a dependent child ceases to meet the definition of dependent as defined in the *Definitions section* of this document; or
- On which a dependent child over age 26 years ceases to have a physical or mental impairment where the child no longer has a disability.

Failure to give such a notification within 60 days will cause the spouse/domestic partner, and/or dependent child(ren) to lose their right to obtain COBRA Continuation Coverage or will cause the coverage of a dependent child with a disability to end when it otherwise might continue. For information regarding other notices that must be furnished to the Plan, see *Qualifying Events*.

Qualified Medical Child Support Orders (QMCSO), National Medical Support Notice (NMSN), or Court Orders

PEBP follows the U.S. Department of Labor, Employee Benefits Security Administration publication on Qualified Medical Child Support Orders or its most current revision: https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/qualified-medical-child-support-orders.pdf.

The Plan Administrator shall enroll for immediate coverage under this Plan any child who is the subject of a QMCSO, NMSN, or court order if such child is not already covered by the Plan as an eligible dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) shall mean a notice that contains the following information:

- Name of the issuing authority.
- Name and mailing address (if any) of an individual who is eligible for coverage as a primary participant under the Plan, whether they are enrolled or in declined coverage status.
- Name and mailing address of one or more alternate recipients (i.e., the child or children of the participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the alternate recipient(s)); and
- Identity of an underlying child support order.

According to federal law, a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) is a child support order of a court or state administrative agency that:

- Designates one parent to pay for a child's health plan coverage.
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO/NMSN.
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the way such type of coverage is to be determined; and
- States the period for which the QMCSO/NMSN applies.

An order is not a QMCSO/NMSN if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an employee who is not eligible for coverage by the Plan to provide coverage for a dependent child, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO/NMSN, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

Upon receiving a QMCSO/NMSN, the Plan Administrator shall:

- Notify the issuing authority with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
  - Whether the child is covered under the Plan; and
  - Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
- Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

If the employee is a Plan participant, the QMCSO/NMSN may require the Plan to provide coverage for the employee's dependent child(ren). If the employee is covered by a medical plan option that will not cover the dependent child(ren) specified in the QMCSO/NMSN (for example, the child lives outside an EPO Plan or HMO coverage area), the participant will be enrolled in the base plan option that allows compliance with the QMCSO/NMSN. Coverage under the new medical plan option begins on the first day of the month following receipt of the QMCSO/NMSN in the PEBP office and may not be reverted until the next open enrollment period.

If the QMCSO/NMSN orders a covered employee to provide coverage for the dependent child(ren) named in the QMCSO/NMSN, PEBP will enroll the dependent child(ren) specified in the QMCSO/NMSN. If the employee is in declined coverage status, but is otherwise eligible for coverage, PEBP will enroll the employee, and the dependent child(ren) specified in the QMCSO/NMSN in an appropriate medical plan option to cover the employee and the dependent child(ren). Coverage will become effective on the first day of the month concurrent with or following the date the QMCSO/NMSN is received by PEBP.

Coverage of the dependent child(ren) named in the QMCSO/NMSN will be subject to all terms and provisions of the Plan, including limits on selection of provider and requirements for authorization of services, as permitted by applicable law. No coverage will be provided for any dependent child under a QMCSO/NMSN unless the employee (as applicable) and dependent contributions are paid, and all the Plan's requirements for coverage of that dependent child have been satisfied. Coverage of a dependent child under a QMCSO/NMSN will terminate when coverage of the employee-parent terminates for any reason, including failure to pay any required contributions, subject to the dependent child's right to elect COBRA continuation coverage if that right applies. Refer to the *COBRA section* for information on the dependent's right to elect COBRA, if applicable.

If the dependent listed on the QMCSO/NMSN is covered under another PEBP Plan participant, the dependent will be dropped from the non-QMCSO/NMSN participant's Plan and added to the QMCSO/NMSN participant's Plan.

If a QMCSO/NMSN is rescinded the participant has the option to continue coverage for the dependent(s) or remove the dependent(s). If the participant would like to remove the

dependent(s), coverage will end at the end of the month of receipt of the order. The primary participant may continue coverage under the same medical Plan, or choose to revert to the Plan they were enrolled in prior to covering the dependent(s).

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

Court Orders

If a court or state administrative agency has issued an order with respect to health care coverage for any dependent child of an employee, PEBP will determine if that order is a QMCSO/NMSN as defined by federal law. That determination will be binding on the employee, the other parent, the child, and any other party acting on behalf of the child. PEBP will notify the parents and each child if an order is determined to be a QMCSO/NMSN and if the employee is covered by the Plan and advise them of the procedures to be followed to provide coverage of the dependent child(ren).

Restoration of Benefits by a Hearing Officer

Restoration of health care coverage when included in the decision of a Nevada state hearing officer will be implemented as follows:

1. If health care coverage was provided to the employee and their eligible dependents under the CDHP, LD PPO Plan,EPO Plan, or HMO plan coverage will be restored retroactively to the date specified by the hearing officer. Any retroactive health insurance subsidy due from the agency will be paid to PEBP. Any retroactive health insurance premiums due from the employee will be paid by the employee to PEBP. The amount due to PEBP will be determined by PEBP.
    a. Restoration of coverage will comply with NRS 287, NAC 287 and this policy.
    b. Upon restoration of coverage, PEBP will notify its third-party administrator, pharmacy benefits manager, life insurance vendor and any other applicable vendors of the restoration of coverage.
    c. If the employee and/or their eligible covered dependents incurred medical, dental, vision or prescription drug expenses, PEBP will assist the employee with obtaining reimbursement for the eligible health care expenses.
2. If an employee chooses not to proceed with a retroactive effective date for health insurance coverage, coverage shall be reinstated on the first day of the month following the hearing officer's decision; or the employee may decline coverage
3. Coverage will be restored to the same coverage that was in place before the suspension of benefits. If a life change occurred during this period, a coverage tier change of adding or removing dependents may be allowed. If a new Plan Year intervenes, the employee will be allowed to indicate the desired coverage retroactive to the beginning of the new Plan Year.
4. Any premiums associated with voluntary insurance products are the employee's responsibility.

PEBP and Medicare

Active Employees

- PEBP does not require active employees, and applicable eligible dependents, age 65 or older to obtain Medicare until the employee retires. If the participant obtains Medicare, they must provide a copy of their Medicare card to PEBP.
- An active employee on the Consumer Driven Health Plan (CDHP) with an HSA and enrolls in Medicare is no longer eligible to contribute to an HSA. PEBP will automatically change the HSA to an HRA. If you wish to return to an HSA, you will need to cancel your Medicare coverage, and select the HSA plan the following open enrollment period. Voluntarily canceling Medicare is not a qualifying life event to switch mid-plan year.

Premium Free Medicare Part A

Retirees and their covered dependents who are eligible for premium free Medicare Part A are required to enroll in premium free Medicare Part A coverage.

Most people aged 65 years or older who are citizens or permanent residents of the United States are eligible for premium free Medicare hospital insurance (Part A).

Individuals are eligible for premium-free Medicare Part A if:

- They receive or are eligible to receive Social Security benefits; or
- They receive or are eligible to receive railroad retirement benefits; or
- The individual or their spouse (living or deceased, including divorced spouses who were married at least 10 years) worked long enough in a job where Medicare taxes were paid.

To determine eligibility for premium-free Medicare Part A, the participant must contact the Social Security Administration (SSA) approximately three months before their 65th birthday.

Premium Free Medicare Part A Enrollment Timeframe

Retirees and/or their covered dependents who are eligible for premium free Medicare Part A are required to enroll in Part A coverage three months prior to their 65th birthday.

Disabled retirees and/or their covered dependents who are eligible for Social Security disability insurance must enroll in premium free Medicare Part A and purchase Medicare Part B coverage.

The participant must submit a copy of their Medicare card indicating the effective date with Part A and Part B to the PEBP office as follows:

- For birthdays occurring on the first day of the month, the Medicare 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 Medicare card must be received no later than the last day of the month, following the 65th birthday month.

- For newly retiring employees, the Medicare card must be received within 60 days of the retirement coverage effective date.

- Disabled retirees and/or their covered dependents who are entitled to Social Security disability benefits must enroll in premium-free Medicare Part A and purchase Medicare Part B coverage and submit a copy of their Medicare card to PEBP within 60 days of their Medicare effective date.

If the participant is not eligible for Premium Free Medicare Part A

If the participant is not eligible for premium free Medicare Part A, PEBP will require a copy of the Medicare benefit verification letter, sometimes referred to as a Medicare Award letter from Social Security. This letter will indicate that the participant is not eligible for premium free Medicare Part A. Retirees who are not eligible for premium free Medicare Part A may remain on the PEBP CDHP, LD PPO, EPO Plan or HMO Plan.

The participant must submit a copy of the Medicare benefit verification letter/Medicare Award letter to the PEBP office as follows:

- For birthdays occurring on the first day of the month, a copy of the benefit verification letter/Medicare Award 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, a copy of the benefit verification letter/Medicare Award letter must be received no later than the last day of the month, following the 65th birthday month.
- For newly retiring employees, a copy of the benefit verification letter/Medicare Award letter must be received within 60 days of the retirement coverage effective date.

NOTE: Failure to provide PEBP with the required documentation will result in termination of coverage for the retiree and any covered dependents. This will result in a break in coverage and may impact a participants retiree benefits.

Medicare Part B

Retirees and dependents of retirees who are eligible for Medicare Part B are required to purchase and maintain Medicare Part B. Eligibility is determined by the Social Security Administration. Contact the Social Security Administration to inquire about purchasing Medicare Part B. Failure to provide proof of Medicare Part B enrollment (through the submission of the individual's Medicare card) will result in termination of coverage.

If the participant is a retiring active employee (or a dependent of a retiring active employee) eligible for Medicare, they will be required to purchase and maintain Medicare Part B.

If the participant is a retiree or dependent of a retiree under age 65 years and are eligible for Medicare, as determined by the Social Security Administration, this Plan requires the participant to purchase Medicare Part B and provide a copy of their Medicare card to PEBP indicating that they have both Medicare Parts A and B.

When a retiree or a retiree's covered spouse is eligible for Medicare Part B, this Plan will always be secondary to Medicare Part B. If a retiree or spouse of a retiree is eligible for but not enrolled in Medicare Part B, this Plan will estimate Medicare's Part B benefit. The Plan will assume that Medicare has paid 80% of Medicare Part B eligible expenses. The Plan will only consider the remaining 20% of Medicare Part B expenses.

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 when the individual turns 65 years of age.
- For birthdays NOT occurring on the first day of the month, the Part B card must be received no later than the last day of the month, following the 65th birthday month.
- For retirees and covered dependents under age 65 who become eligible for Medicare as determined by the Social Security Administration, proof of Medicare Part B enrollment must be received within 60 days of the effective date.
- For newly retiring employees eligible for Medicare at retirement, the Part B card must be received within 60 days of the retirement coverage effective date.
- Disabled retirees and/or their covered dependents who are entitled to Social Security disability benefits must enroll in premium-free Medicare Part A and purchase Medicare Part B coverage and submit a copy within 60 days of Medicare effective date.

NOTE: For retirees, failure to provide proof of Medicare Part B coverage within 60 days of the coverage effective date or retirement date will result in termination of PEBP coverage.

Retirees eligible for premium free Medicare Part A are required to purchase Medicare Part B, enroll in a medical plan, and maintain medical coverage through the Medicare Exchange to receive a years of service Health Reimbursement Arrangement (HRA) contribution (if applicable).

Exceptions:

- Retirees who are eligible for premium-free Medicare Part A and who have purchased Medicare Part B coverage and who cover a non-Medicare dependent(s) may enroll in a:
  - PEBP Plan with the non-Medicare dependent(s) until covered dependents become Medicare eligible.
- Retirees who permanently reside outside the United States may remain on a PEBP Plan.

Medicare Retirees Covered through the Medicare Exchange

Retirees who are eligible for premium-free Medicare Part A must enroll in a medical plan through the Medicare Exchange no later than the last day of the month, following the Medicare Part A and B effective date, or no later than the end of the month following the date of retirement, whichever occurs later.

Contributions to a retiree's Health Reimbursement Arrangement through the Medicare Exchange will become effective concurrent with the retiree's medical plan effective date through the Medicare Exchange.

Dependents are not eligible for a Health Reimbursement Arrangement contribution through the Medicare Exchange.

Medicare Retirees Covered under the Medicare Exchange who have break in coverage

Retirees who experience a break in medical coverage or who terminate medical coverage through the PEBP-sponsored Medicare Exchange will also terminate the years of service HRA contribution, PEBP dental coverage, basic life insurance, and voluntary life insurance (if applicable). See the *Retiree Late Enrollment* section for re-enrollment rights.

Retirees that elect PEBP dental and fail to pay dental premiums will be subject to forfeiture of PEBP dental benefits and retroactive termination of PEBP dental to the last day of the month the dental premium was received.

Medicare Retirees Not Eligible for Premium Free Medicare Part A

Retirees who are not eligible for premium-free Medicare Part A and who purchase Medicare Part B and/or cover one or more non-Medicare eligible dependents may remain on the PEBP CDHP, LD PPO, EPO Plan, or HMO Plan.

A retiree/survivor covered under the PEBP CDHP, LD PPO, EPO Plan, or HMO that experiences a qualifying event that changes their eligibility status to participant only, must enroll in a medical plan through the Medicare Exchange.

Medicare Part B Premium Credit

Retirees who are covered under the PEBP CDHP, LD PPO, EPO Plan, or HMO and who have Medicare Part B will receive a premium credit in an amount determined by PEBP. Dependents are not eligible for the Part B premium credit.

The premium credit will apply concurrent with the Medicare Part B effective date or the first of the month concurrent with or following PEBP's receipt of the retiree's Medicare Part B card, whichever is later.

Eligibility for the Medicare Part B Premium credit is subject to NRS 287.046.

Retiree Years of Service Benefit

Years of Service Eligibility

Retirees eligible for a subsidy (NAC 287.485) must submit a Years of Service Certification Form with the appropriate enrollment documents.

Retirees who retired prior to January 1, 1994, receive a premium subsidy or HRA contribution equal to the base amount or 15 years of service.

Retirees who retired on or after January 1, 1994, receive a premium subsidy or HRA contribution based on the sum of the total years and months of service credit earned from all Nevada public employers, excluding purchased service (minimum 5 years; maximum 20 years).

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

Initial date of hire is defined by NAC 287.059 as "the first date on which service credit is earned by a participant during the participant's last period of continuous employment with a public employer, as determined by the appropriate certifying agency." Continuous employment, as defined by NAC 287.021, includes a break in employment of less than 1 year; and does not include a break in employment of 1 year or more.

Employees with an initial date of hire on or after January 1, 2012, may continue to participate in the program but will not be eligible for any subsidy or Exchange HRA contribution upon retirement. The retiree will have to pay the entire premium or contribution for the coverage selected.

Years of Service Premium Subsidy

Retired public employees enrolled in the CDHP, LD PPO, EPO Plan, or HMO Plan may qualify for a premium subsidy based on the date of hire, date of retirement, and total years of service credit earned with each Nevada public employee.

Years of Service HRA Contribution for Medicare Retirees Enrolled in a Medical Plan through the Medicare Exchange

Retired public employees enrolled in a medical plan through Medicare Exchange may qualify for an HRA contribution based on the date of hire, date of retirement, and total years of service credit earned with each Nevada public employer.

Health Reimbursement Arrangement for Retirees Covered Through the Medicare Exchange

The Medicare Exchange HRA accounts are employee-owned accounts established on behalf of eligible retirees covered in a medical plan through the Medicare Exchange.

The Medicare Exchange HRA funds can be used to pay for qualified medical expenses as defined by the IRS including medical plan premiums. Funds placed in the Medicare Exchange HRA for a retiree's use are based on the years of service of the retiree. Dependents and surviving dependents are not eligible to have an Exchange HRA. For more information see Publication 502 at www.irs.gov.

For more information regarding uses, contribution amounts, and other rules, see the Medicare Exchange HRA Summary Plan Document available on the PEBP website.

Medicare Exchange HRA Contribution Eligibility

To receive the PEBP HRA contribution, an eligible retiree must enroll in and maintain coverage through the PEBP-sponsored Medicare Exchange. If the eligible retiree does not enroll and maintain medical coverage as described above, the eligible retiree will NOT receive the PEBP HRA contribution amount and will lose their PEBP sponsored benefits entirely. For re-enrollment eligibility and information, please see the *Retiree Late Enrollment* section for re-enrollment rights.

***NOTE**: This policy does not apply to eligible retirees who have health coverage under TRICARE for Life and Medicare. These individuals must submit a copy of their military ID card(s) to PEBP. PEBP will coordinate their enrollment with the HRA administrator.*

Summary of Supporting Eligibility Documents

Dependent Type	Social Security Number	Marriage Certificate	Birth Certificate	Hospital Birth Confirmation	Adoption Decree Signed by a Judge	Certificate of Registered Domestic Partner	Legal Permanent Guardianship signed by a judge	Disabled Dependent Child aged 26 Years or Older
Newborn Child	✓		✓	✓				
Child Under Age 26	✓		✓					
Adoption	✓		✓		✓			
Permanent Legal Guardianship (child)	✓		✓				✓	
Stepchild	✓	✓	✓					
Domestic Partner's Child	✓		✓			✓		
Domestic Partner's Adopted Child	✓		✓		✓	✓		
Disabled Child	✓		✓					✓
Disabled Stepchild	✓	✓	✓					✓
Domestic Partner's Disabled Child	✓		✓			✓		✓
Spouse	✓	✓						
Domestic Partner	✓					✓		

- A complete notification also means a completed event when the member submits a request for changes. To complete an event/notification the required supporting documentation must be provided to PEBP within the specified timeframe.

  - Failure to provide the required documentation within the specified timeframe will result in an incomplete event/notification that will void the change request.
- When adding a dependent, other dependents cannot be dropped for the same qualifying event.
- Enrollment of a newly acquired spouse, domestic partner, and/or dependent child(ren) must occur no later than 60 days after the date of the qualifying event.
- Employees in declined coverage status and who experience a change in number of dependents may opt to enroll in coverage mid-year if adding a newly acquired dependent.
- All foreign documents must be translated to English.

Enrollment and Eligibility Events Quick Reference Table

Enrollment and Eligibility Events Quick Reference Table			
Event Type	**Notification Period**	**When Coverage Begins or Ends**	**Allowable Changes Based on Event**
New Hire	No later than the last day of the month in which coverage is scheduled to become effective	Full-time employees are eligible for coverage on the first day of the month concurrent with or following the date of hire.	**May add eligible dependent(s) in the family unit**

Required Supporting Documents

Spouse/domestic partner

- ❑ Social Security number of spouse or domestic partner
- ❑ Copy of the certified marriage certificate or domestic partnership certificate

Dependent child(ren):

- ❑ Social Security number of child(ren)
- ❑ Copy of child(ren)'s certified birth certificate(s)

Child(ren) under legal guardianship to age 19 years:

- ❑ Copy of legal guardianship papers (signed by a judge)
- ❑ Copy of certified birth certificate(s)
- ❑ Social Security number of child(ren)
- ❑ If not the primary insured's child, a copy of the certified marriage certificate or domestic partnership certificate recognized under Nevada law

Stepchild(ren) and child(ren) of a domestic partnership:

- ❑ Copy of certified birth certificate(s)

Enrollment and Eligibility Events Quick Reference Table			
Event Type	**Notification Period**	**When Coverage Begins or Ends**	**Allowable Changes Based on Event**
❑ Social Security number of child(ren) ❑ A copy of the certified marriage certificate or domestic partnership			
Newborn Child	Within 60 days of the event date	Newborn coverage is effective on the date of birth for the first 31 days, also known as the initial coverage period. Coverage for other dependent(s) is effective on the first day of the month concurrent with or following notification.	**Participant shall enroll in coverage to cover the newborn.** **May add the newborn child and other eligible dependent(s) in the family unit.**
<u>Required Supporting Documents</u> ❑ Copy of the hospital's birth confirmation for the child (within 60 days of the date of birth) ❑ If not the primary insured's child, a copy of the certified marriage certificate or domestic partnership certificate (within 60 days of the date of birth) ❑ Child's Social Security number (within 120 days of the date of birth) ❑ Copy of child's certified birth certificate (within 120 days of date the date of birth)			
Adoption of a Child or Placement for Adoption of a Child	Within 60 days of the event date	Coverage effective on the date of adoption or placement for adoption for the first 31 days, also	**Participant shall enroll in coverage to cover the adopted child.** **May add the designated adopted child(ren) and**

Enrollment and Eligibility Events Quick Reference Table			
Event Type	**Notification Period**	**When Coverage Begins or Ends**	**Allowable Changes Based on Event**
		known as the initial coverage period. Coverage for a child adopted within 60 days of the child's date of birth becomes effective on 1) the date of adoption, or 2) placement for adoption. Coverage for other dependent(s) is effective on the first day of the month concurrent with or following notification	**other eligible dependent(s) in the family unit.**
Required Supporting Documents ❑ Within 2 months (60 days) of the adoption date: ○ Copy of initial legal adoption papers or placement for adoption (signed by a judge) ❑ Within 6 months (180 days) of the adoption date: ○ Final adoption papers (signed by a judge) ○ Child's Social Security number ○ A copy of the child's certified birth certificate			

Enrollment and Eligibility Events Quick Reference Table			
Event Type	**Notification Period**	**When Coverage Begins or Ends**	**Allowable Changes Based on Event**
Permanent Guardianship of a Child to Age 19	Within 60 days of the event date	Coverage effective on the first day of the month concurrent with or following notification. Coverage is provided only up to age 19 years Coverage for other dependent(s) is effective on the first day of the month concurrent with or following notification	**May add the child(ren) to age 19 years and other eligible dependent(s) in the family unit**
Required Supporting Documents ❑ Copy of legal guardianship papers (signed by a judge) ❑ Child's Social Security number ❑ Copy of certified birth certificate ❑ If not the primary insured's child, a copy of the certified marriage certificate or domestic partnership certificate			
Permanent Guardianship of Unmarried Child Aged 19 to Age 26 Currently Enrolled in a PEBP Plan	Within 60 days of the event date	Coverage continues to age 26 assuming child continues to meet eligibility requirements as set forth in Legal Guardianship Form	**Not applicable**

Enrollment and Eligibility Events Quick Reference Table			
Event Type	**Notification Period**	**When Coverage Begins or Ends**	**Allowable Changes Based on Event**
		Coverage ends the last day of the month child turns age 19 or last day of the month PEBP determines the child is no longer eligible	
Required Supporting Documents ❑ Completion of the Legal Guardianship Certification Form; and ❑ Any required supporting documents listed in the certification			
Disabled Child (Age 26 or Older)	Within 31 days of dependent child turning age 26 years	If already covered under PEBP, coverage will continue If the disabled child is new to PEBP Plan, coverage becomes effective on the first day of the month concurrent with or following the notification.	**Not applicable**
Required Supporting Documents • Certification of Disabled Dependent Child Form (completed by primary participant and child's physician) • Child's Social Security number • If not the participant's child, copy of the certified marriage certificate or domestic partnership certificate			

Enrollment and Eligibility Events Quick Reference Table			
Event Type	**Notification Period**	**When Coverage Begins or Ends**	**Allowable Changes Based on Event**
• Verification that the child has had continuous health insurance since the age of 26 years; and proof of support and maintenance through the submission of a copy of the participant's preceding year's income tax returns showing the child may be claimed as a tax dependent. The Plan will thereafter require proof of the child's continuing incapacity and dependency not more than once a year beginning 2 years after the child attains age 26 per NRS 689B.035.			
Qualified Medical Child Support Order (QMCSO), National Medical Support Notice (NMSN), or Court Order	Within 60 days of issuance of order or Release of order	Begins: First of the month concurrent with or following a determination that an order is qualified. Ends: Coverage terminates on the last day of the month concurrent with or following the date of determination that the release of order is qualified.	**Participant shall enroll in coverage to comply with the order.** **Must add dependent(s) as stated in the order**
Required Supporting Documents ❑ Copy of QMCSO, NMSN, or court order appropriately signed by issuing agency/county.			
Declination of coverage for an employee, retiree, spouse, domestic partner, or dependent who becomes eligible for and enrolls in Medicare Part A or B	Within 60 days of Medicare effective date	Coverage terminates on the last day of the month preceding the Medicare coverage effective date, or the last day of the month of notification, whichever is later.	**Employee/Retiree may decline coverage** **May delete spouse/domestic partner or dependent who enrolls in Medicare Part A or B.**

Enrollment and Eligibility Events Quick Reference Table			
Event Type	**Notification Period**	**When Coverage Begins or Ends**	**Allowable Changes Based on Event**
Required Supporting Documents ❑ Copy of the Medicare card confirming the Medicare effective date.			
Declination of Coverage for employee, retiree, or dependent who becomes eligible for and enrolled in CHIP, Medicaid, or Nevada Check Up	Within 60 days of the event date.	PEBP coverage terminates on the last day of the month before gaining new coverage or the last day of the month of notification, whichever is later.	**Employee, retiree, or dependent may decline coverage due to enrollment in CHIP, Medicaid, or Nevada Check Up**
Required Supporting Documents ❑ Documentation from Medicaid, CHIP or Nevada Check Up showing that the eligibility was approved and the coverage effective date			
Special enrollment opportunity due to the loss of Medicare Part A, CHIP, Medicaid, or Nevada Check UP (applies to employees and their eligible dependents, does not apply to retirees)	Within 60 days of the event date.	Coverage effective on the first day of the month following loss of coverage or the notification of loss of coverage, whichever is later	**Eligible employee and/or applicable dependents may enroll for coverage.**
Required Supporting Documents ❑ Documentation from Medicaid, CHIP or Nevada Check Up showing that eligibility was 1) denied, 2) the date it was denied or that 3) Medicaid, CHIP or Nevada Check Up coverage ended or will end, ❑ Copy of a marriage certificate, domestic partnership certification, or ❑ certified birth certificate(s) for each dependent child(ren) being added to the Plan.			

Enrollment and Eligibility Events Quick Reference Table			
Event Type	**Notification Period**	**When Coverage Begins or Ends**	**Allowable Changes Based on Event**
Dependent Gains Coverage **Eligible dependent experiences a change of status resulting *in a gain of eligibility and enrolls in* another employer group health plan.**	Within 60 days of the event date.	PEBP coverage terminates on the last day of the month before gaining new coverage or the last day of the month of notification, whichever is later.	**Must remove spouse or domestic partner if coverage is employer based; and may delete any dependent(s) that are being added to the spouse/domestic partner's employer group health plan**
Required Supporting Documents ❑ Documentation from the spouse's/domestic partner's or dependent's employer or from the other health plan listing the first and last name(s) of the individuals to be deleted from PEBP coverage, including their new plan's coverage effective date.			
Dependent Loses Coverage **Eligible dependents experiences a change of status *resulting in a loss* of eligibility from another employer group health plan.**	Within 60 days of the event date	PEBP coverage is effective on the first day of the month following loss of coverage or the first day of the month following notification, whichever is later.	**May add eligible dependent(s) in the family unit who experienced a loss of coverage**
Required Supporting Documents ❑ Documentation from the spouse/domestic partner or dependent's employer or from the other health plan listing the first and last name(s) of the individuals being added to their plan and the coverage termination date of that other plan.			

Enrollment and Eligibility Events Quick Reference Table

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
❑ Social Security number for all dependent(s) being added. ❑ Copy of a certified marriage certificate or domestic partnership certificate recognized under Nevada law. ❑ If adding dependent child(ren), a copy of the child(ren)'s certified birth certificates.			
Marriage or the establishment of Domestic Partnership	Enrollment election must be submitted within 60 days of the event date	Coverage effective on the first day of the month following the date of marriage or domestic partnership registration, or the first day of the month following notification, whichever is later.	**Participant shall enroll in coverage to add dependents.** **May add eligible dependent(s) in the family unit**
<u>Required Supporting Documents</u> ❑ Copy of marriage certificate or registered domestic partnership certificate ❑ Social Security Number for spouse or domestic partner and/or covered child(ren) ❑ If adding dependent child(ren), copy of the child(ren)'s certified birth certificates; and a copy of the marriage or domestic partnership registration if not adding the spouse or domestic partner.			
Declination of Coverage due to Marriage or Establishment of Domestic Partnership (DP) and enrollment in spouse's/DP's Employer Group Health Plan	Within 60 days of the event date.	Coverage for the primary participant and any covered dependents will terminate on the last day of the month of marriage or establishment of domestic partnership or the first day of the month following the	**Primary participant may decline coverage**

Enrollment and Eligibility Events Quick Reference Table			
Event Type	**Notification Period**	**When Coverage Begins or Ends**	**Allowable Changes Based on Event**
		date of notification, whichever is later.	
Required Supporting Documents ❑ Copy of certified marriage certificate or copy of domestic partnership certificate recognized under Nevada law; and ❑ Documentation from the other employer or group health plan stating the effective date of the new coverage and the first and last name(s) of the newly covered individual(s).			
Employer of Spouse/ Domestic Partner Offers an Open Enrollment Period **OR** **Initial Benefit Enrollment Period**	Within 60 days of the event date	Enrolling in PEBP coverage: PEBP coverage becomes effective on the first day of the month following the end date of coverage under the other employer's health plan, or the first day of the month following notification to PEBP, whichever is later. Declining PEBP coverage: PEBP coverage terminates on the last day of the month prior to the effective date of coverage under the other group health plan; or,	**Participant and any covered dependents may decline PEBP coverage to newly enroll in the other employer's coverage; or** **Participant and eligible dependent in declined status with PEBP may re-enroll in PEBP coverage if the other employer coverage is terminated**

Enrollment and Eligibility Events Quick Reference Table			
Event Type	**Notification Period**	**When Coverage Begins or Ends**	**Allowable Changes Based on Event**
		the last day of the month following notification to PEBP coverage, whichever is later.	
Required Supporting Documents ❑ Proof of open enrollment from the employer ❑ Documentation from the other employer or group health plan stating the effective date of the new coverage and the first and last name(s) of the newly covered individual(s)			
Medicare Part B Premium Credit (Retirees covered under the CDHP, LD PPO, EPO plan, or HMO plan only.)	No later than the end of the month in which Medicare Part B is effective	The Part B premium credit will apply concurrent with the Medicare Part B effective date or the first day of the month concurrent with or following PEBP's receipt of the retiree's Medicare Part B card, whichever is later.	**Premium credit will only apply to primary retirees covered under the CDHP, LD PPO, EPO plan, or HMO plan**
Required Supporting Documents ❑ Copy of Medicare Part B card; or ❑ Copy of the Medicare Part B award letter			

Enrollment and Eligibility Events Quick Reference Table			
Event Type	**Notification Period**	**When Coverage Begins or Ends**	**Allowable Changes Based on Event**
Initial Retirement Coverage for Eligible Retiring Employees	Within 60 days of the employee's date of retirement	Retiree coverage is effective on the first day of the month concurrent with or following the date of retirement	**May add or remove eligible dependent(s).** **May select a new health plan option.** **If retiree is eligible for free Medicare Part A, must purchase Part B, and may be required to enroll for coverage through the Medicare Exchange as shown in the *Initial Enrollment Section***
Required Supporting Documents ❑ Enrollment election completed via paper form. ❑ Years of Service Certificate Form ❑ If age 65 or older, copy of Medicare Parts A and/or B card ❑ If age 65 or older and ineligible for premium-free Medicare Part A, a copy of the Medicare Benefits Verification Letter and a copy of the Medicare B card			
Retiree/ Dependent or Survivor's entitlement to Medicare Parts A and/or B	End of the month following the date the individual becomes eligible for Medicare	Coverage under Medicare Exchange becomes effective within 60 days of Medicare effective date or	**Must enroll in a Medicare Exchange plan if retiree and covered dependents (if any) are eligible for free Part A;**

Enrollment and Eligibility Events Quick Reference Table			
Event Type	**Notification Period**	**When Coverage Begins or Ends**	**Allowable Changes Based on Event**
		retirement date, whichever is later	**otherwise, coverage is terminated.** **If one family member is not eligible for free Part A, the participant may remain on the CDHP, LD PPO, EPO Plan, or HMO, or the individual with Part A may choose coverage through the Medicare Exchange.**
Required Supporting Documents ❑ **Copy of** Medicare **Parts A and B card, if eligible for free Part A, or** ❑ **Copay of Part B card (if ineligible for free** Medicare **Part A); and a copy of the** Medicare **Benefit Verification Letter from the Social Security Administration (**Medicare**); or** ❑ **If covered under Tricare for Life, a copy of the military ID card and a copy of the** Medicare **A and B card** ❑ Enrollment election completed via online/paper form (only if Medicare entitlement includes Parts A and B and participant is changing health plans to the Medicare Exchange).			
Divorce, Annulment, or Termination of Domestic Partnership*	Within 60 days of the event date	Coverage terminates on the last day of the month from 1) notification or 2) the divorce decree is signed by the judge or termination of domestic partnership is official, whichever is later.	**Must remove ex-spouse or ex-domestic partner and all other ineligible dependent(s)**

Enrollment and Eligibility Events Quick Reference Table			
Event Type	**Notification Period**	**When Coverage Begins or Ends**	**Allowable Changes Based on Event**
		If the divorce decree/ termination of domestic partnership is received more than 60 days after the divorce, coverage ends at the end of the first of the month following receipt of the divorce decree/termination of domestic partnership	
Required Supporting Documents ❑ **Copy of the divorce/annulment decree signed by the judge (all pages)** ❑ Copy of the termination of domestic partnership filed with appropriate issuing agency			
PEBP's Open Enrollment Period	Typically, May 1- May 31 of each year	Coverage effective date is July 1 immediately following open enrollment period	**May add or delete dependents, change plan options, or decline coverage**
Required Supporting Documents ❑ If adding a dependent, refer to the Summary of Supporting Eligibility Documents provided in this document ❑ Required supporting documents are due by June 15			

Enrollment and Eligibility Events Quick Reference Table			
Event Type	**Notification Period**	**When Coverage Begins or Ends**	**Allowable Changes Based on Event**
Primary Participant Moves Outside the EPO Plan or HMO Plan Coverage Area	Within 30 days after moving outside EPO Plan or HMO coverage area	Coverage under the CDHP, LD PPO, EPO Plan, or HMO plan will begin on the first day of the month concurrent with or following notification.	**Participants who move outside an EPO Plan or HMO coverage area must select another coverage option.** ***Note: Moving outside the EPO Plan or HMO coverage area is not a qualifying event to add or delete dependents.***
Required Supporting Documents ❑ Copy Provide proof of address change, including, but not limited to, an updated driver's license, USPS change of address, etc. ❑ Call PEBP to update address; or ❑ Send a secure message through the ePEBP portal			
Termination of Retiree Benefits	Upon request from participant	Written request by the retiree to decline all PEBP benefits effective on the first day of the month concurrent with or following notification.	**Coverage terminates for retiree and any covered dependents on the last day of the month request is received**
Required Supporting Documents ❑ Must provide a written request to decline PEBP benefits.			

Enrollment and Eligibility Events Quick Reference Table

Event Type	Notification Period	When Coverage Begins or Ends	Allowable Changes Based on Event
Survivor's Coverage **Surviving dependent must covered on as dependent on the primary participant's plan on the date of death**	Within 60 days of the primary participant's date of death	Coverage for eligible survivor(s) is effective on the first day of the month following the primary participant's date of death	**May qualify for survivor's coverage if the dependent meets the survivor's eligibility requirements as shown in the *Initial Enrollment Section***
Required Supporting Documents ❑ Copy of certified death certificate ❑ Submission of a completed Retiree Benefit Enrollment and Change Form			
Employee or Retiree Death* **AND/OR** **Dependent Death***	Within 60 days of the event date	Participant coverage terminates on the date of death; and Coverage for any covered dependent terminates on the last day of the month concurrent with the participant's date of death Coverage for the deceased dependent terminates on the date of death.	**Covered dependents may qualify for re-enrollment in survivor's coverage if he/she meets the eligibility requirements as stated in this document** **Must remove the deceased dependent from coverage and any ineligible dependent(s) (e.g., children of domestic partner or stepchildren)**
Required Supporting Documents ❑ Copy of certified death certificate			

Enrollment and Eligibility Events Quick Reference Table			
Event Type	**Notification Period**	**When Coverage Begins or Ends**	**Allowable Changes Based on Event**
*Late Notification of Death: Adjustments in premiums resulting from the death of a covered participant or dependent will be refunded if notification of death is received within 60 days of the participant's or dependent's date of death. Notification of death beyond the 60-day period will not be refunded.			
Survivor of Police/ Firefighter killed in the line of Duty (NRS 287.0477)	Within 60 days of the police officer's or firefighter's date of death	Coverage for eligible survivor(s) is effective on the first of the month following the police officer's or firefighter's date of death, or after notification, whichever is later.	**May qualify for survivor's coverage if the dependent meets the survivor's eligibility requirements as stated in this document** **Eligible dependents may join the plan.**
Required Supporting Documents ❑ Submission of a completed Retiree Benefit Enrollment and Change Form (RBECF). ❑ Copy of death certificate. ❑ SSN and copy of the certified marriage certificate			
Settlement Agreement (Hearing Decision)	Within 60 days of Settlement Agreement (Hearing Decision)	Retroactive to date established by the Nevada state hearing officer decision	**Employee may re-enroll in coverage; or** **Decline coverage**

Enrollment and Eligibility Events Quick Reference Table			
Event Type	**Notification Period**	**When Coverage Begins or Ends**	**Allowable Changes Based on Event**
		; or If the employee chooses not to pay back premiums, the first month after notification.	
Required Supporting Documents ❑ Copy of the hearing officer's decision.			

Examples of Timelines

This is intended to be an example of Qualifying Life Events timeframes and impact on participants.

Event Date	Complete Notification Deadline (60-days)	Notification Date	Effective Date of Change	Benefit Impact
April 21st	June 20th	April 28th	May 1st	**Because the notification was timely, benefit changes may take effect. Subject to providing supporting documents.**
April 21st	June 20th	May 21st	June 1st	
April 21st	June 20th	June 15th	July 1st	
April 21st	June 20th	June 25th	NONE	**Because the notification was not timely, benefit changes will <u>not</u> take effect.**

The Complete Notification Deadline means the date a notification must be wholly completed. This may include required supporting documents such as certified certificates, proof of coverage, etc.

The Notification Date is an example when a member notifies PEBP, subject to required supporting document.

Retiree Coverage Examples

Termination Date	Retirement Date	Retiree Health Benefit Start Date	Benefit Impact
May 30th	May 31st	June 1st	**NO BREAK IN COVERAGE**
May 31st	June 1st	June 1st	

Because the retirement occurred immediately after the termination date, with no gap, there is no break in coverage.

May 30th	June 3rd	July 1st	**BREAK IN COVERAGE**

Generally, when a termination/separation date and retirement date occur in different months with a gap, participants 1) will be offered COBRA coverage or 2) will have a break in coverage & loss of PEBP benefits.

Qualifying Events

IRS Code Section 125

IRS Code Section 125 states that Qualifying Life Events, or HIPAA Special Enrollments, are generally prospective from the notification date when subject to "cafeteria plan" rules. In the event there is a conflict, IRS Code Section 125 controls.

See Section 125 Health and Welfare Benefits Master Plan Document, specifically section 3.5 and 5.1, regarding changes on a prospective basis.

Dependent Loses Other Employer Group Health Care Coverage

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

- Loss of eligibility because of divorce, dissolution of a domestic partnership, cessation of dependent status (such as attaining the limiting age for a dependent child), death, termination of employment, reduction in hours; or
- An HMO or other arrangement in the employer group market that does not provide benefits to individuals who no longer reside or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; or
- A plan no longer offers any benefits to a class of similarly situated individuals; or
- The termination of COBRA Continuation Coverage for any of the following reasons:
    - When the employer or other responsible entity terminates the health care plan and there is no other COBRA Continuation Coverage available to the individual;
    - When the individual no longer resides or works in a service area of an EPO, HMO, or similar program (whether or not by the choice of the individual) and there is no other COBRA Continuation Coverage available to the individual; or
    - The 18-month, 24-month, 29-month or 36-month period of COBRA Continuation Coverage has expired.

However, if an employee or dependent lost other health care coverage as a result of the individual's voluntary cancellation of coverage, termination of coverage through the state health exchange (Affordable Care Act (ACA)), failure to pay premiums, reduction, or elimination of employer financial payment of premiums, or for cause, such as making a fraudulent claim, that individual does not have enrollment rights.

Gain of Other Employer Group Health Care Coverage

If an otherwise eligible spouse/domestic partner gains health care coverage through their employer, they are no longer eligible to maintain PEBP coverage. For additional information, see the section on *Significantly Inferior Coverage*.

The primary participant and any covered dependents may opt to accept the other employer's coverage and decline PEBP coverage during the spouse's/domestic partner's initial benefit enrollment period. The participant will be required to submit an enrollment election along with proof of the new hire date, effective date of coverage, including the names of covered dependents within 60 days of the new coverage effective date.

PEBP must be notified within 60 days of the effective date of the spouse's or domestic partner's coverage under the spouse's or domestic partner's employer group health plan. Notification after 60 days will result in coverage terminating at the end of the month PEBP receives proof of the other employer's coverage. Premium refunds will not be given for late notification.

If a dependent child gains coverage through their employer, the dependent child can be removed from coverage by the participant or the child can remain on the PEBP Plan. The order of benefit determination rules is described in the Coordination of Benefits section in the PEBP EPO Plan, Low Deductible PPO or Consumer Driven Health Plan for Medical, Vision and Prescription Drug Benefits Master Plan Document or the HMO Evidence of Coverage Certificate to establish which plan is the primary plan (pays first) and which is secondary (pays second).

Open Enrollment for Employer of Spouse or Domestic Partner

If the employer of an eligible spouse or domestic partner offers an open enrollment period for their employees, the primary participant and any covered dependents may opt to accept the other employer's coverage and decline PEBP coverage during the spouse's/domestic partner's open enrollment period. This option only applies when the participant's coverage is new under the spouse's/domestic partner's plan.

The participant will be required to submit an enrollment election along with proof of the open enrollment period, effective date of coverage, including the names of covered dependents within 60 days of the new coverage effective date.

Change of Residence

A qualifying event may be initiated by a participant's change in place of residence, if that change impairs the ability of a participant to access the services of in-network health care providers. Participants who move outside of the EPO Plan or HMO coverage area must select another coverage option by updating their information with PEBP within 30 days after moving out of the previous service area. If a participant does not select a coverage option that is available at the new address within 30 days, the participant will be defaulted into the CDHP with an HRA. If the enrollment update is not received within 30 days, the change will be made for the first of the month following submission of the change of address. Any overpayments due to lack of notification within 30 days will not be refunded.

Retirees covered through Medicare exchange who move out of the United States may select coverage under an eligible PEBP Plan. Retirees who are eligible for premium-free Medicare Part A and who move back into the United States must select coverage through the Exchange.

Declining Active Employee Coverage

An employee may decline coverage for these events:

- initial enrollment,
- during PEBP's open enrollment, or
- during the spouse's/domestic partner's employer's
    - initial enrollment period,
    - open enrollment period, or
    - Qualifying Life Event

  contingent on the employee furnishing proof of coverage under the spouse/DP's plan.

(see open enrollment for employer of spouse or domestic partner section).

An employee will not receive a financial incentive or compensation when in declined coverage status and will not be eligible for other PEBP benefits, including but not limited to, basic life insurance.

Declining Retiree or Survivor's Coverage

Retirees and survivors may decline coverage at any time during the year. Coverage will terminate on the last day of the month PEBP receives notification, generally written, request to decline coverage. Declining coverage will terminate medical, dental, vision, prescription drug coverage, basic life insurance, voluntary life insurance, years of service premium subsidy and HRA contribution (if applicable). See the *Retiree Late Enrollment* section for re-enrollment rights.

Declining Unsubsidized Dependent Coverage

Unsubsidized dependents enrolled in a PEBP-sponsored medical plan may decline coverage at any time during the year. Coverage will terminate on the last day of the month PEBP receives notification, generally written, to decline coverage.

Significantly Inferior Coverage

If PEBP determines the coverage available to the spouse/domestic partner by their employer meets the definition of "Significantly Inferior Coverage," the spouse/domestic partner is required to decline such coverage from their employer prior to being enrolled as a dependent on the participant's PEBP plan.

The PEBP Board has defined significantly inferior coverage as either:

- A mini-med or other limited benefit plan (see definitions, below); or
- A catastrophic coverage plan which includes a Deductible equal to or greater than $5,000 for single coverage with no employer contributions to a Health Savings Account or Health Reimbursement Arrangement

In order for PEBP to make the determination to allow a spouse/domestic partner with "Significantly Inferior Coverage" to enroll as a dependent in the PEBP Plan, an official summary of the coverage details from spouse/domestic partner's employer outlining the health insurance coverage plans available to their employees must be provided to PEBP.

If the participant's spouse/domestic partner cannot decline coverage from their employer until the open enrollment period, the decline of coverage at that time will be considered a qualifying event to add the spouse/domestic partner to the participant's PEBP Plan.

Leaves of Absence

Family and Medical Leave Act (FMLA)

The FMLA entitles an eligible employee to up to 12 weeks of unpaid, job-protected leave during a rolling 12-month period measured backward from the date an eligible employee uses any qualifying FMLA leave. The FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period, measured forward from the first day of usage.

During FMLA leave, the employer must maintain the employee's health coverage under any employer group health plan on the same terms as if the employee had continued to work, regardless of whether the employee is on paid or unpaid leave. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Employees are eligible for FMLA leave if they have worked for 12 months and for 1,250 hours over the previous 12 months. For an overview of FMLA provided by the Department of Administration, Human Resource Management visit https://www.dol.gov/general/topic/benefits-leave/fmla.

Employees who return to work promptly at the end of that leave, regardless of whether they kept their coverage while on leave, may continue or reinstate the same plan option and coverage tier without any additional limits or restrictions imposed on account of the leave. If an employee declines coverage while on family or medical leave, coverage will be reinstated to the same plan option and coverage tier on the first of the month in which the employee is in paid status 80 hours using a combination of FMLA and/or paid time.

The National Defense Authorization Act of 2008 (NDAA) expanded provisions of the FMLA. The NDAA extends family medical leave entitlements to the relatives of members of the armed services (including the National Guard and Reserves). NDAA makes two significant changes to FMLA: (i) an eligible employee who is a spouse or domestic partner, son, daughter, parent or "next of kin" of a covered service member is now entitled to a total of 26 weeks of FMLA during a 12 month period to care for the serious injury or illness of the wounded/disabled service member; and (ii) an employee will be entitled to FMLA on account of a "qualifying exigency" that occurs because the spouse or domestic partner, son, daughter, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

Any changes in the Plan's terms, rules or practices that went into effect while an employee is away on leave will apply to the employee and any dependents in the same way they apply to all other employees and their dependents. Employees should contact their agency representative to find out more about their entitlement to family or medical leave as required by federal and/or state law, and the terms on which it may be entitled.

Leave Without Pay (LWOP)

NAC 287.450

A State agency that employs an individual who is on LWOP (other than FMLA leave) 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 .

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

At the initial start of leave, it is the employee's responsibility to inform PEBP of their coverage preference while on leave. If the employee fails to inform PEBP of his or her coverage preference while on leave, PEBP will continue the same medical plan and coverage tier that the employee had in effect prior to taking that leave. When the employee returns from leave, their coverage will revert to their original plan selection prior to going on leave.

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

Employees who go into active military service for up to 31 days can continue their health care coverage during that leave period if they continue to pay their contributions for that coverage during the period of that leave.

State employees who go into active military service for 31 days or more are eligible to enroll in health care coverage provided by the military the day the employee is activated for military duty. This coverage is also available to dependents. The employee is also eligible to purchase continued health care coverage through PEBP for up to 24 months in a manner like the provisions of COBRA. When the employee returns from military leave within the required reemployment period, there will be an immediate reinstatement of PEBP-sponsored medical coverage with no waiting period. Questions regarding entitlement to this leave and to the continuation of health care coverage should be referred to PEBP. Questions regarding reemployment rights should be addressed with the employer.

Worker's Compensation Leave

Employee and dependent health care coverage during the period of Worker's Compensation leave will automatically be continued for a period of up to 9 months. To continue coverage, employees must pay their contribution for that coverage during the period of that leave directly to PEBP by the date on the bill. Late payment will result in termination of coverage. Coverage terminated for non-payment may not be reinstated until the employee returns to work. Employees may elect to discontinue dependent coverage while on Workers' Compensation leave.

Following the 9-month period during which the employee has been on Worker's Compensation leave, the employee will be required to make the full, unsubsidized payment for health care coverage for themselves and their dependents. Once the employee returns to work, insurance coverage will be reinstated exactly the way it was before the employee was placed on Workers'

Compensation leave, unless the employee selected different coverage during an open enrollment period or experienced a qualifying event.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB

under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See . U.S.C. U.S.C.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Payment for Coverage

Most eligible State employees are provided with a subsidy toward the cost of plan coverage. To obtain information about subsidy amounts. Employees on leave without pay (other than FMLA), dependents, legislators and survivors are not eligible for a subsidy. The option of electing additional voluntary products at cost may be available to an employee or retiree.

Retirees eligible for a subsidy must submit the required Years of Service Certification Form to the PEBP office by the last day of the month preceding the retirement effective date to receive the first month's subsidy.

To receive a Medicare Part B premium credit, eligible retirees must send a copy of their Medicare Card to PEBP. The Medicare Part B premium credit will be applied to the retiree account the first day of the month following the receipt of the Medicare Card, but no earlier than the effective date of the Medicare Part B coverage. The Medicare Part B premium credit is for retirees on the CDHP, HMO or EPO Plan only.

Premiums for CDHP, LD PPO Plan, HMO or EPO Plan coverage are automatically deducted from the participant's paycheck or pension. Each monthly premium applies to coverage for that same month. In the following circumstances, premiums shall be paid directly to PEBP monthly:

- The employee is on unpaid leave.
- The retiree's pension is not large enough to cover the premium amount, or if PERS payroll deductions rules cause the PEBP contribution to not be taken.
- The participant is a retiree of the Nevada System of Higher Education who participates in an alternative retirement plan.
- The participant is an active legislator.
- The participant is on COBRA coverage.
- The individual is an unsubsidized dependent; or
- For survivors who do not receive a PERS pension benefit.

If COBRA coverage is terminated due to non-payment, that individual will not be able to re-enroll in the Plan under COBRA. If employee coverage is terminated due to non-payment, that employee will not be able to re-enroll in the Plan until the next open enrollment, he or she experiences a special enrollment or mid-year change event, or until the employee returns from leave and the account has been paid in full. If coverage of a retiree, survivor or unsubsidized dependent is terminated for non-payment that individual will not be able to re-enroll in the Plan until the next open enrollment period (if eligible) and until the account is paid in full.

Participants will be billed via premium invoice and will be required to pay the following directly to PEBP:

- Contributions resulting from retroactive coverage changes; or
- Claims incurred by the participant or their dependents who access the Plan during a period when they are ineligible for coverage.

Premium overpayments due to lack of proper notification by the participant will not be refunded. Participants who fail to pay their premiums or ineligible claims may be reported to the State Controller's office or to a private collection agency for collection of past due amounts. Collection costs may also be assessed to the participant.

PERS Deduction for the Medicare Exchange Plan

Federal rules for the Medicare Exchange require the individual to pay medical insurance premiums directly to the carrier. PEBP will not take automatic deductions from retirement distributions to pay for coverage provided through the Medicare Exchange except dental coverage provided by PEBP if the retiree elects to enroll in the PEBP Self-funded PPO dental plan.

Late Notification of Death

Adjustments in premiums resulting from the death of a covered participant or dependent will be refunded if notification of death is received within 60 days of the participant's or dependent's date of death. Notification of death beyond the 60-day period will not be refunded.

Billing Errors

It is the participant's responsibility to ensure the premiums paid by the participant are accurate. Refunds for premiums billed in error and paid by the participant more than six months old are at the sole discretion of PEBP.

Termination for Non-Payment

Payment for the current month's coverage is due on the 20th of each month. Acceptance and deposit of a payment does not in itself guarantee coverage. If the participant fails to meet eligibility and enrollment requirements, coverage may be terminated, and the payment refunded to the participant.

Any account 30 days past due, including Retirees enrolled in the Medicare Exchange with PEBP Dental, is subject to termination retroactive to the last day of the month for which premium payment was received in full. Participants will be billed for any claims incurred and paid for by the Plan after the effective date of termination.

Change to Years of Service Re-Audit Results for Retirees

Years of service premium subsidy and years of service Exchange HRA contribution are effective upon the date of retirement, based on the audit from either the Public Employees' Retirement System (PERS) or the Nevada System of Higher Education (NSHE). Changes to the years of service premium subsidy and years of service Exchange HRA contribution resulting from a future audit

will occur on the first (1st) day of the month concurrent with or following the date PEBP receives the audit results from the PERS or NSHE. (NAC 287.485)

COBRA

COBRA – the Consolidated Omnibus Budget Reconciliation Act – requires group health plans to offer continuation coverage to covered employees, former employees, spouses, former spouses, and dependent children when group health coverage would otherwise be lost due to certain events. Those events include:

- A covered employee's or retiree's death,
- A covered employee's job loss or reduction in hours for reasons other than gross misconduct,
- A COBRA beneficiary becoming entitled to Medicare,
- A covered employee's divorce or legal separation, and
- A child's loss of dependent status (and therefore coverage) under the plan.

COBRA sets rules for how and when plan sponsors must offer and provide continuation coverage, how employees and their families may elect continuation coverage, and what circumstances justify terminating continuation coverage.

Employers may require individuals to pay for COBRA continuation coverage.

Life insurance and disability benefits are not considered "medical care." COBRA does not cover plans that provide only life insurance or disability benefits.

Alternatives to COBRA Continuation Coverage

Those entitled to elect COBRA continuation coverage may have more affordable or generous alternatives for coverage. One option may be "special enrollment" in other group health coverage. Under the Health Insurance Portability and Accountability Act (HIPAA), upon certain events, group health plans and health insurance issuers are required to provide a special enrollment period. During that period, individuals who previously declined coverage for themselves and their dependents, and who are otherwise eligible, may enroll without waiting until the next open season for enrollment. One event that triggers special enrollment is an employee or dependent losing eligibility for other health coverage. For example, an employee who loses group health coverage may be able to special enroll in a spouse's health plan. The employee or dependent must request special enrollment within 30 days of losing other coverage.

Who Is Entitled to Continuation Coverage

A group health plan must offer COBRA continuation coverage only to qualified beneficiaries and only after a qualifying event has occurred.

Qualified Beneficiaries

A qualified beneficiary is an employee who was covered by a group health plan on the day before a qualifying event occurred, or that employee's or retiree's spouse, former spouse, or dependent child. In certain cases, involving employer bankruptcy, a retired employee and their spouse, former spouse, or dependent children may be qualified beneficiaries. In addition, any child born to or placed for adoption with a covered employee during a period of continuation coverage is

automatically considered a qualified beneficiary. An employer's agents, independent contractors, and directors who participate in the group health plan may also be qualified beneficiaries.

Qualifying Events

"Qualifying events" are events that cause an individual to lose group health coverage. The type of qualifying event determines who the qualified beneficiaries are and the period of time that a plan must offer continuation coverage. COBRA establishes only the minimum requirements for continuation coverage. A plan may always choose to provide longer periods of continuation coverage and/or to contribute toward the cost.

The following are qualifying events for a covered employee if they cause the covered employee to lose coverage:

- Termination of the covered employee's employment for any reason other than "gross misconduct," or
- Reduction in the covered employee's hours of employment.

The following are qualifying events for a spouse and dependent child of a covered employee or retiree if they cause the spouse or dependent child to lose coverage:

- Termination of the covered employee's employment for any reason other than "gross misconduct,"
- Reduction in hours worked by the covered employee,
- Covered employee becomes entitled to Medicare,
- Divorce or legal separation from the covered employee or retiree, or
- Death of the covered employee or retiree.

In addition to the above, the following is a qualifying event for a dependent child of a covered employee or retiree if it causes the child to lose coverage: Loss of "dependent child" status under the plan rules. Under the Affordable Care Act, plans that offer coverage to children on their parents' plan must make coverage available until the child reaches the age of 26.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment.
- Death of the employee.
- Commencement of a proceeding in bankruptcy with respect to the employer;]; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to PEBP.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent

child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA continuation coverage is generally either 18 months or 36 months, depending on which qualifying event occurred, measured from the time the qualifying event occurs. The 18-month period of COBRA continuation coverage may be extended for up to 11 months under certain circumstances (described in another area of this section on extending COBRA in cases of disability). That period may also be cut short for the reasons set forth in the

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section "When COBRA Continuation Coverage May Be Cut Short" that appears later in this section.

Who is entitled to COBRA continuation coverage (the qualified beneficiary), when (the qualifying event), and for how long is shown in the following chart:

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries		
	Employee	Spouse or Domestic Partner	Dependent Child(ren)
Employee terminated (for other than gross misconduct).	18 months	18 months	18 months
Employee reduction in hours worked (making Employee ineligible for the same coverage).	18 months	18 months	18 months
Employee or Retiree dies.	N/A	36 months	36 months
Employee or retiree becomes divorced.	N/A	36 months	36 months
Employee becomes entitled to Medicare.	N/A	36 months	36 months
Dependent child ceases to have dependent status.	N/A	N/A	36 months
Retiree coverage is terminated or substantially eliminated within one year before or after PEBP files for bankruptcy reorganization under Chapter 11 of the federal Bankruptcy Act.	Life	Life plus 36 months after death of retiree	Life plus 36 months after death of retiree

When Cobra Continuation Coverage May be Cut Short

The Plan may terminate continuation coverage earlier than the end of the maximum period for any of the following reasons:

- Premiums are not paid in full on a timely basis.
- The employer ceases to maintain any group health plan.
- A qualified beneficiary begins coverage under another group health plan after electing continuation coverage.
- A qualified beneficiary becomes entitled to Medicare benefits after electing continuation coverage; or
- A qualified beneficiary engages in fraud or other conduct that would justify terminating coverage of a similarly situated participant or beneficiary not receiving continuation coverage.

If continuation coverage is terminated early, the plan must provide the qualified beneficiary with an early termination notice. If you decide to terminate your COBRA coverage early, you generally will not be able to enroll in a Marketplace plan outside of the open enrollment period.

If you have questions

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Subrogation and Third-Party Recovery

Subrogation applies to situations where the Participant is injured, and another person or entity is or may be responsible, liable, or contractually obligated, for whatever reason, for the payment of certain damages or claims arising from or related in any way to the Participant's injury (the "Injury"). These damages or claims arising from the Injury, irrespective of the way they are categorized, may include, without limitation, medical expenses, pain and suffering, loss of consortium, and/or wrongful death. The Plan has a right of subrogation irrespective of whether the damages or claims are paid or payable to the Participant, the Participant's estate, the Participant's survivors, or the Participant's attorney(s). All payments made by the Plan for which it claims a right of subrogation are referred to as Subrogated Payments.

The subrogation provision provides the Plan with a right of recovery for certain payments made by the Plan, irrespective of fault, or negligence wrongdoing. Any and all payments made by the Plan relating in any way to the injury may be recovered directly from the other person or from any judgment, verdict or settlement obtained by the participant in relation to the injury.

The Participant must cooperate fully, at all times, and provide all information needed or requested by the Plan to recover payments, execute any papers necessary for such recovery, and do whatever is necessary or requested in order to secure and protect the Subrogation rights of the Plan. The Participant's required cooperation includes, but is not limited to, the following actions, which must be performed immediately, upon request by the Plan:

(1) Executing an acknowledgment form or other document acknowledging and agreeing to protect the Plan's right of Subrogation.

(2) Cooperating and participating in the Plan's recovery efforts, including but not limited to participating in litigation commenced or pursued by the Plan or its Board; and

(3) Filing a claim or demand with another insurance company, including but not limited to the Participant's own first party insurance policy or another person's or entity's insurance policy.

Refer to the separate Health and Welfare Benefits Wrap Plan document available at https://www.pebp.nv.gov for more information regarding third party liability and subrogation.

Key Terms and Definitions

The following terms or phrases are used throughout the MPD. These terms or phrases have the following meanings. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Base Plan: The Self-Funded Consumer Driven Health Plan (CDHP). The base Plan is also defined as the "default Plan" where applicable in this document and other communication materials produced by PEBP.

Business Day: Refers to all weekdays, except Saturday or Sunday, or a State or Federal holiday.

Child(ren): See the definition of dependent child(ren).

Claims Administrator: The person or company retained by the Plan to administer claim payment responsibilities and other administration or accounting services as specified by the Plan.

COBRA: means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Complete Notification: means a completed event when the member submits a request for changes. To complete an event/notification the required supporting documentation must be provided to PEBP within the specified timeframe.

- Failure to provide the required documentation within the specified timeframe will result in an incomplete event/notification that will void the change request.

Coordination of Benefits (COB): The rules and procedures applicable to the determination of how plan benefits are payable when a person is covered by two or more health care plans. (See also the Coordination of Benefits section of the Consumer Driven Health Plan, Low-Deductible PPO Plan, EPO Plan Master Plan Documents, or the HMO or EPO Plan Evidence of Coverage Certificate).

Coverage Tier: the category of rates and premiums or contributions for coverage that correspond to:

- An eligible participant only.
- An eligible participant and eligible spouse.
- An eligible participant and eligible dependent child(ren).
- An eligible participant, their eligible spouse, and their eligible child(ren).
- An eligible participant and eligible domestic partner.
- An eligible participant and eligible domestic partner's child(ren); or
- An eligible participant, their eligible domestic partner, and their eligible child(ren).

Covered Individual: Any employee or retiree (as those terms are defined in this Plan), and that person's eligible spouse/domestic partner or dependent child who has completed all required formalities for enrollment for coverage under the Plan and is covered by the Plan.

Dependent: Any of the following individuals: dependent child(ren), spouse or domestic partner as those terms are defined in this document.

Dependent Child(ren): For the purposes of this Plan, a dependent child is any child/ren under the age of 26 years, including:

- natural child,
- child(ren) of a domestic partner,
- stepchild,
- legally adopted child or child placed in anticipation for adoption (the term placed for adoption means the assumption and retention by the employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child and the child must be available for adoption and the legal adoption process must have commenced),
- child who qualifies for benefits under a QMCSO/NMSN (see the *Eligibility* section for details on QMCSO/NMSN),
- any other person who:
  (1) Bears a relationship described in 26 U.S.C. § 152(c)(2) to the participant or his or her spouse or domestic partner.
  (2) Is unmarried.
  (3) Has not attained the age set forth in 45 C.F.R. § 147.120(a).
  (4) Either resides with the participant or is enrolled in a program of secondary education or an independently accredited program of postsecondary education, including, without limitation, a college, university, community or junior college, graduate school or accredited trade or business school, on a full-time basis
  (5) Satisfies one of the following conditions:
    a. Is currently under a permanent legal guardianship of the participant or his or her spouse or domestic partner pursuant to chapter 159 of NRS; or
    b. Was eligible to be claimed as a dependent on the federal income tax return of the participant or his or her spouse or domestic partner for the immediately preceding calendar year; and

(6) Is in a relationship with the participant or his or her spouse or domestic partner that is like a child-parent relationship. The participant or his or her spouse or domestic partner must complete and submit to the Program an affidavit attesting to the fact of the relationship.

Dependent Coverage Ends: Coverage of a dependent child ends at the end of the month:

- The child reaches his or her 26th birthday.
- The active employee or retiree coverage ends.
- The spouse, domestic partner, or dependent child(ren) no longer meets the definition of spouse, domestic partner, or dependent child(ren) as provided in the Definitions section of this document.
- Premium payment was last received (see Termination for Non-Payment);

- The plan is discontinued

Disability: A determination by the Plan Administrator or its designee (after evaluation by a Physician) that a person has a permanent or continuing physical or mental impairment causing the person to be unable to be self-sufficient as the result of having the physical or mental impairment such as mental retardation, cerebral palsy, epilepsy, neurological disorder, or psychosis.

Domestic Partner/Domestic Partnership: As defined by NRS 122A.030. The Plan will require the participant to provide a copy of the domestic partner certification from the Nevada Secretary of State. Participants who have a legal union or domestic partnership validly formed in another jurisdiction which is substantially equivalent to a domestic partnership in Nevada, are not required to file with, or provide a certification from the Nevada Secretary of State. The participant must also provide a statement acknowledging the participant's responsibility for any federal income tax consequences resulting from the enrollment of the domestic partner in the Plan. A domestic partner is not eligible for coverage as a dependent after termination of the domestic partnership.

Eligible Dependent: A spouse/domestic partner and any dependent child(ren). An eligible dependent may be enrolled for coverage under the Plan by following the procedures required by the Plan.

Employee: Unless specifically indicated otherwise when used in this document, employee refers to a person employed by an agency or entity that participates in the PEBP program, and who is eligible to enroll for coverage under this Plan.

Employer: Unless specifically indicated otherwise when used in this document, employer refers to an agency or entity that participates in the PEBP program, including (but not limited to) most State agencies, as well as some county and city agencies and organizations.

Employer Group Health Plan: Any employer who sponsors a health plan for their active employees.

Enroll, Enrollment: The process of completing enrollment, either by use of the e-PEBP online enrollment tool or submitting a written form indicating that coverage by the Plan is requested by the employee or retiree. An employee or retiree may request coverage for an eligible dependent only if he or she is or will be covered by the Plan.

Family Unit: The covered employee or retiree and the family members who are covered as dependents under the covered employee's or retiree's plan.

Full-Time Employment: Employees working 80 hours a month (NAC 287.150) or an average of at least 130 hours per month as defined by the IRS ("Identifying Full-time Employees")**.**

Employer Group Health Plan; Group Health Insurance: Group health insurance is any group health policy which contains provisions for the payment by the insurer of benefits for expenses incurred on account of hospital, nursing, medical, dental or surgical services, home health care or health supportive services for members of the family or dependents of a person in the insured group may provide for the continuation of such benefit provisions, or any part or parts thereof, after the death of the person in the insured group. Group health insurance is declared to be that form of health insurance covering groups of two or more people, formed for a purpose other than obtaining insurance (NRS 689B.020).

Health Reimbursement Arrangement: A Health Reimbursement Arrangement (HRA) is an employee-funded spending account that can be used to pay qualified medical expenses. The HRA is 100% funded by the employer. The terms of these arrangements can provide first dollar medical coverage until the funds are exhausted, or insurance coverage kicks in. The contribution amount per employee is set by the employer, and the employer determines what the funds can be used to cover and if the dollars can be rolled over to the next year. In most cases, if the employee leaves the employer, they cannot take remaining HRA funds with them.

Health Care Provider: A health care practitioner, hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility.

Health Savings Account: An account that allows qualified employees to pay for current health expenses and save for future qualified medical and Retiree health expenses on a tax-free basis.

HIPAA: Health Insurance Portability and Accountability Act of 1996. Federal regulation affecting portability of coverage; electronic transmission of claims and other health information; privacy and confidentiality protections of health information.

HIPAA Special Enrollment: Enrollment rights for certain employees and dependents who experience a loss of other employer group coverage and when there is an adoption, placement for adoption, birth, marriage, or a domestic partnership certification from the office of the Nevada Secretary of State or a domestic partnership validly formed in another jurisdiction which is substantially equivalent in Nevada.

Ineligible Dependents: Individuals who are not eligible as defined above are not eligible dependents under this Plan.

Medicare: The health insurance for the aged and disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Medicare Part A: Hospital insurance provided by the federal government that helps cover inpatient care in hospitals, skilled nursing facility, hospice, and home health care.

Medicare Part B: Medical insurance provided by the federal government that helps pay for medically necessary services like doctors' services, outpatient care, durable medical equipment, home health services, and other medical services.

Medicare Part D: Prescription drug coverage subsidized by the federal government but is offered only by private companies contracted with Medicare such as HMOs and PPOs.

Mini-med or other limited benefit plan: Mini-med health plans or other limited benefit plans feature limited benefits. There is a maximum amount that the plan will pay. Once that limit is hit, remaining medical expenses have to be covered "out-of-pocket" by the enrollee.

National Medical Support Notice (NMSN)/Qualified Medical Child Support Order (QMCSO): A court order that complies with requirements of federal law requiring an employee to provide health care coverage for a dependent child and requiring that benefits payable on account of that dependent child be paid directly to the health care provider who rendered the services.

Notification: When a member initiates a change to their benefits with PEBP (Open Enrollment, Qualifying Life Event, or HIPAA Special Enrollment) through their online PEBP account. The date a notification is received may control the effective date of benefit changes. A notification may be subject to requirements for supporting documentation (see the definition of "completed notification" for more information).

Open Enrollment Period: The period during which participants in the Plan may select among the alternate health benefit programs that are offered by the Plan or eligible individuals not currently enrolled in the Plan may enroll for coverage. The Plan's open enrollment period is described in the *Eligibility* section of this document.

Over age Child with a Disability or Disabled Dependent Child over the age of 26 years: As determined by the Plan Administrator or its designee, is an unmarried child who has reached his or her 26th birthday who, as evaluated by a physician, has a permanent or continuing mental or physical impairment and is incapable of self-sustaining employment or self-sufficiency as a result of having that impairment; depending chiefly on the participant or the participant's spouse/domestic partner for support and maintenance and whom the participant claims as a dependent on IRS tax forms under the IRS Code 152(1) (without regard to the gross income test). This Plan will require proof of having a disability at reasonable intervals during the two years following the date the dependent reaches the limiting age of 26 years and after this two-year period the Plan Administrator may require proof not more than once each year. The Plan Administrator reserves the right to have the dependent examined by a physician of the Plan Administrator's choice (and at the Plan's expense) to determine that the dependent meets the definition of a disabled dependent child over the age of 26 years. Children covered under legal guardianship are not included in this definition.

Placed for Adoption: For the definition of placed for adoption as it relates to coverage of adopted dependent children, see the definition in the section on adopted dependent children in the *Eligibility* section.

Plan, The Plan, This Plan: In most cases, the programs, benefits, and provisions described in this document as provided by the Public Employees' Benefits Program (PEBP).

Plan Administrator: The person or legal entity designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan.

Plan Participant: The employee or retiree or their enrolled spouse/domestic partner or dependent child(ren) or a surviving spouse/domestic partner of a retiree.

Plan Year: Typically, the 12-month period from July 1 through June 30. PEBP has the authority to revise the Plan Year if necessary. PEBP has the authority to revise the benefits and rates, if necessary, each Plan Year. For medical, dental, vision and pharmacy benefits, all Deductibles, Out-of-Pocket Maximums and Plan Year maximum benefits are determined based on the Plan Year.

Positive Open Enrollment: This process requires that each participant affirmatively make their benefit elections during the PEBP open enrollment period. Even if they do not want to make any coverage changes, they must affirmatively make their elections, or they will be defaulted to self-coverage only under the PEBP Base Plan.

Program: Means the Public Employees' Benefits Program established in accordance with NRS 287.0402 to 287.049, inclusive.

Provider: See the definition of Health Care Provider.

Qualified Medical Child Support Order (QMCSO)/National Medical Support Notice (NMSN): A court order that complies with requirements of federal law requiring an employee to provide health care coverage for a dependent child and requiring that benefits payable on account of that dependent child be paid directly to the health care provider who rendered the services.

Rescission: A cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance is not a rescission if the cancellation or discontinuance of coverage has only a prospective effect, or the cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay premium or costs of coverage.

Retiree: Unless specifically indicated otherwise, when used in this document, retiree refers to a person formerly employed by an agency or entity that may or may not participate in the PEBP program and who is eligible to enroll for coverage under this Plan.

Significantly Inferior Coverage: A "mini med" or other limited benefit plan; or a catastrophic coverage plan with a Deductible equal to or greater than $5,000 with no employer contributions to Health Savings Accounts or Health Reimbursement Arrangements or any other coverage. PEBP will determine if an employer sponsored group health plan meets the definition of significantly inferior coverage.

Spouse: The employee's or retiree's lawful spouse (opposite sex or same sex) as determined by the laws of the State of Nevada**.** The Plan will require proof of the legal marital relationship. The former spouse of an employee or retiree is not an eligible spouse under this Plan.

State: When capitalized in this document, the term State means the State of Nevada.

Tier of Coverage: The category of rates and premiums or contributions for coverage that correspond to either an eligible participant only, or an eligible participant and one or more eligible dependents.

Unsubsidized Dependent of a Retiree: An unsubsidized dependent is defined as the eligible spouse/domestic partner and/or eligible dependent(s) of a retiree who remains covered under the Consumer Driven Health Plan (CDHP), Low-Deductible PPO (LD PPO), HMO Plan or EPO Plan while the primary participant transitions coverage to the Medicare Exchange.