NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

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PEBP Active Employee Health and Welfare Wrap Plan Document

Plan Year 2022
Effective July 1, 2021 – June 30, 2022

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Article 1 Introduction

1.1 Introduction

The Plan includes the Component Benefits listed in Schedule 1 to this Plan document for Employees and their eligible Dependents participating in the Public Employees' Benefits Program, hereafter referred to as PEBP. The provisions of the Component Benefits are contained in the Incorporated Documents.

(a) This PEBP Plan is governed by the State of Nevada.

(b) This document is intended to comply with the Nevada Revised Statutes (NRS) Chapter 287, and the Nevada Administrative Code 287 as amended and certain provisions of NRS 695G, NRS 689B and the Patient Protection and Affordable Care Act (PPACA)

The Plan described in this document is effective July 1, 2021, and unless stated differently, replaces all prior medical and prescription drug benefit plan documents/summary plan descriptions. Per NRS 287.0485 no officer or Employee, of the State has any inherent right to benefits provided under the PEBP.

PEBP intends to maintain this Plan indefinitely, but reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason. As the Plan is amended from time to time, Participants will be sent information explaining the changes. This Plan is administered in accordance with regulations of Section 125 of the Internal Revenue Code ("Code") as described in the PEBP Section 125 Health and Welfare Benefits Plan Document available at www.pebp.state.nv.us.

This Plan is not established under and subject to the Employee Retirement Income Security Act of 1974, as amended, a federal law commonly known as ERISA. The self-funded portions of this Plan are funded with contributions from participating Employers and eligible Participants, held in an internal service fund. An independent Claims Administrator pays benefits out of the fund's assets. An independent Claims Administrator pays the claims for medical and prescription drug benefits.

1.2 Legal Status of Plan

The Plan is intended to qualify as an accident and health plan under Sections 105 and 106 of the Code and as a plan providing group-term life insurance coverage, as described in Section 79 of the Code. The Plan is intended to comply with the laws of the State of Nevada, the Code, and the Public Health Service Act (PHSA) and the regulations and rules promulgated under each, to the extent applicable, and any other applicable law.

The Plan shall be construed and interpreted in a manner consistent with the requirements of Sections 79, 105 and 106 of the Code, and any other applicable sections of the Code, the PHSA or any other applicable law.

1.3 Applicability of the Plan

Except as otherwise provided herein, the provisions of this Plan shall apply only to covered services and covered events (e.g., death) which are provided, or which occur on and after July 1, 2021 to Eligible Employees. The terms of this Plan govern all claims for benefits hereunder as of July 1, 2021. In the case of services or events which are provided, or which occur prior to July 1, 2021, coverage shall be available (if at all) under the terms of the applicable prior plan.

Article 2 Definitions

2.1 Definitions

The following words and phrases as used in the Plan shall have the following meanings unless a different meaning is required by the context:

(a) "**Allowable Expense**" means a health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering the person, except as described below, or where a statute requires a different definition. An expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense.

(b) "**Benefit Option**" means an option for coverage within an underlying Component Benefit (such as a particular "benefit package" within a group health plan).

(c) "**Cafeteria Plan**" means the PEBP Section 125 Health and Welfare Benefits Plan, intended to meet the requirements of Code Section 125 and the regulations thereunder.

(d) "**Claims Administrator**" means the person or company retained by the Plan to administer claim payment responsibilities and other administration or accounting services as specified in the Plan.

(e) "**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(f) "**Code**" means the Internal Revenue Code of 1986, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder, and any successor statute of similar import. Reference to any section or subsection of the Code includes references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

(g) "**Component Benefit**" means an employee welfare benefit that is designated on Schedule 1 as one of the Component Benefits of the Plan and described in the Incorporated Documents. Incorporated Documents describing the specific benefits provided by each Component Benefit, the terms of eligibility and other terms and conditions, as they may be amended from time to time by the PEBP, are incorporated herein by reference, and are considered part of the Component Benefits.

(h) "**Covered Person**" means an Eligible Employee or eligible Dependent who is covered under a Component Benefit who enrolls in the Plan in accordance with Article 3, who has commenced participation in the Plan accordingly and whose participation has not terminated under any other applicable provisions of the Plan.

(i) "**Dependent**" generally refers to individuals other than an Eligible Employee who may be eligible for, and enrolled in, coverage under a Component Benefit, as defined and determined under the Master Plan Document for the PEBP Enrollment and Eligibility, based on their relationship to the Eligible Employee (e.g., Dependent Child(ren), Spouse, or Domestic Partner).

(j) "**Dependent Child(ren)**" means any of an Eligible Employee's children under the age of 26 years including: (i) natural child; (ii) child(ren) of a Domestic Partner; (iii) stepchild; (iv) legally adopted child or child placed in anticipation of adoption (the term placed for adoption means the assumption and retention by the Employee or Retiree 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); (v) child who qualifies for benefits under a Qualified Medical Child Support Order/National

Medical Support Notice; and (vi) child under 19 years for whom an Employee or Retiree has legal guardianship under a court order.

(k) "**Domestic Partner**" means a domestic partner as defined by NRS 122A.030 and as defined and determined under the Master Plan Document for the PEBP Enrollment and Eligibility.

(l) "**Effective Date**" means the effective date of this Plan which is July 1, 2021.

(m) "**Eligible Employee**" means an Employee who is an "eligible employee" as defined in the Master Plan Document for the PEBP Enrollment and Eligibility. PEBP may at any time and from time to time remove any one or more Employees or any other group(s) or class(es) of Employees from eligibility for participation in this Plan.

(n) "**Employee**" means 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 as defined and determined under the Master Plan Document for the PEBP Enrollment and Eligibility.

(o) "**Employer**" means, unless specifically indicated otherwise when used in this document, 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.

(p) **"Executive Officer"** means the Executive Officer of PEBP.

(q) "**FMLA**" means the Family and Medical Leave Act of 1993, as amended.

(r) "**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996 as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import.

(s) "**Incorporated Document**" shall mean any and all of the following documents, each of which is incorporated by reference into this Plan document and made a part hereof, and as each is amended from time to time by the PEBP; an Incorporated Document describes the specifics of a Component Benefit(s) including eligibility:

(1) PEBP Premier Plan Master Plan Document (for Medical and Prescription Drug Benefits);

(2) Premier Plan Summary of Benefits and Coverage (for Individual and Family);

(3) Consumer Driven Health Plan (CDHP) Master Plan Document (Medical, Vision, Prescription Drug, Health Savings Account (HSA) and Health Reimbursement Arrangement (HRA));

(4) Low Deductible PPO (LD PPO) Master Plan Document

(5) Consumer Driven Health Plan (CDHP) Summary of Benefits and Coverage (Individual);

(6) Consumer Driven Health Plan (CDHP) Summary of Benefits and Coverage (Family).

(7) PEBP Enrollment and Eligibility Master Plan Document;

(8) PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document.

(9) PEBP Section 125 Health and Welfare Benefits Plan Document;

(10) Health Plan of Nevada Evidence of Coverage and Summary of Benefits and Coverage;

(11) Summaries of Coverage and Summaries of Insurance; Insurance Contract(s); and,

(12) Plan Materials.

(t) "**Insurer**" means an insurance company with which the Plan Administrator has entered into an Insurance Contract.

(u) "**Insurance Contract**" means a contract between the Plan Administrator and an Insurer for the provision of one or more Component Benefits.

(v) "**Leave of Absence**" means the Employee has obtained an approved leave of absence from the Employer as provided for in the Employer's rules, policies, procedures and/or practices, including absence under the FMLA and leave for duty in the Uniformed Services under USERRA. Leave of Absence shall also mean any other unpaid Leave of Absence as administered and approved by the Employer.

(w) "**Participant**" means the Employee or their enrolled Spouse or Domestic Partner or Dependent Child(ren) per NAC 287.095 and as defined and determined under the Master Plan Document for the PEBP Enrollment and Eligibility.

(x) "**Participant Contributions**" means contributions made by a Participant under the Cafeteria Plan, including, without limitation, Salary Reduction Contributions, as applicable. For this purpose, Participant Contributions shall also include contributions by Covered Persons, such as contributions required following an election of continuation coverage under COBRA.

(y) "**PEBP**" means the Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043.

(z) "**PEBP Board**" or "Board" means the Board of the Public Employees' Benefits Program created by NRS 287.041.

(aa) "**Plan**" means the PEBP Active Employee Health and Welfare Wrap Plan as set forth herein, including the Component Benefits as set forth in Schedule 1 and all other schedules hereto and all Incorporated Documents, as each is amended from time to time.

(bb) "**Plan Administrator**" means the person or legal entity designated by the Plan as the party who has the fiduciary responsibility for the overall administration of the Plan. As of the Effective Date, the Plan Administrator is the Executive Officer of PEBP. The Executive Officer of PEBP may from time to time designate in writing an individual, group of individuals, or staff to formally act on its behalf (designee).

(cc) "**Plan Materials**" means updates to a Component Benefit that is communicated to Participants, to the extent that such update is approved by the Plan Administrator or a delegate of the Plan Administrator.

(dd) "**Plan Year**" means 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, with respect to a Component Benefit, to revise the benefits and rates, if necessary, each Plan Year.

(ee) "**Qualified Medical Child Support Order**" means an order that creates or recognizes the existence of a child's right to health benefits under the Plan and must be in the form of a judgment, decree, or order (including a settlement agreement approved by the court) issued by a court (or state administrative agency with jurisdiction) that is deciding the child support issues in a divorce or other family law action. A Qualified Medical Child Support Order must clearly specify:

(1) The name and last known mailing address of a Participant and the name and last known mailing address of each child covered by the order,

(2) a reasonable description of the type of coverage to be provided by the Plan to each child covered by the order, or the manner in which such type of coverage is to be determined,

(3) The period to which the order applies, and

(4) Each plan to which such order applies.

A Qualified Medical Child Support Order cannot require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan. The Plan Administrator shall adopt procedures respecting a Qualified Medical Child Support Order in accordance with Section 2714 of the PHSA and Section 401(e)-(f) of the Child Support Performance and Incentive Act of 1998 (CSPIA).

(ff) "**PPACA**" means the Patient Protection and Affordable Care Act enacted on March 23, 2010, as amended by the Health Care and Education Reconciliation Act enacted on March 30, 2010, and as may be amended from time to time thereafter.

(gg) "**Rescission**" means a cancellation or discontinuance of coverage under the Plan that has a retroactive effect. In accordance with Section 2712 of the PHSA, rescission does not include a cancellation or discontinuance of coverage under the Plan if: (a) the cancellation or discontinuance of coverage has only a prospective effect; or (b) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage; or (c) fraud.

(hh) "**Salary Reduction Contributions**" means contributions made under the Cafeteria Plan based on an election by a Participant to have amounts withheld from the Participant's compensation on a pre-tax or after-tax basis to pay for benefits or coverage provided under a Component Benefit.

(ii) "**Spouse**" means an Employee's lawful Spouse (opposite sex or same sex) as determined by the laws of the State of Nevada, and as defined and determined under the Master Plan Document for the PEBP Enrollment and Eligibility.

(jj) "**State**" means the State of Nevada.

(kk) "**State Law**" means the law of the State of Nevada, as set forth in the Nevada Revised Statutes (NRS) and the regulations thereunder.

(ll) "**Subrogation**" means the right of one party to be substituted in place of another party in a lawsuit. See Section 4.5 Third Party Liability of this document for an explanation of how the Plan may use the right of Subrogation to be substituted in place of a covered individual (any Employee and that person's eligible Spouse or Dependent Child who has completed all required formalities for enrollment for coverage under

the Plan and is actually covered under a Component Benefit of the Plan) in that person's claim against a third party who wrongfully caused that person's injury or illness, so that the Plan may recover medical benefits paid if the covered individual recovers any amount from the third party either by way of a settlement or judgment in a lawsuit.

(mm) "**Summary of Coverage**" means the description of health care services and benefits prepared on behalf of the PEBP by the third-party administrator to describe the details of a self-insured benefit program.

(nn) "**Summary of Insurance**" means the description of health care services and benefits prepared by an Insurer.

(oo) "**Tortfeasor**" means an individual or entity who commits a wrongful act, either intentionally or through negligence, that injures another or for which the law provides a legal right through a civil case for the injured person to seek relief.

(pp) "**Uniformed Services**" means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or emergency.

(qq) "**USERRA**" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import.

2.2 Construction

Whenever any words are used in the singular form, they shall be construed as though they were also used in the plural form in all cases where the plural would so apply. Headings of articles and sections are inserted for convenience and reference, and they constitute no part of the Plan. Except where otherwise indicated by the context, any masculine terminology herein shall include the feminine and gender neutral.

Article 3 Eligibility and Participation

3.1 Eligibility

Active Employees and their eligible Dependents are eligible to enroll in this Plan, subject to the terms of the Master Plan Document for the PEBP Enrollment and Eligibility, which document is incorporated herein by reference.

3.2 Commencement of Participation

An Eligible Employee and his Dependent(s) shall become Covered Persons under the Plan, subject to the terms of the Master Plan Document for the PEBP Enrollment and Eligibility, which document is incorporated herein by reference.

3.3 Elections and Changes in Elections for Benefits

For purposes of the benefits provided under the Component Benefits, the Plan Administrator will designate an annual or open enrollment period and the Benefit Options available for election for the following Plan Year. The election of the Benefit Options and changes thereto shall be made in the manner, and subject to the conditions, specified by the Plan Administrator.

3.4 Participation During Leaves of Absence

Participation during Leaves of Absence is as set forth in the Master Plan Document for the PEBP Enrollment and Eligibility.

3.5 Effective Dates and Conditions

In order to participate in a Component Benefit and receive benefits under this Plan, an Employee and his Dependent(s) must meet any additional participation requirements of the Component Benefits as provided in the Incorporated Documents. An Employee must elect any such benefits on forms provided by the Plan Administrator or through electronic means designated by the Plan Administrator unless the benefit is automatically provided. Such coverage shall be effective as of the date or dates set forth in the applicable Component Benefit's Incorporated Documents.

3.6 Termination of Coverage

Termination of coverage under this Plan of any Participant/Covered Person will terminate in accordance with the rules and procedures set forth in the Master Plan Document for the PEBP Enrollment and Eligibility.

3.7 Continuation

Opportunities to continue coverage under this Plan shall be as set forth in the Master Plan Document for the PEBP Enrollment and Eligibility and provided in accordance with applicable state and federal law.

3.8 Incorporation of Plans and Policies and Master Plan Documents

The eligibility provisions, benefit provisions and such other provisions of the applicable Component Benefit's Incorporated Documents as may be modified from time-to-time hereafter, and as are consistent with the terms and conditions of this Plan are incorporated herein by reference and shall be of the same force and effect under this Plan as if they were set forth herein. Furthermore, if any provision of a Component Benefit shall at any time hereafter

conflict with the provisions of this Plan, such provision of the Component Benefit shall no longer be deemed a part of this Plan.

3.9 Qualified Medical Child Support Orders

The Plan shall provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (QMCSO) as set forth in the Master Plan Document for the PEBP Enrollment and Eligibility.

Article 4 Benefits

4.1 Generally

Benefits hereunder shall be provided through the Component Benefits listed in Schedule 1. As permitted by this Section 4.1, the PEBP, as Plan Administrator, has the authority to determine what Component Benefits will be provided to Eligible Employees and Dependents provided the availability of such Benefit Options are properly communicated to Eligible Employees.

The persons covered and the benefits provided by each Component Benefit shall be determined in accordance with the applicable Incorporated Documents; provided that, except to the extent the Master Plan Document for the PEBP Enrollment and Eligibility expressly provides otherwise, persons who are not Eligible Employees shall not be eligible for coverage or benefits under the Plan; and provided further that, except to the extent required by applicable law, coverage and benefits under the Plan shall not be provided in excess of the coverage and benefits described in the applicable Summary of Coverage, Summary of Insurance and/or Insurance Contract.

4.2 Compliance with Federal Group Health Plan Benefits and Coverage Mandates

A group health plan Benefit Option shall comply with benefit and coverage provisions to the extent required by law including:

(a) **Coronavirus Aid, Relief, and Economic Security Act (CARES Act); Families First Coronavirus Response Act (HR 6201) ("CARES Act").** This Plan shall comply with the CARES Act to the extent it applies. The Plan shall cover COVID-19 testing and certain COVID-19 testing related items and services without cost sharing (deductibles, coinsurance, copayments), prior authorization or other medical management requirements. This coverage includes the COVID-19 test and COVID-19 testing-related visit to order or administer the test. A testing related visit may occur in a physician's office, via telehealth, in an urgent care center or emergency room. In- network and out-of-network costing sharing will not apply. To the extent it applies, this Plan will cover qualifying items, services, or immunizations intended to prevent or mitigate COVID-19 (qualifying coronavirus preventive services) without imposing cost sharing. In order to be covered, the services must be either (i) an evidenced-based item or service that has a "A" or "B" rating in the current recommendations from the United States Preventive Services Task Force, or (ii) an immunization with a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Expansion of Health Savings Accounts (HSAs), Flexible Spending Accounts (FSAs), and Health Reimbursement Arrangements (HRAs): Effective January 1, 2021, individuals may use HSAs, FSAs, and HRAs to purchase over-the-counter medicines without a prescription, and to purchase menstrual care products. To the extent it applies, this Plan shall allow early prescription refills to ensure members have sufficient supply of medication on hand. The refill shall stay consistent with the standards' supply previously filled by the member as allowed by the Plan (e.g., 30- or 90-days' supply). To the extent it applies, the Plan shall allow HSA members to continue to contribute to their 2020HSAs to July 15, 2021 in accordance with IRS Notice IR-2020-58) This Act is effective March 18, 2020 to apply retroactively.

(b) **Pediatric Vaccines**. To the extent it applies, the Plan shall not reduce the continued coverage costs of a pediatric vaccine below the coverage the Plan provided as of May 1, 1993, under the Omnibus Budget Reconciliation Act of 1993 (OBRA '93).

(c) **Newborns and Mothers**. A group health plan Benefit Option that is not exempt or an excepted benefit, as defined in Sections 2725 and 2791 of the PHSA or has not opted out under Section 2722(a) of the PHSA, shall continue coverage for newborns and mothers in accordance with Section 2725 of the PHSA.

(d) **Mental Health Parity.** A group health plan Benefit Option that is not exempt or an excepted benefit, as defined in Sections 2726 and 2791 of the PHSA or has not opted out under Section 2722(a) of the PHSA, that provides mental health or substance use disorder benefits (MH/SUD), shall provide such MH/SUD benefits in accordance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

(e) **Women's Health and Cancer Rights Act**. A group health plan Benefit Option that is not exempt or an excepted benefit, as defined in Section 2791 of the PHSA, or has not opted out, shall provide coverage for reconstructive surgery following mastectomy to the extent required by Section 2727 of the PHSA.

(f) **Group Market (Insurance) Reforms**. A group health plan Benefit Option that is not exempt or an excepted benefit, as defined in Section 2791 of the PHSA, shall comply with the applicable group market (insurance) reforms that apply to a group health plan under PPACA. As of the Effective Date, no Benefit Option is a "grandfathered health plan." Further, the Health Reimbursement Arrangement is intended to be integrated for purposes of PPACA and related guidance.

PPACA group market (insurance) reforms that apply to all grandfathered and non-grandfathered group health plan Benefit Options under the Plan that are not exempt or excepted benefits under Section 2791 of the PHSA are:

(1) Prohibition of preexisting condition exclusions under PHSA 2704.

(2) Prohibiting discrimination against Participants and beneficiaries based on a health factor under PHSA 2705.

(3) Prohibition on waiting periods that exceed 90 days under PHSA 2708.

(4) Prohibition on lifetime or annual dollar limits on essential health benefits under PHSA 2711.

(5) Prohibition on rescissions under PHSA 2712.

(6) Eligibility of children until at least age 26 under PHSA 2714.

(7) Summary of benefits and coverage and uniform glossary under PHSA 2715; and,

(8) Solely with respect to insured Benefit Options, the medical loss ratio requirements under PHSA 2718.

Additional PPACA group market (insurance) reforms that apply to group health plan Benefit Options that have lost grandfathered health plan status and are not exempt or excepted benefits under Section 2791 of the PHSA are:

(9) Provider non-discrimination under PHSA 2706(a).

(10) Limitations on cost sharing (i.e., the out-of-pocket expense maximum requirements) under PHSA 2707(b).

(11) Coverage for individuals participating in approved clinical trials under PHSA 2709.

(12) Coverage of preventive health services under PHSA 2713.

(13) Internal claims and appeals and external review process as discussed in Article 7 of the Plan and under PHSA 2719; and

(14) Consumer patient protections (choice of health care professional and coverage of emergency services) under PHSA 2719A.

While not referenced in this Plan document, the Benefit Options that are subject to the group market (insurance) reforms will comply with respect to both regulatory and sub-regulatory guidance to the extent applicable. To the extent that the U.S. Department of Labor, Internal Revenue Service or Department of Health and Human Services, as applicable, implements additional group market (insurance) reforms required by the PPACA, the Plan shall comply to the extent necessary.

(g) **National Defense Authorization Act (NDAA)**. The Plan shall comply with Section 585 of the National Defense Authorization Act (NDAA), which amends the Family and Medical Leave Act of 1993 (FMLA), to permit a "Spouse/ Domestic Partner, son, daughter, parent, or next of kin" to take up to 26 workweeks of leave to care for a "member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness." The NDAA also permits an employee to take FMLA leave for "any qualifying exigency (as the Secretary [of Labor] shall, by regulation, determine) arising out of the fact that the Spouse/Domestic Partner, or a 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."

(h) **Heroes Earning Assistance and Relief Tax Act (HEART Act).** The Plan shall comply with the Heroes Earnings Assistance and Relief Tax Act of 2008 (HEART Act), which requires that certain retirement and welfare benefits be provided for returning military personnel and their beneficiaries.

(i) **Uniformed Services Employment and Reemployment Rights Act (USERRA).** The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA, 38 U.S.C. § 4301 –4335) is a federal law intended to ensure that persons who serve or have served in the Armed Forces, Reserves, National Guard or other "uniformed services": (1) are not disadvantaged in their civilian careers because of their service; (2) are promptly reemployed in their civilian jobs upon their return from duty; and (3) are not discriminated against in employment based on past, present, or future military service.

(j) **The Americans with Disability Amendments Act (ADA).** To the extent applicable, the Plan shall comply with the Americans with Disability Act (ADA), including the requirement that any condition that substantially limits a major life activity will be considered a disability, even if the individual can offset or compensate for the disability with the mitigating measures such as hearing aids or artificial limbs.

(k) **Genetic Information Non-discrimination Act of 2008 (GINA).** The Plan shall comply with the Genetic Information Non-discrimination Act of 2008 (GINA) to the extent applicable including: Title I (regarding genetic nondiscrimination in group health plans) and Title II (regarding genetic nondiscrimination in employment). Under GINA, the Plan shall not base enrollment decisions, premium costs, or Participant contributions on genetic information. The Plan shall not require that individuals undergo genetic testing. PEBP is prevented from conditioning hiring or firing decisions based on genetic information. Lastly, GINA will extend medical privacy and confidentiality rules to the disclosure of genetic information. Currently, PEBP and the State of Nevada do not use genetic information regarding either employment or the determination of benefits.

(l) **Michelle's Law.** The Plan shall comply with Michelle's Law to the extent it applies to Dependent Child(ren)'s eligibility for health coverage conditioned on maintaining full-time student status as described in the Master Plan Document for the PEBP Enrollment and Eligibility. Should Michelle's Law apply and a Dependent Child takes a medically necessary leave of absence for a serious illness or injury that causes loss of full-time student status, the Plan shall not terminate his or her coverage before the date that is the earlier of: (1) one year after the first day of the medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the PEBP. A written certification stating that the Dependent Child is suffering from a serious illness or injury and that the leave of absence is medically necessary must be provided by a treating physician of the Dependent Child to PEBP for eligibility and coverage to continue.

4.3 Benefit Election

During the enrollment period, an Eligible Employee or Eligible Retiree may elect to either receive any or all the benefits described in the Component Benefits for which the Eligible Employee or Eligible Retiree and any eligible Dependent(s) is eligible as described in the enrollment materials. Each Participant shall be notified of the Eligible Employee's or Eligible Retiree's share of the cost, if any, of each Benefit Option prior to the enrollment period for the Plan Year.

4.4 Coordination of Benefits

When Participants have medical, dental or vision coverage from some other source, benefits are determined using Coordination of Benefits (COB). COB operates so that one of the plans (i.e., the primary plan) will pay its benefits first. The other plan or policy, (i.e., the secondary plan) may then pay additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the medical or dental allowable expenses incurred. Sometimes the combined benefits that are paid will be less than the total expenses.

Participants must let the Plan Administrator, or its designee know about all other coverages when submitting a claim. If the PEBP Plan is secondary coverage, the Participant will be required to meet their PEBP Plan Year medical and dental deductibles. This Plan's prescription drug benefit does not coordinate benefits for prescription medications, or any covered over the counter (OTC) medications, obtained through retail or home delivery pharmacy programs. Meaning, there will be no coverage for prescription drugs under this Plan if a Participant has additional prescription drug coverage that is primary.

For the purposes of this COB section, the word "plan" refers to any group or individual medical or dental policy, contract, or plan, whether insured or self-insured, that provides benefits payable for medical or dental services incurred by the covered individual either on an individual basis or as part of a group of employees, retirees or other individuals.

A Participant in a fully insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures under such fully insured plan and the rules and procedures described in such fully insured plan's applicable Summary of Insurance.

A Participant in a self-insured plan seeking to obtain payment of benefits shall follow and be bound by the COB procedures set forth in this Section 4.4. The PEBP delegates to the third-party administrator of such self-insured plan the duty to administer and interpret the provisions of this Section 4.4. and to adopt, document and communicate any rules and procedures necessary or appropriate to implement the COB procedures, as set forth herein:

(a) **Which Plan Pays First: Order of Benefit Determination Rules.** PEBP uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC), and which are commonly used by insured and self-insured plans. Any plan that does not use these same rules always pays its benefits first.

When two plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan (pays first) and which is the secondary plan (pays second). If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established.

These rules are:

(1) Non-Dependent /Dependent

The plan that covers a person other than as a dependent (e.g., as an employee, retiree, member, or subscriber) is primary and the plan that covers the person as a dependent is secondary. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is:

- Secondary to the plan covering the person as a dependent.
- Primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee).
- Then the order of benefits is reversed, so that the plan covering the person as a dependent will pay first; and the plan covering the person other than as a dependent (e.g., as a retired employee) pays second.

This rule applies when both spouses are employed and cover each other as dependents under their respective plans. The plan covering the person as an employee pays first, and the plan covering the same person as a dependent will pay benefits second.

(2) Dependent Child Covered Under More Than One Plan

The plan that covers the parent whose birthday falls earlier in the calendar year pays first; the plan that covers the parent whose birthday falls later in the calendar year pays second, if:

- The parents are married.
- The parents are not separated (whether or not they ever have been married); or
- A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.
- If both parents have the same birthday, the plan that has covered one of the parents for a longer period pays first, and the plan that has covered the other parent for the shorter period of time pays second.
- The word “birthday” refers only to the month and day in a calendar year; not the year in which the person was born.

If the specific terms of a court decree state that one parent is responsible for the child’s health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child’s health care services or expenses, but that parent’s current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any plan year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

- The plan of the custodial parent pays first; and
- The plan of the spouse of the custodial parent pays second; and
- The plan of the non-custodial parent pays third; and
- The plan of the spouse of the non-custodial parent pays last.

(3) Active/Laid-Off or Retired Employee

The plan that covers a person, as an active employee (i.e., an employee who is neither laid-off nor retired) or as an active employee's dependent pays first; the plan that covers the same person as a laid-off/retired employee or as a laid-off/retired employee's dependent pays second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule (1) Non-Dependent/Dependent rather than by this rule.

(4) Continuation Coverage

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If a person is covered other than as a Dependent (that is, as an employee, former employee, retiree, member, or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule (1) Non-Dependent/Dependent rather than by this rule.

(5) Longer/Shorter Length of Coverage

If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period pays first; and the plan that covered the person for the shorter period of time pays second. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan.

(b) **Administration of COB.** To administer COB, the Plan reserves the right to:

- Exchange information with other plans involved in paying claims.
- Require that Participants or Participants' health care provider(s) furnish any necessary information.
- Reimburse any plan that made payments this Plan should have made; or
- Recover any overpayment from a Participant's hospital, physician, dentist, other health care provider, other insurance company, or a Participant.

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount the Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

This Plan follows the customary COB rule that the medical program coordinates with only other medical plans or programs (and not with any dental plan or program), and the dental program coordinates only with other dental plans or programs (and not with any other medical plan or program). Therefore, when this Plan is secondary, it will pay secondary medical benefits only when the coordinating primary plan provides medical benefits, and it will pay secondary dental benefits only when the primary plan provides dental benefits.

If this Plan is primary, and if the coordinating secondary plan is a health maintenance organization (HMO), Exclusive Provider Organization (EPO) or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the prevailing rates for such services in the community in which the services were provided.

If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained out-of-network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary Plan.

If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Participant may have against the other plan, and the Participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

This Plan does not coordinate pharmacy benefits when PEBP is the secondary or tertiary payor.

(c) **Coordination with Medicare.** Coordination with Medicare is not applicable for Participants and their Dependents who are eligible for Medicare Part A and Medicare Part B and who are required to transition to the Medicare Exchange. The Enrollment and Eligibility Master Plan Document includes information regarding enrollment in the Medicare Exchange.

(1) **Entitlement to Medicare Coverage.** When a Participant is retired and reaches Medicare eligible age, the Participant must enroll in the Medicare plan for which the Participant is eligible. Generally, anyone age 65 years or older is entitled to Medicare Part A and Medicare Part B coverage. Anyone under age 65 years who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.

(2) **When the Participant is Not Eligible for Premium Free Medicare Part A.** This Plan will pay as primary for services that would have been covered by Part A when a retired Participant is not eligible for Premium Free Medicare Part A. However, a retired Participant must enroll in Medicare Part B and PEBP will be the secondary payer for Medicare Part B services. This Plan will always be secondary to Medicare Part B, whether or not a retired Participant has enrolled. This Plan will assume that Medicare has paid 80% of Medicare Part B eligible expenses. This Plan will only consider the remaining 20% of Medicare Part B expenses.

(3) **Coverage Under Medicare and This Plan When a Participant Has End-Stage Renal Disease.** If, while actively employed, a Participant becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins, or the first month in which the individual

receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage or the first month after the individual receives a kidney transplant, Medicare pays first, and this Plan pays second.

If a retired Participant is under age 65 years and receiving Medicare ESRD benefits the Participant will not be required to transition to PEBP's Medicare Exchange program. When a Participant reaches age 65 years, the Participant will be transitioned to the Medicare Exchange in accordance with PEBP's eligibility requirements as stated in the Enrollment and Eligibility Master Plan Document.

(4) **How Much This Plan Pays When It Is Secondary to Medicare.** When the Participant is covered by Medicare Parts A and B and this Plan is secondary to Medicare, this Plan pays as secondary to Medicare, with the Medicare negotiated allowable fee taking precedence. If a service is not covered under Medicare but is covered under this Plan, this Plan will pay as Primary with the Plan's allowable fee for the service taking precedence.

(a) When the Retiree or the Retiree's covered Spouse or Domestic Partner is enrolled in Medicare Part B: This Plan will always be secondary to Medicare Part B. If eligible Retirees or their covered Spouses or Domestic Partners are not enrolled in Part B, this Plan will estimate Medicare's Part B benefit, assuming Part B pays 80% of the eligible expenses. This Plan will only consider the remaining 20% of Medicare Part B expenses.

(b) When the Participant Enters into a Medicare Private Contract: A Medicare Participant is entitled to enter into a Medicare private contract with certain health care practitioners under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that health care practitioner. If a Medicare Participant enters into such a contract this Plan will not pay any benefits for any health care services and/or supplies the Medicare Participant receives pursuant to it.

(d) **Coordination with Other Government Programs**.

(1) Medicaid. If a Participant is covered by both this Plan and Medicaid, this Plan pays first, and Medicaid pays second.

(2) Tricare. If a Participant or their covered Dependent is covered by this Plan and Tricare (the program that provides health care services to active or retired armed services personnel and their eligible Dependents), this Plan pays first, and Tricare pays second. For an Employee called to active duty for more than 30 days, Tricare is primary, and this Plan is secondary.

(3) Veterans Affairs Facility Services. If a Participant receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of a military service-related illness or injury, benefits are not payable by the Plan. If a covered individual receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any other condition that is not a military service-related illness or injury, benefits are payable by the Plan at the in-network benefit level at the usual and customary charge, only to the extent those services are medically necessary and are not excluded by the Plan.

(4) Worker's Compensation. This Plan does not provide benefits if the expenses are covered by workers' compensation or occupational disease law. If a Participant contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they

are covered under a Workers' Compensation or occupational disease law. However, before such payment will be made, a Participant must execute a Subrogation and reimbursement agreement (described in the Third-Party Liability Section 4.5) that is acceptable to the Plan Administrator or its designee.

4.5 Third Party Liability

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 manner in which 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). Any and all payments made by the Plan for which it claims a right of subrogation are referred to as Subrogated Payments.

The other person or entity who may be responsible, liable, or contractually obligated for the payment of damages or claims may be an individual, a corporation or other business entity, an insurance company (including the Participant's own insurance company), or a public or private entity. By way of example only, and without limitation, automobile accident injuries or personal injuries on another's property (i.e. a slip and fall) are examples of cases frequently subject to Subrogation.

Subrogation includes situations where the Injury is or may be covered by another insurance policy, including but not limited to the Participant's own first-party automobile insurance, any third-party automobile liability insurance, any applicable no-fault insurance or medical payments coverage, and premises medical payments coverage (including homeowner's insurance), irrespective of fault, negligence, or wrongdoing.

The Subrogation provision provides the Plan with a right of recovery for certain payments made by the Plan, irrespective of fault, negligence, or 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. "Injury" means any harm or damage sustained to the person of a Participant resulting in some form of medical treatment.

(a) **Subrogation.** By accepting coverage under the Plan, the Participant automatically assigns to the Plan or its Board any and all rights the Participant may have to recover damages or payments from any other person or entity arising from or relating in any way to the Injury, with regard to any and all tort, contractual or other liability or obligation on the part of a person or entity other than the Participant. This includes payments made, or to be made, to or for the Participant from another insurance company, including the Participant's own insurance policy (a "first-party" insurance policy). The Board may, but is not required to, act as the substitute for the Participant in the event any payment made by the Plan for health care or other benefits, including any payment for a known or discovered pre-existing condition, may be the responsibility or contractual liability of another person or entity. This express assignment allows the Plan or its Board to directly pursue any claim that the Participant may have, whether or not the Participant chooses to pursue that claim. The Plan or its Board may pursue any such claims on behalf of the Participant and/or in the Participant's own name, as if the Participant were pursuing the claim on his/her own behalf. This includes the right to sue the other person or entity in order to recover any and all payments made by the Plan relating in any way to the Injury. This also includes the right to pursue and/or make a claim against an insurance policy, on behalf of the Participant and/or in the Participant's own name.

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.

(a) **Right of Reimbursement and Recovery.** By accepting coverage under the Plan, the Participant agrees that if he/she or someone else receives a recovery of any kind in the form or a judgment, verdict, settlement, payment, or other compensation, irrespective of fault, wrongdoing, or negligence, and irrespective of how the recovery is classified, the Plan or its Board has the unequivocal right to recover its Subrogated Payments from the Participant and/or from any other person or entity, including but not limited to the Participant's estate, survivors, or family members. This also includes, but is not limited to, the right of recovery from the following:

(1) Tortfeasor.
(2) Tortfeasor's insurance company; and/or
(3) Any other source, including but not limited to any form of first-party insurance coverage carried by, or insuring, the Participant; uninsured or underinsured motorist coverage; any medical payments coverage; no-fault coverage; school insurance coverage; sports insurance coverage; workers' compensation coverage; premises liability coverage, including homeowner's and boating coverage; any medical malpractice recovery; or any other form of insurance coverage, of whatever kind.

The Plan and its Board have an equitable lien against the recovery rights of the Participant. The Plan and its Board have the legal right to be paid from any such recovery, or potential recovery, an amount not to exceed the total amount of benefits paid or to be paid by the Plan, irrespective of whether or not the Participant has been "made whole" for the injuries received.

The Plan's right to Subrogation applies on a first-dollar basis, and has priority over all other rights or claims, including the Participant's attorney fees. The Plan's right of Subrogation applies irrespective of whether the funds paid to (or for the benefit of) the Participant constitute a full or partial recovery and applies to recovered funds paid for non-health care charges or attorney fees, or other costs and expenses, including lost wages. The Plan's first priority right of Subrogation in contravention of the "make whole" doctrine shall not be affected or limited in any way by the manner in which the Participant or any other person or entity attempts to designate or characterize the Recovery, including but not limited to claims for loss of consortium or wrongful death, and irrespective of whether the Recovery itemizes or identifies an amount recovered, adjudicated, or characterized specifically as medical expenses, or is specifically linked to certain kinds of damages or payments.

The Plan's first priority right of Subrogation extends to any and all recoveries arising from or related in any way to the Injury, including but not limited to any recovery obtained by the Participant's estate, or obtained by the Participant's heirs, survivors, successors, assigns, dependents, and/or the like, and/or irrespective of

whether the claim is characterized as a wrongful death claim or a survivorship claim.

The Plan's first priority right of Subrogation extends to the Participant's attorney and/or to other agents, successors, and assigns of the Participant.

Payment of Subrogated Payments shall be made without reduction, set-off, or abatement for attorney fees or costs incurred by the Participant in the collection of a Recovery.

The Plan or its Board shall be entitled to seek any equitable or legal remedy to recover money damages or claims against any person or entity possessing or controlling such monies or properties, including but not limited to the Participant and/or his/her attorney. At the sole discretion of the Plan and/or its Board, the Plan may reduce any and all eligible medical expenses, or deny any and all claims, otherwise available to the Participant under the Plan by an amount up to the total Subrogated Payments which are subject to the Plan's right of Subrogation. The Plan's right to reduce eligible medical expenses and to deny claims applies to all eligible medical expenses and claims, irrespective of whether such eligible medical expenses and claims bear any relation to the Injury. All rights of the Plan's recovery will be limited to the amount of payments made under this Plan, plus the Plan's reasonable attorney fees and costs incurred to enforce the terms and conditions of the Plan.

The Plan or its Board shall be entitled to payment of reasonable attorney fees and costs incurred to enforce the terms and conditions of the Plan. This may include, but is not limited to, situations in which: (i) the Plan or its Board commence litigation; (ii) the Plan or its Board intervene in existing litigation; (iii) the Participant or his/her attorney has not paid the Plan the full amount of Subrogated Payments within fifteen (15) days of recovery, as required by NRS 287.0465(3); and/or (iv) the Participant or his/her attorney is not fully cooperative with respect to the Plan's right of Subrogation.

The Plan's equitable lien shall also attach to any money or property that is obtained, held, or to be paid by any person or entity, including but not limited to the Participant, the Participant's attorney, an insurance company, and/or a trust for the direct or indirect benefit of the Participant or for his/her "special needs," as a result of an exercise of the Participant's rights of recovery.

If the Participant attempts to assert that certain Subrogated Payments are not causally related to the Injury, it shall be the Participant's burden to prove the relatedness of the Subrogated Payments in question. If the Subrogated Payments in question are referred to, referenced, or included in any way by the Participant in any settlement negotiations or in any demand package tendered by the Participant to the person or entity from which a recovery is sought, it shall be deemed conclusive evidence that said Subrogated Payments are causally related to the Injury. At its sole discretion, the Plan or its Board may consider additional evidence concerning the causal relation of Subrogated Payments to the Injury.

The Plan or its Board may require the Participant or the Participant's attorney or substitute, as a pre-condition to receiving benefit payments, to sign a Subrogation agreement or acknowledgment and to agree in writing to assist the Plan and to protect the Plan's right to payment of the Subrogated Amount from any person or entity including the Participant.

In addition to all Subrogation rights afforded to the Plan herein and by Nevada law, the following provisions also apply to the Plan's right of Subrogation, reimbursement, and/or creation of an equitable lien:

(i) "**Pay and Pursue.**" The Plan, in its sole discretion, may elect to process claims under the "pay and pursue" option. If the Plan elects to "pay and pursue," benefit payments will be made prior to, or concurrently with, necessarily applying the Subrogation, reimbursement, and lien rights under the Plan. This is at the sole discretion of the Plan or its Board and remains subject to the Participant's required cooperation with and protection of the Plan's right of Subrogation.

(ii) **Scope of Subrogation, Reimbursement and Lien Rights.** The Subrogation, reimbursement, and lien rights apply to any and all benefits paid by the Plan for or on behalf of the Participant arising from or related in any way to the Injury, and apply to all the following, enumerated without limitation:

(a) Any no-fault insurance.
(b) Medical benefits/payments coverage under any automobile insurance coverage. This includes any first-party insurance plan under which the Participant is covered or an insured, or any third person's insurance policy under which the Participant may be entitled to benefits.
(c) Underinsured and uninsured motorist coverage, and any other first-party insurance coverage.
(d) Any automobile medical payments and personal injury protection ("PIP'') benefits.
(e) Any third person's liability insurance, whether automobile coverage or other.
(f) Any premises/guest medical payments coverage, including homeowner's insurance.
(g) Any medical malpractice recovery or insurance policies covering medical malpractice.
(h) Any professional negligence or attorney malpractice recovery or insurance policies covering professional negligence.
(i) Workers' compensation benefits or claims.
(j) Any other governmental agency reimbursement (i.e., state medical malpractice compensation funds), to the extent permitted by law.
(k) Restitution in a criminal matter.

(iii) **Subrogated Payments.** The term "Subrogated Payments" refers to any benefit payments made by the Plan that are eligible for recovery from any other person as described hereinabove and/or any benefits payments for which the Plan asserts a right of Subrogation.

(iv) "**Make Whole**" **and** "**Common Fund**" **Rules Do Not Apply.** The Plan's right of Subrogation, reimbursement, equitable liens, and other legal and equitable remedies are specifically intended to supersede the applicability of any and all common law doctrines and/or any and all local, state, and federal laws, including but not limited to the "make whole" rule and the "common fund" rule, to the extent permitted by law.

(b) **Role of the Executive Officer.** PEBP has delegated to the Executive Officer its powers and its authority and discretion to enforce its rights under this Section 4.5.

A Subrogation lien of the Executive Officer upon the proceeds of any recovery from an insurer providing first-party coverage to a member must be reduced by the applicable in-network or out-of-network out-of-pocket maximum balance of the member remaining at the time of the incident giving rise to the subrogation lien. If the subrogation lien includes medical claims from medical costs resulting from the incident giving rise to the subrogation lien which occurred over multiple plan years, the out-of-pocket maximum balances

for each plan year must be used for purposes of reducing the subrogation lien amount. Notwithstanding the foregoing, the provisions of this paragraph do not apply to the coordination of benefits for coverage of the cost of medical services which may be provided under:

(a) The plan of self-insurance established by PEBP; and
(b) Any other health insurance coverage.

A decision of the Executive Officer is final and not subject to judicial review.

Applicable Law. The Plan's right of Subrogation under Nevada law is set forth in part at NRS 287.0465. The Plan's Subrogation rights as set forth in this Section 4.5 are established, maintained, operated, and carried out in accordance with Nevada law, including but not limited to NRS 287.0465 and NAC 287.755, and in accordance with the statutory delegation to the Board of the powers and duties to establish and carry out PEBP.

4.6 Dual Coverage Rules

The rules with respect to a Covered Person who is an eligible Dependent and an Eligible Employee under the Plan are set forth in the Master Plan Document for the PEBP Enrollment and Eligibility.

4.7 Payment of Benefits

The Component Benefits shall be paid for by the Plan. The Plan (or the Plan Administrator acting on behalf of the Plan) may contract with an Insurer, or another third party to provide a Component Benefit under the Plan. The liability of the Plan, PEBP, the Plan Administrator, and, if applicable, the Insurer or other third-party provider to provide benefits under a Component Benefit shall be limited by the terms of this Plan instrument and the applicable Incorporated Document(s).

4.8 Payment to Participant/Covered Person

(a) Except as otherwise provided in subsection (b) below, benefit payments under a Component Benefit shall be made to the Participant, the Participant on behalf of the Covered Person or if applicable, the Covered Person in accordance with the terms of this Plan, including the Incorporated Documents.

(b) To the extent permitted under a Component Benefit, payments may be made to a third party to whom a Covered Person has made a valid assignment of his right to receive such payments. In addition, if the Plan Administrator determines that a Covered Person is unable to care for his own affairs, the Plan Administrator may authorize the Plan to make benefit payments to the court-appointed legal guardian of the Covered Person, to an individual who has become the legal guardian of the Covered Person by operation of state law, or to another individual who the Plan Administrator determines to be entitled to receive such payments on behalf of the Covered Person.

(c) If a payment of benefits is made under a Component Benefit to a third party in accordance with subsection (b), above, the Plan, PEBP, the Plan Administrator, and, if applicable, the Insurer or other third party provider shall be relieved, to the fullest extent permitted by law, of any obligation to make a duplicate payment to or on behalf of such Participant and/or Covered Person.

4.9 Tax Withholding

The amount of any benefit paid from the Plan to, or in respect of, a Participant under a Component Benefit shall be reduced by the amount of any income tax or employment tax that is required to be withheld pursuant to any applicable federal, state, or local law, or any applicable foreign law.

4.10 Other Adjustments—Overpayment Provision

If, for any reason, any benefit payable under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Covered Person, the Covered Person shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the Plan Administrator or the applicable Insurer may recover that incorrect payment, whether or not it resulted from the Plan Administrator, an Insurer, or any other third-party provider's own error, from the person to whom it was made or from any other appropriate party.

In the sole discretion of the Plan Administrator, the refund or repayment may be made in one or a combination of the following methods (a) in the form of a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, or (c) any other method as may be permitted in the sole discretion of the Plan Administrator or Insurer and as permitted by law.

With respect to Component Benefits provided through an Insurer, the contract language may contain information regarding the Plan's right to subrogate or seek reimbursement of erroneously paid benefits (including payments exceeding the amount appropriately payable). With respect to self-insured Component Benefit programs, Subrogation or reimbursement rights may be set forth in Section 4.5 of this Plan.

4.11 Unclaimed Benefits

If, within the time period specified by the third party administrator or Insurer of the Component Benefit and communicated to Plan Participants or if not specified and communicated to Plan Participants twelve (12) months, after any amount becomes payable hereunder to a Covered Person and the same shall not have been claimed or any check issued under the Plan remains uncashed, provided reasonable care shall have been exercised in attempting to make such payments, the amount thereof shall be forfeited and shall cease to be a liability of the Plan.

Article 5 Funding and Contributions

5.1 Plan is a Single Plan—Funding

The Plan and all its Component Benefits shall be a single plan.

All costs of the Plan, including Plan benefits, Plan administrative expenses, and the retention of experts and advisors, are paid out of the fund and, in some cases, Insurance Contracts.

Benefits may be provided though one or more Insurance Contracts with insurance carriers or such other funding vehicles established with respect to the Component Benefits. The Plan may maintain reinsurance or stop-loss insurance to protect the Plan in the event claims exceed projections.

Component Benefits under the Plan may be provided on an insured or self-insured basis, or a combination thereof, at the discretion of the Plan Administrator. The Summary of Coverage or Summary of Insurance shall set forth whether a Component Benefit is provided on an insured or self-insured basis.

5.2 Contributions to the Plan

(a) **Employer Contributions**. The Employer shall make such contributions in such amounts and at such times as the Plan Administrator shall direct, in accordance with the funding policy and methods of the Plan.

(b) **Participant Contributions**.

(1) To be eligible to receive benefits under any Component Benefit for which Participant Contributions are required (which may be pre-tax or after-tax, subject to the terms of the Cafeteria Plan and applicable Component Benefit program), each Participant shall make any required contributions in such amounts and at such time as the Plan Administrator shall from time to time direct, as outlined in the Incorporated Documents. Participant Contributions shall be made in accordance with procedures established by the Plan Administrator.

(2) Failure of a Participant to make Participant Contributions with respect to any Component Benefit by the required due date shall be deemed an election by such Participant to cease participation in such Component Benefit as of the date established by the Incorporated Documents or as directed by the Plan Administrator, for which the missed Participant Contribution was due; provided however, that termination of benefits under any Component Benefit shall in all instances be subject to and in accordance with applicable legal requirements, including but not limited to coverage requirements imposed by the FMLA.

(3) If a Participant fails to pay Participant Contributions during a Leave of Absence and the Plan Administrator in its discretion continues coverage under any Component Benefit in effect during such Leave of Absence, any unpaid Participant Contributions during such period will be collected in arrears through payroll deductions through the Cafeteria Plan, or as otherwise directed by the Plan Administrator upon the Participant's return to employment with the Employer or expiration of the Participant's Leave of Absence, as applicable.

Article 6 Insurance

6.1 Insurance Generally

If a Participant elects an insured benefit, any such benefit shall be provided solely and exclusively by the insurer under the applicable insurance contract. A Participant's or Covered Person's right to such benefit shall be limited to the amount payable under such insurance contract and the receipt thereof shall be subject to satisfaction of all of the terms, covenants, conditions, rules, and regulations of the insurer. The Plan Administrator shall have the right from time to time to change the coverage or carrier of any one or more insurance policies.

6.2 Provisions Relating to Insurers

No Insurer shall be required or permitted to issue an insurance policy or contract that is inconsistent with the purposes of this Plan, nor be bound to take any action not in accordance with the terms of any policy or contract in connection with this Plan.

6.3 Conflicting Provisions

If any provision or term of any insurance policy or contract conflicts with or is inconsistent with any provision or term of this Plan, such Plan provision or term shall govern.

Article 7 Claims and Appeals Procedures

7.1 Claims and Appeals Procedures

(a) The claims procedure to be followed by Covered Persons to obtain payment of benefits under this Plan shall be in accordance with the rules and procedures set forth in the applicable Incorporated Documents for the Component Benefits. Benefits that are covered under this Plan shall be paid in accordance with the rules and procedures set forth in the Plan, as applicable, which shall govern the claims and appeals procedures. Notwithstanding the foregoing, unless a Component Benefit's Incorporated Document issued by the third-party administrator or Insurer who administers the Component Benefit specifically provides otherwise, a claim for benefits must be filed within 12 months from the date of service (for example, with respect to a medical claim, the date a medical service is provided and the charge is incurred).

(b) The claims procedure to be followed by Employees for eligibility under this Plan shall be in accordance with the rules and procedures set forth in the Master Plan Document for the PEBP Enrollment and Eligibility and in the Incorporated Documents for the Component Benefits. The Executive Officer or his designee makes all final determinations concerning eligibility (NAC 287.313).

(c) The Plan Administrator has the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to eligibility for the Plan and entitlement to Plan Benefits. Any interpretation or determination made under that discretionary authority would be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious. Services that are covered, as well as specific Plan exclusions are described in the Incorporated Documents. The claims procedures applicable to claims made for benefits under this Plan do not apply to casual or general inquiries regarding eligibility for Component Benefits that may be provided under the Plan. For an inquiry to constitute a claim for benefits or an appeal of a denial of a claim for benefits, a Plan Participant must follow the claim procedures under the applicable Component Benefit as set forth in the Incorporated Documents.

(d) For purposes of the determination of the amount of, and entitlement to, benefits under the Component Benefits provided under Insurance Contracts, the Insurer is the named fiduciary under the Component Benefit, with the full power to interpret and apply the terms of the Component Benefit as they relate to the benefits provided under the applicable Insurance Contract.

To obtain benefits from the Insurer of a Component Benefit, a claimant must follow the claims procedures under the applicable Insurance Contract, which may require a claimant to complete, sign and submit a written claim on the Insurer's form.

The Insurer will decide a claim in accordance with its reasonable claim's procedures, applicable state insurance law or other applicable law as required. The Insurer has the right to secure independent medical advice and to require such other evidence, as it deems necessary, in order to decide a claim. If the Insurer denies a claim, in whole or in part, a claimant will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, a claimant may appeal to the Insurer for a review of the denied claim. The Insurer will decide the appeal in accordance with its reasonable claim's procedures.

Upon a final decision to deny a claim for benefits under a Component Benefit that is a non-grandfathered group health plan, the claimant may request an external review that follows the state external review process applicable to and binding on, that Component Benefit, per Section 2719 of the PHSA. To the extent that a Component Benefit is not required to comply with a state external review process under Section 2719 of the PHSA, it must comply with the federal external review process as set forth in Section 2719 of the PHSA. External review is not available for a denial, reduction, termination, or failure to provide payment for a benefit based on a determination that an Employee, Retiree or Dependent fails to meet the requirements for eligibility under the terms of the Component Benefit.

(e) For purposes of determining the amount of or the entitlement to benefits under a Component Benefit provided through a self-funded arrangement, the applicable designated claims fiduciary (as provided in the applicable Incorporated Document) is the named fiduciary under the Component Benefit, with the full power to interpret and apply the terms of the Component Benefit as they relate to the benefits provided under the applicable self-funded arrangement. In addition, such procedures shall be described in the applicable Incorporated Documents in accordance with Section 2719 of the PHSA (applicable to non-grandfathered plans only); NAC 287.610-287.695; NAC 287.750; NRS 287.043; NRS 287.04335; NRS 689B.255; NRS 695G.200; NRS 695G.210; NRS 695G.220; NRS 695G.230; NRS 695G.241-695G.300; and NRS 695G.310.

(f) The Incorporated Documents shall specify the claims fiduciary for each Component Benefit.

Upon a final decision to deny a claim for benefits under a self-funded Component Benefit that is a non-grandfathered group health plan, the claimant may request an external review that follows the federal external review requirements set forth in Section 2719(b) of the PHSA, the terms of which are described in the applicable Incorporated Document. External review is not available for a denial, reduction, termination, or failure to provide payment for a benefit based on a determination that an Employee, Retiree or Dependent fails to meet the requirements for eligibility under the terms of the Component Benefit.

(g) Unless otherwise specified in a Component Benefit or prohibited by federal law, any claimant seeking benefits under a Component Benefit must initiate legal action against the Plan no later than 1 (one) year from the deadline for filing a claim unless a different time frame is set forth in the applicable Incorporated Document.

7.2 Prohibition Against Rescission

Under Section 2712 of the PHSA, 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 PHSA, unless 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; (ii) the Plan erroneously covers an ex-spouse of a Participant because the Participant failed to timely report a divorce to the Plan Administrator; (iii) the Plan erroneously covers a Participant due to a reasonable administrative delay in terminating coverage; or (iv) any other circumstance under which retroactive termination would not violate the PPACA.

The Plan Administrator shall provide a Covered Person with thirty (30) days' prior written notice of intent to rescind coverage. The Covered Person may appeal the rescission of coverage as a denial of a post-service claim under this Article 7. 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.

Article 8 Administration of Plan

8.1 Plan Administrator

The Plan Administrator shall have the discretionary authority to interpret the Plan, including each Component Benefit, and to decide any and all matters arising hereunder. The Plan Administrator's discretionary authority shall include, but shall not be limited to, the following authority:

(a) To make and enforce such rules and regulations as the Plan Administrator deems necessary or proper for the efficient administration of the Plan;

(b) To construe and interpret the Plan, to decide all questions concerning the Plan, including without limitation the discretionary authority to resolve questions of fact and to remedy possible ambiguities, inconsistencies, and/or omissions, in the Plan and related documents by general rule or particular decision, and to determine the eligibility of any person to participate in the Plan and the entitlement of any person to any benefits thereunder;

(c) To establish and maintain the Component Benefits and to maintain records of pre-tax Salary Reduction Contributions;

(d) To prescribe procedures to be followed and the format to be used by Eligible Employees and Participants to make elections pursuant to this Plan, including any Component Benefit;

(e) To prepare and distribute information explaining this Plan and the benefits under this Plan or any Component Benefit in such manner as the Plan Administrator determines to be appropriate;

(f) To make available to each Participant or Covered Person his or her records and related Plan Materials as may be required by applicable law;

(g) To request and receive from all Employees and Covered Persons such information as the Plan Administrator shall from time to time to determine to be necessary for the proper administration of the Plan;

(h) To appoint, remove, or substitute agents, counsel, accountants, consultants, actuaries, or other persons to assist in administering the Plan or any Component Benefit;

(i) To designate specified other persons to carry out any of its responsibilities under the Plan or any Component Benefit to the extent necessary;

(j) To sign documents for purposes of administering the Plan, or to designate an individual or individuals to sign documents for purposes of administering this Plan;

(k) To secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(l) To prepare, file, and disseminate all reports and disclosures required by applicable law.

The Plan Administrator's determination on any and all questions arising out of the interpretation or administration of the Plan shall be final, conclusive, and binding on all parties.

8.2 Records and Reports of the Plan Administrator

The Plan Administrator shall keep such written records as it shall deem necessary or proper, which records shall be open to inspection by the Employer.

8.3 Reliance on Participants and Tables

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. In administering the Plan, the Plan Administrator shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports which are furnished by, or in accordance with the instructions of, accountants, counsel or other experts employed or engaged by the Plan Administrator. All actions taken in a good faith reliance on advice from such advisors are conclusive and binding upon all persons.

8.4 Delegations of Authority by the Plan Administrator

The Plan Administrator may, in its discretion, delegate to any other person or persons the authority to act on behalf of the Plan Administrator, including but not limited to the authority to make any determination or to sign checks, warrants, or other instruments incidental to the operation of the Plan or any Component Benefit (or portion thereof) that the Plan Administrator administers, or to the making of any payment specified therein.

8.5 Employment of Assistants

The Plan Administrator is authorized to employ counsel and to employ persons to provide such actuarial, clerical, or other services as they may require in carrying out their duties under the Plan or any Component Benefit.

8.6 Availability of Documents

A copy of the Plan and any and all future amendments and such records and data as may be required under applicable law shall be available to any Covered Person, Employee, Retiree or an Employee organization that represents Employees of the Employer at reasonable times during normal business hours at the business office of the Plan Administrator or by contacting the Plan Administrator.

8.7 Legal Process

The Plan Administrator shall be the agent for service of legal process unless it designates another person to be such agent. See Section 10.2 for such designation.

8.8 Administrative Expenses

All expenses incurred prior to termination of the Plan that shall arise in connection with the administration of the Plan, including but not limited to administrative expenses, and compensation and other expenses and charges of any actuary, accountant, counsel, specialist, or other person who shall be employed by the Plan Administrator in connection with the administration, shall be paid by Employees, Retirees, and the fund.

8.9 Several Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act, except for its own willful misconduct or willful breach of this Plan.

8.10 Nondiscrimination

The Plan Administrator shall not operate the Plan in a manner that causes discrimination in favor of those Participants or Employees who are (or were) officers or highly compensated Employees or key Employees of the Employer. In addition, whenever in the administration of the Plan any discretionary action by the Plan Administrator is required, the Plan Administrator shall exercise its authority in a nondiscriminatory manner so that all persons similarly situated shall receive substantially the same treatment.

8.11 Electronic Administration

The Plan Administrator may distribute and collect information or conduct transactions by means of electronic media, including, but not limited to, electronic mail systems, Internet, or voice response system, except when a specific provision of the Code, or other guidance of general applicability sets forth rules or standards regarding the media through which such dissemination of information or transaction may be conducted.

8.12 Coordination with Component Benefits

Article 8 of this Plan applies with respect to each Component Benefit which appears in Schedule 1, unless the Component Benefit specifically addresses these issues in a manner that is consistent with applicable state and federal law. However, any references to the Plan Administrator shall be construed in accordance with the definition and description of duties contained in this Article 8.

8.13 Indemnification

A participating Employer shall only be liable for indemnification of the Board and its employees against liability relating to the administration of the Plan to the extent set forth in this section 8.13 and to the extent consistent with, and subject to the limitations specified in, NRS 41.0349 and any other provision of applicable state law.

A participating Employer shall indemnify and hold harmless the Plan Administrator or its designee who act as Plan fiduciary(ies) or act in an administrative capacity relating to the Plan and the Board and its employees relating to the administration of the PEBP from and against any and all liabilities, demands, claims, suits, proceedings, actions or causes of action, losses, approved settlements, penalties, costs, damages, and expenses (including reasonable attorneys' fees) (together, the "liabilities") sustained or incurred by act or omission of said Plan Administrator or its designee(s), or of the Board; provided, however, that this indemnification shall not apply to the extent such liabilities arise from such Plan Administrator's (or its designee's) or such Board's (or its employees') willful negligence, gross negligence, willful misconduct or criminal action.

Notwithstanding the foregoing, the provisions of this section 8.13 shall not apply to any person or entity seeking indemnification if:

(1) The person or entity failed to submit a timely request for defense;
(2) The person or entity failed to cooperate in good faith in the defense of the action;
(3) The act or omission of the person or entity was not within the scope of the person's or entity's public duty or employment; or
(4) The act or omission of the person or entity was wanton or malicious.

Article 9 Plan Adoption, Amendment, and Termination

9.1 Amendment and Termination

The Plan was established with the bona fide intention and expectation that it will be continued indefinitely. However, PEBP reserves the right to amend or terminate the Plan or any Component Benefit at any time and from time to time. Amendments may occur on the approval of the PEBP Board, or on such other date as may be specified in the document amending the Plan. The Plan or any coverage under it may be terminated by the PEBP Board, and new coverages may be added by the PEBP Board.

Such amendments or modifications may be made retroactively where necessary, including, for example, to ensure compliance with the Code's nondiscrimination rules.

The termination of a Component Benefit (including terminating an Insurance Contract through which such benefits are provided) is not a termination of the Plan; rather, it is an amendment to the Plan.

9.2 Termination of Insurance Contract

In the case of any Component Benefit paid by an Insurer pursuant to an Insurance Contract, the Plan Administrator may terminate such contract at any time by providing the Insurer with such notice as may be required under the terms of such contract. The Plan Administrator may enter into contracts with other Insurers or through other funding arrangements as the Plan Administrator may establish for the purpose of providing the Component Benefit.

9.3 Amendment of Schedule 1

The Plan Administrator may amend Schedule 1 to add or remove a Component Benefit. Such change will be subject to the laws of the State of Nevada, to the extent required. Any such modification shall not necessitate a formal amendment to this Plan document.

9.4 Effect of Amendment or Termination

(a) No amendment to or termination of the Plan or any Component Benefit shall cause or permit the assets of the Plan to be used for any purpose other than to defray administrative expenses with respect to Component Benefits and to pay benefits provided for under such Component Benefit.

(b) All changes to this Plan shall become effective as of a date established by the Plan Administrator, as appropriate, except that no increase or reduction in benefits shall be effective with respect to covered expenses incurred prior to the date a change was adopted by such person(s), regardless of the effective date of the change. Upon termination or discontinuance, contributions, and benefits (including benefit elections) relating to the Plan shall terminate.

(c) Upon termination of any Component Benefit, any assets of the Plan funding such Component Benefit shall be used to pay benefits that Participants have become entitled to receive under the terms of such Component Benefit (or, if applicable, to pay premiums due to an Insurer with respect to such Component Benefit) as of the date of termination, and to pay the administrative expenses incurred by the Plan before, and in connection with, the termination, all in accordance with the written direction of the Plan Administrator. The remaining assets shall be used to pay benefits that Participants have become entitled to receive under other Component Benefits (or, if applicable, to pay premiums due to an Insurer with respect to such other Component Benefits) and to pay the related administrative expenses of such other

Component Benefits in accordance with the written direction of the Plan Administrator. In no event shall the assets of the Plan inure to the benefit of the Employer.

(d) Upon termination of the Plan, the assets of the Plan shall be used to pay benefits that Participants have become entitled to receive under the terms of a Component Benefit, and to pay the administrative expenses incurred by the Plan relating to such Component Benefit before and in connection with the termination, both in accordance with the written direction of the Plan Administrator. The Plan's remaining assets shall be disposed of in accordance with the written direction of the Plan Administrator. In no event shall the assets of the Plan inure to the benefit of the Employer.

Article 10 Miscellaneous

10.1 Governing Law

(a) This Plan and Component Benefits shall be construed, administered, and enforced according to laws of the State of Nevada and federal law, including the PHSA, governing employee benefit plans. Any provision of this Plan in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

(b) In the case of Component Benefits provided by an Insurer under an Insurance Contract, the Insurance Contract shall be governed by the Code and applicable Nevada state law, as applicable to such Insurance Contract.

(c) Such federal laws to the extent applicable to a Component Benefit, in addition to the requirements in Section 4.2 of this Plan, shall include but shall not be limited to:

(1) **Continuation of Coverage under COBRA**. For each benefit made available under this Plan that is considered to be a "group health plan" under Section 2208(1) of the PHSA due to Employees and their spouses and Dependents being provided with health care benefits within the meaning of Section 213(d)(1) of the Code, the Plan shall provide health care continuation coverage to qualified beneficiaries in the manner and to the extent required by Sections 2201 – 2208 of the PHSA and related regulations, including applicable amendments to such Sections.

(2) **USERRA**. For each Component Benefit that is subject to continuation coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994, the Plan shall comply.

(3) **HIPAA**. The Plan shall administer the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") dealing with special enrollment rights in the manner and to the extent required by the applicable requirements of Section 9801 et seq. of the Code, as well as the provisions of the HIPAA Privacy Rule and the HIPAA Security Rule.

(4) **GINA**. The Plan shall comply with the provisions of GINA and accordingly, shall not, unless expressly permitted by GINA or corresponding regulations, restrict enrollment, or adjust premiums based on genetic information, or require or request genetic information or genetic testing, prior to, or in connection with, enrollment.

(5) **PPACA**. The Plan shall comply with the relevant provisions of the PPACA.

(d) **NAC and NRS Regarding the PEBP Plan.** The information provided below is a summary of the applicable NRS and NAC. For detailed information, refer to the Nevada Legislature website at https://www.leg.state.nv.us/law1.cfm.

NAC 287.005 to 287.160 – General Provisions

NAC 287.170 to 287.196 – Board of the Public Employees' Benefits Program

NAC 287.310 to 287.320 - Participation in the Public Employees' Benefits Program

NAC 287.355 to 287.389 - Option of Group to Leave Public Employees' Benefits Program

NAC 287.400 - Option of Group to Renter the Public Employees' Benefits Program

NAC 287.420 to 287.548 - Payment of Premiums and Contributions; Coverage

NAC 287.600 to 287.695 - Claims

NAC 287.095 - Participant defined.

NAC 287.135 - Retired officer or employee defined.

NAC 287.317 - Participating public agency to notify the Program of appointment of persons eligible to participate in the Program or of termination of appointment, enrollment.

NAC 287.3105 – Persons eligible to participate in Program.

NAC 287.320 - Withdrawal from Program: Procedure; termination of coverage; limitation on reentry; eligibility of certain officers and employees after exclusion of group; liability of Program.

NAC 287.357 - Application to leave Program.

NAC 287.440 - Payment of premiums or contributions by retired officers and employees.

NAC 287.450 - Employees on leave without pay: Payment of premiums or contributions; eligibility for coverage as a dependent of a Participant; coverage upon return to work.

NAC 287.460 Officers and employees on leave because of injuries in course of employment; Payment of premiums or contributions; reports of change in status; coverage of dependents upon return to work.

NAC 287.470 - Overpayment or underpayment of premiums or contributions.

NAC 287.485 - Subsidy for retired officer or employee: Report required to obtain subsidy; audit of service credit required; billing; commencement of payment; adjustment of amount of subsidy; assumption of liability for service credit earned.

NAC 287.530 - Coverage of retired person, spouse, domestic partner or surviving dependent.

NAC 287.540 - Coverage of participating employee of State who reenrolls upon retirement or total disability; coverage of nonparticipating employee of State.

NAC 287.542 - Coverage of participating employee of local governmental agency who retires on or before September 1, 2008 and reenrolls upon retirement or total disability.

NAC 287.546 - Coverage of participating employee of local governmental agency who retires after September 1, 2008 and reenrolls upon retirement or total disability.

NAC 287.548 - Coverage of nonparticipating employee of local governmental agency who retires after September 1, 2008.

NAC 286.610 - Period for submission (NRS 287.043) A claim made to the Program must be submitted to the Claims Administrator of the Program not later than 1 year after the date on which the expense reported in the claim is incurred. A claim submitted after that time will not be paid.

NAC 287.620 - Assumption regarding availability of benefits under Medicare; coordination under Medicare.

NAC 287.660 – Notification of adverse determination; grounds for appeal (NRS 287.043).

NAC 287.670 - Appeal of adverse determination: Requirements; duties of Appeals Manager (NRS 287.043).

NAC 287.680 - Appeal of decision of Appeals Manager: Requirements; duties of Executive Officer or designee (NRS 287.043).

NAC 287.690 – Request for external review (NRS 287.043).

NAC 287.695 – Request for expedited review by Claims Administrator (NRS 287.043).

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Senate Bill No. 380 [NRS 439B amendment] Revises the information that is reported under the program for tracking and reporting of information concerning the pricing of prescription drugs.

Assembly Bill No. 48 [NRS 287.0475 amendment] Authorizing certain retired public officers and employees of nonparticipating local governmental agencies to reinstate insurance under PEBP. (Effective July 1, 2021.)

Assembly Bill No. 178 [NRS 287.04335 amendment] Act requiring an insurer to take certain actions relating to the acquisition of prescription drugs for an insured who resides in an area for which a declared disaster or state of emergency is in effect; authorizing a pharmacist to dispense a prescription drug to a patient who resides in such an area in an amount greater than is authorized by the prescribing practitioner under certain conditions. (Effective July 1, 2021.)

Assembly Bill 181 [NRS 287.04335 amendment] An insurer or other organization providing health coverage pursuant to Chapter 689A, 689B, 689C, 695A, 695B, 695C, 695F or **695G** of NRS, shall adhere to applicable provisions of the Paul Wellstone Act of 2008, Public Law 110-343, Division C, Title V, Subtitle B. and any federal regulations issues pursuant thereto. On or before July 1 of each year, the Commissioner shall prescribe and provide to each insurer or other organization providing health coverage subject to the provisions of subsection 1 a data request that solicits information necessary to evaluate the compliance of an insurer or other organization with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, without limitation, the comparative analyses specified in 42 U.S.C. § 300gg-26(a)(8). (Sections 1 to 10.5, inclusive become effective upon passage for the purpose of adopting any regulations and performing any preparatory administrative tasks to carry out the provisions of this act; and on January 1, 2022, for all other purposes.)

Assembly Bill No. 48 [NRS 287.0475 amendment] An Act relating to public employees; authorizing certain retired public officers and employees of nonparticipating local governmental agencies to reinstate insurance under the Public Employees' Benefits Program; and providing other matters properly relating thereto. (Effective July 1, 2021.)

Assembly Bill No. 250 [NRS 287.04335 amendment] An insurer that issues a Medicare supplemental policy shall offer to a person currently insured under any such policy an annual open enrollment period commencing with the first day of the birthday month of the person and remaining open for at least 60 days thereafter, during which the person may purchase any Medicare supplemental policy made available by the insurer in this state that includes the same or lesser benefits. Innovative benefits, as described in 42 U.S.C. § 1395ss(p)(4)(B), must be considered when determining whether a Medicare supplemental policy includes the same benefits as or lesser benefits than another such policy. (Effective January 1, 2022.)

Assembly Bill No. 436 [NRS 287.04335 amendment] An act relating to health care; prohibiting an insurer from entering into a contract with a provider of vision care that contains certain provisions; requiring an insurer to provide certain information to a provider of vision care before entering into a contract to include the provider in the network of the insurer; prescribing certain requirements concerning the advertising and marketing of vision coverage; authorizing the imposition of an administrative penalty; and providing other matters properly relating thereto. (Effective March 22, 2021.)

Senate Bill No. 40 [NRS 287.0438 amendment] An act relating to health care; authorizing the Patient Protection Commission to request certain reports from a state or local governmental entity; requiring DHHS to establish an all-payer claims database containing information relating to health insurance claims for benefits provided in this State under certain circumstances. (Effective January 1, 2022.)

Senate Bill No. 190 [NRS 287.04335 amendment] An act relating to contraceptives; requiring the State Board of Pharmacy to establish a protocol under which a pharmacist may dispense self-administered hormonal contraceptives to any patient; requiring the State Plan for Medicaid and certain health insurance plans to provide certain benefits relating to self-administered hormonal contraceptives. (Effective January 1, 2022.)

Senate Bill No. 251 [NRS 287.04335 amendment] An act relating to health care; requiring certain providers of health care to screen women for harmful BRCA gene mutations and provide referrals for genetic counseling and testing under certain circumstances; requiring notice concerning genetic counselling and testing to be provided with the results of a mammogram; authorizing certain education relating to genetic counseling and testing; requiring certain policies of health insurance to include coverage for screening, genetic counseling and testing for harmful BRCA gene mutations for certain women. (Effective January 1, 2022.)

Senate Bill No. 269 [NRS 287.04335 amendment] Imposing requirements governing the recovery of overpayments under a plan that provides dental coverage; prohibiting a dental insurer or the administrator of a plan that provides dental coverage from denying a claim for which prior authorization has been granted except in certain circumstances. (Effective July 1, 2021.)

Senate Bill No. 289 [NRS 287.04335 amendment] Requires certain insurers to allow a person who has been diagnosed with state 3 or 4 cancer and is covered by the insurer to apply for an exemption from required step therapy for certain drugs; requiring such insurers to grant such an exemption in certain circumstances; making appropriations. (Effective January 1, 2022.)

Senate Bill No. 305 [NRS 287.04335 amendment] Prohibits certain providers of medical or related services from taking certain actions relating to organ transplants solely on the basis of a person's

disability; limiting the extent to which such a provider is authorized to consider a person's disability when making recommendations or decisions concerning an organ transplant; authorizing a person aggrieved by the failure of such a provider to comply with certain requirements to institute a civil action for injunctive or other appropriate relief; prohibiting an insurer from taking certain actions related to organ transplant because the insured is a person with a disability. (Effective October 1, 2021.)

Senate Bill No. 325 [NRS 287.04335 amendment] Requires the State Board of Pharmacy to prescribe a protocol authorizing a pharmacist to prescribe, dispense and administer drugs to prevent the acquisition of human immunodeficiency virus and perform certain laboratory tests; requiring certain health plans to include coverage for such drugs and testing. (Effective October 1, 2021.)

Senate Bill No. 380 [NRS 287.043 amendment] An act relating to prescription drugs; revising the information that is reported under the program for tracking and reporting of information concerning the pricing of prescription drugs; requiring wholesalers to make a report; requiring certain reporting entities to affirm the accuracy of the information in the reports; revising requirements concerning the report of the DHHS on the pricing of prescription drugs; revising the authorized uses of certain administrative penalties; excluding certain information from protection as a trade secret. (Effective October 1, 2021.)

Senate Bill No. 451 [NRS 287.044 amendment] Establishing for the 2021-2023 biennium the subsidies to be paid to the Public Employees' Benefits program for insurance for certain active and retired participants. (Effective July 1, 2021.)

Senate Bill No. 420 [NRS 287.04335 amendment] Establishment of a public health benefit plan; revising requirements related to health insurance coverage for enteral formulas.

NRS 287.007 - Inapplicability of chapter regarding matters within scope of collective bargaining agreements.

NRS 287.023 - Option of retired officer or employee or dependent to cancel or continue group insurance, plan of benefits, medical and hospital service, or coverage under Public Employees' Benefits Program; notice of selection of option; payment of costs for coverage.

NRS 287.0402 to 287.04064 – General provisions; Group insurance for state officers and employees

NRS 287.041 - 287.04345 - Board of the Public Employees' Benefits Program

NRS 287.0435 – Fund for the Public Employees' Benefits Program

NRS 287.0436 to 287.04364– State Retiree' Health and Welfare Benefits Fund

NRS 287.0438 – 287.049 – Administration of the Program

NRS 287.050 – 287.240 – Participation of Employees of State and its Political Subdivisions in Federal Old-Age and Survivors' Insurance

NRS 287.245 – Programs for Reduction of Taxable Income for Public Employees

NRS 287.0406 - Program is defined as the Public Employees' Benefits Program established pursuant to subsection 1 of NRS 287.043.

NRS 287.043 - Defines the PEBP Board's powers and duties related to the benefit structure, rate setting and administration of certain parts of the Public Employees' Benefits Program.

NRS 287.0433 – Power to establish plan of life, accident, or health insurance; reinsurance; power to use list of preferred prescription drugs developed by Department of Health and Human Services and obtain prescription drugs through certain purchasing agreements [effective January 1, 2020].

NRS 287.04335 – Compliance with certain provisions required to provide health insurance through plan of self-insurance. NRS 687B.409, 689B.0353, 689B.255, 695C.1723, 695G.150, 695G.155, 695G.160, 695G.162, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.170 to 695G.174, inclusive, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

NRS 287.0435 - Creation; investment; disbursements; administration by State Treasurer; checking account for payment of claims.

NRS 287.0436 - Creation and purpose of the State Retirees' Health and Welfare Benefits Fund.

NRS 287.046 - Department of Administration to establish assessment to pay portion of premiums or contributions for participating retirees with state service; amounts assessed to be deposited in Retirees' Fund; adjustments to portion paid to Program by Retirees' Fund.

NRS 287.047 - Retention by certain retired State officers and employees of membership in and dependents' coverage under Program.

NRS 287.0475 - Reinstatement of insurance by retired public officer or employee or surviving spouse.

NRS 287.0477 - Option of surviving spouse or child of police officer, firefighter or volunteer firefighter killed in the line of duty to join or continue coverage under Public Employees' Benefits Program; notification; payment of costs for coverage; duration of eligibility. [As used in this section "police officer" has the meaning ascribed to it in NRS 617.135].

NRS 287.0487 - Participant in Program may seek assistance from Office for Consumer Health Assistance regarding coverage.

NRS 689B.255 – Insurer to pay claim with negotiable instrument.

NRS 687B.409 - Payments to out-of-network providers for treatment of mental health or alcohol or substance abuse disorder.

NRS 689B.020 - Group health insurance defined; eligible groups and benefits.

NRS 689B.255 - Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements.

NRS 689B.033 - Required provision concerning coverage for newly born and adopted children and children placed for adoption.

NRS 689B.287 - Insurer prohibited from denying coverage solely because insured was intoxicated or under influence of controlled substance; exceptions.

NRS 695G.150 - Authorization on recommended and covered health care services required.

NRS 695G.155- Requirements regarding issuance of health benefit plans and adjustment of costs.

NRS 695G.160 – Written criteria concerning coverage of health care services and standards for quality of health care services.

NRS 695G.162 – Required provisions concerning coverage for services provided through telehealth.

NRS 695G.164 - Required provision concerning coverage for continued medical treatment.

NRS 695G.1645 – Required provision concerning coverage for autism spectrum disorders.

NRS 695G.1665 - Required provision concerning coverage for prescription drugs irregularly dispensed for purpose of the synchronization of chronic medications.

NRS 695G.167 – Required provision concerning coverage for orally administered chemotherapy.

NRS 695G.170 - Required provision concerning coverage for medically necessary emergency services; prohibitions.

NRS 695G.171 – Required provision concerning coverage for human papillomavirus vaccine.

NRS 695G.1713 - Required provision concerning coverage for mammograms for certain women; prohibited acts.

NRS 695G.1715 - Required provision concerning coverage for drug or device for contraception and related health services; prohibited actions by managed care organizations; exceptions.

NRS 695G.1716 - Health care plan that includes coverage for maternity care must not deny coverage for gestational carrier; status of child in relation to intended parent. [Effective January 1, 2020.]

NRS 695G.1717 Coverage for certain services, screenings and tests relating to wellness; prohibited actions by managed care organization.

NRS 695G.172 - Required provision concerning coverage for early refills of topical ophthalmic products.

NRS 695G.173 - Required provision concerning coverage for treatment received as part of clinical trial or study.

NRS 695G.174 - Required provision concerning coverage for management and treatment of sickle cell disease.

NRS 695G.177 - Required provision concerning coverage for prostate cancer screening.

NRS 695G.200 - Approval; requirements; assistance for persons filing complaints; examination.

NRS 695G.210 - Review board; appeal; right to expedited review of complaint; notice to insured.

NRS 695G.220 – Annual report; managed care organization to maintain records of complaints concerning something other than health care services.

NRS 695G.230 - Written notice to insured explaining rights of insureds regarding decision to deny coverage; notice to insured when health carrier denies coverage of health care services.

NRS 695G.241 - External review of adverse determination.

NRS 695G.243 -Applicability.

NRS 695G.245 - Written notice of right to request external review; form; contents.

NRS 695G.247 - Requests for external review to be in writing; exception; form and content.

NRS 695G.251 - Request for review; assignment of independent review organization; provision of documents relating to adverse determination of independent review organization.

NRS 695G.261 - Review of documents by independent review organization; decision of independent review organization.

NRS 695G.271 - Expedited approval or denial of request.

NRS 695G.275 - Experimental and Investigation health care service or treatment: Request for external review; request for expedited external review.

NRS 695G.280 - Basis for decision of independent review organization.

NRS 695G.290 - Decision in favor of covered person binding on health carrier; limitation of liability; cost for independent review organization.

NRS 695G.300 - Submission of complaint of covered person to independent review organization.

NRS 695G.303 - Independent review organization and health carrier to maintain written records; submission of report upon request.

NRS 695G.307 - Health carrier to provide description of external review procedures; format; contents.

NRS 695G.310 - Annual report; requirements.

NRS 695G.405 - Managed care organization prohibited from denying coverage solely because insured was intoxicated or under the influence of controlled substance; exceptions.

10.2 Agent for Service of Process

For disputes arising under the Plan, service of legal process may be made on the Plan Administrator, and must comply with NRS 41.031, in care of:

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

Phone: (775) 684-7000 or (800) 326-5496

10.3 No Vested Rights

To the maximum extent permitted by law, no person shall acquire any right, title, or interest in or to any portion of an Insurance Contract otherwise than by the actual payment or distribution of such portion under the provisions of the Plan or a Component Benefit, or acquire any right, title, or interest in or to any benefit referred to or provided for in the Plan or any Component Benefit otherwise than by actual payment of such benefit. Further, no person has any right, title, or interest in or to the assets of the Employer because of the Plan.

10.4 Information to be Furnished

Any person eligible to receive benefits hereunder shall furnish to the Plan Administrator, its delegate, or to an Insurer, as applicable, any information or proof requested by the Plan Administrator, its delegate, or any such Insurer and reasonably required for the proper administration of the Plan or a Component Benefit. Failure on the part of any person to comply with any such request within a reasonable period of time shall be sufficient ground for delay in the payment of any benefits that may be due under the Plan or a Component Benefit until such information or proof is received by the Plan Administrator, its delegate, or Insurer, as the case may be. If any person claiming benefits under the Plan or a Component Benefit makes a false statement that is material to such person's claim for benefits, the Plan Administrator or Insurer, as the case may be, may offset against future payment any amount paid to such person to which such person was not entitled under the provisions of the Plan or a Component Benefit. Further, the Plan Administrator has the authority to take such additional action, as may be deemed necessary, to make the Plan whole, in accordance with the law.

10.5 Non-Alienation

To the extent permitted or required by law, the rights or interests of any Participant or his beneficiary to any benefits hereunder shall not be subject to attachment or garnishment or other legal process by any creditor of any such Participant or beneficiary, nor shall any such Participant or beneficiary have any right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits which he may expect to receive, contingently or otherwise, under this Plan, and any attempt to anticipate, alienate, commute, pledge, encumber, or assign any right to benefits hereunder shall be void. Notwithstanding the foregoing, the Plan Administer may pay Plan benefits directly to the provider of services. Such payment shall fully discharge the Plan Administrator from further liability under the Plan.

10.6 Non-Guarantee

Neither the Employer nor any fiduciary shall be held or deemed in any manner to guarantee the Plan or a Component Benefit against loss or depreciation.

10.7 No Guarantee of Employment

Neither the establishment and maintenance of this Plan, nor any modification thereof, nor the creation of any account, nor the payment of any benefits shall be construed as giving to any Employee or other person, any legal right or equitable right against the Employer, any officer, director or Employee of the Employer, or against the Plan Administrator, except as herein provided. Under no circumstances shall the terms of employment of any Participant or Employee be modified or in any way affected by this Plan nor shall such establishment or continuance interfere with the right of the Employer to discharge any Employee or any other person or to deal with him without regard to the existence of the Plan or the Component Benefit.

10.8 No Guarantee of Tax Consequences

Neither the Employer nor the Plan Administrator makes any commitment or guarantee that any amounts paid or allocated to or for the benefit of a Participant under the Plan or any Component Benefit will be excludable from Participant's gross income for federal, state, and/or local income tax purposes, or that any other federal, state, and/or local tax treatment will apply or be available to any Participant. It shall be the obligation of each Participant to determine whether any coverage, benefit, or other payment under the Plan is excludable from the Participant's gross income for federal, state, and/or local income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment treated by the Employer as nontaxable is, in fact, not so excludable.

If the Plan Administrator determines that any benefits which the Employer had treated as nontaxable to any Participant for federal, state, and/or local income tax purposes are, in fact, taxable to the Participant due to any reason, including but not limited to erroneous information provided by the Participant or otherwise used by the Employer, such Participant shall pay all such taxes (including any related penalties and interest) directly or reimburse the Employer for any such taxes (including any related penalties and interest) paid by the Employer.

10.9 Incapacity

If the Plan Administrator determines that a Covered Person entitled to benefits hereunder is unable to care for his affairs because of illness or accident, any benefit payment due to such Covered Person shall be paid to his duly appointed guardian or legal representative; provided that, if there shall be no such duly appointed guardian or legal representative, any benefit payment due to such Covered Person may be paid for the benefit of such Covered Person to his spouse, parent, brother, sister, or other third party deemed by the Plan Administrator to have incurred expenses for such Covered Person unless specified otherwise by the Incorporated Documents. Benefit payments made to a third party pursuant to this section shall completely discharge the Plan, the Plan Administrator, and the Employer of any liability to such Participant or other person arising under the Plan.

10.10 Death

Unless otherwise provided under the terms of an applicable Summary of Coverage, Summary of Insurance, or Insurance Contract, claims on behalf of a Participant after the Participant's death may be made by, and, unless denied, shall be paid to, the Participant's estate. Payments made pursuant to this Section 10.10 shall completely discharge the Plan, the Employer, the Plan Administrator, and, if applicable, the Insurer of any liability to the Participant or other person arising under the Plan.

10.11 Clerical Error/Delay

Clerical errors made on the records of the Plan Administrator and delays in making entries on such records shall not invalidate coverage or cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

10.12 Responsibility for Health Care

The provisions of any health benefit program under the Plan shall not be construed to limit a Participant with regard to the choice of medical treatment or services, such choices including, but not limited to, the kind, type, duration, amount, or results thereof. Obtaining medical or other health care treatment or services and determining which services to utilize shall be at the sole discretion of the Participant/Covered Person and shall not be construed, interpreted, or deemed as resulting from the Plan.

Each Participant/Covered Person shall be solely responsible for deciding the health care that the individual receives and shall make such a decision as to his or her health care independent of any determinations to whether reimbursement will or will not be made under the Plan for a health care service or supply. The determination of whether or not a service or supply is medically necessary is made solely for purposes of determining whether benefits will be paid under the Plan and is not intended to be advice to an individual concerning that individual's health care treatment. Each Participant/Covered Person shall be solely responsible for selecting the health care professionals, hospitals, and other institutions that will provide health care services and supplies to that individual.

10.13 Covered Person's Responsibilities

Each Covered Person shall be responsible for providing the Plan Administrator and/or the Employer with the Covered Person's current U.S. mailing address and/or electronic address. Any notices required or permitted to be given hereunder shall be deemed given if directed to such address furnished by the Covered Person and mailed either by regular United States mail or by electronic means as specified in the applicable Treasury Regulations and other guidance. The Plan Administrator and the Employer shall not have any obligation or duty to locate a Covered Person. If a Covered Person becomes entitled to a payment under this Plan and such payment is delayed or cannot be made:

(a) Because of conflicting claims to such payments; or

(b) For any other reason, the amount of such payment, if and when made, shall be determined under the provisions of this Plan without payment of any interest or earnings.

10.14 No Examination or Accounting

Neither the Plan nor any action taken thereunder shall be construed as giving any person the right to an accounting or to examine the books or affairs of the Employer.

10.15 Severability

If any provision of the Plan (including a Component Benefit) is held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining parts of the Plan, and the Plan shall be construed and enforced as if the illegal or invalid provision had not been included in the Plan. The Plan Administrator shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

10.16 Waiver

The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator shall have the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

10.17 Legal Actions

In any action or proceeding involving the Plan assets or any property constituting part or all thereof, or the administration thereof, no Employee, former Employee, Dependent, Covered Person, or any other person having or claiming to have an interest in this Plan shall be necessary parties and no such person shall be entitled to any notice or process, except to the extent required by applicable law. Any final judgment which is not appealed or appealable that may be entered in any such action or proceeding shall be binding and conclusive on the parties hereto and upon all persons having or claiming to have any interest in this Plan.

10.18 Employee Authorization of Payroll Deductions

By using electronic media as discussed in Section 8.11 of the Plan, a Participant consents to deductions from his compensation in accordance with his elections made through the system.

10.19 Misrepresentation or Fraud

A person who receives a benefit under the Plan as a result of false information or a misleading or fraudulent representation shall repay all amounts paid by the Plan and shall be liable for all costs of collection, including attorneys' fees. Notwithstanding the foregoing, the Plan shall comply with respect to the rules pertaining to rescissions as discussed in Section 4.2(e)(5) and Section 7.2 of the Plan.

10.20 Force Majeure

Should the performance of any act required by the Plan be prevented or delayed by reason of a natural catastrophe, strike, lock-out, labor dispute, war, riot, or any other cause beyond the Plan's control, the time for performance of the act will be extended for a reasonable period of time, and non-performance of the act during the period of delay shall be excused. In such event, however, all parties shall use reasonable efforts to perform their respective obligations under the Plan.

Article 11 HIPAA Privacy and Security of Protected Health Information

The Component Benefits of the Plan that are a "group health plan" shall comply with the provisions of HIPAA, in accordance with this Article. The Component Benefits of the Plan that are not subject to HIPAA shall not be subject to this Article.

11.1 Introduction

This Article describes the requirements under a federal law known as HIPAA that apply to health benefits for Employees and certain Retirees, and their eligible Dependents, participating in the PEBP. The confidentiality of Participant Health Information is important to the PEBP. The PEBP is committed to ensuring that the privacy of all Participants is protected and all legal requirements under HIPAA are satisfied. Accordingly, the PEBP will not use or disclose Protected Health Information other than as permitted or required by HIPAA, the HIPAA regulations, and this Article.

The PEBP provides medical, dental, vision, and prescription drug benefits, which are considered "Health Care Components" under HIPAA. The PEBP also provides other benefits that are not subject to HIPAA and some non-covered benefits. Under HIPAA, the PEBP is considered a "Hybrid Entity." The HIPAA Privacy and Security provisions of this Article apply only to:

(a) The Health Care Components of the PEBP and to the Health Plan, Health Care Provider, or Health Care Clearinghouse functions performed by the Health Care Component;

(b) Protected Health Information that is created or received by or on behalf of the Health Care Component of the Plan; and

(c) Electronic Protected Health Information created, received, maintained, or transmitted by or on behalf of the Health Care Component of the Plan.

11.2 Definitions

The following are definitions of specific terms and words used in this Article 11. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

(a) "**Breach**" means the acquisition, access, use, or disclosure of Protected Health Information in a manner not permitted by HIPAA which compromises the security or privacy of the Protected Health Information, unless the acquisition, access, use, or disclosure is otherwise excluded in the definition of "Breach" under 45 CFR Section 164.402.

(b) "**Business Associate**" has the meaning set forth in 45 CFR Section 160.103, including any third party administrator or actuarial, legal, accounting, consulting, or similar firm that performs services involving the disclosure of Protected Health Information.

(c) "**Electronic Protected Health Information**" means Protected Health Information that is transmitted by or maintained in electronic media.

(d) "**Covered Entity**" means

(1) A Health Plan

(2) A Health Care Clearinghouse; or

(3) A Health Care Provider that transmits any Health Information in electronic form in connection with a transaction covered by HIPAA, as defined more fully in 45 CFR Section 160.103.

The Plan is a Covered Entity.

(e) "**Genetic Information**" has the meaning set forth in 45 CFR Section 160.103.

(f) "**Health Care**" means care, services, or supplies related to the health of an Individual within the meaning of 45 CFR Section 160.103. Health care includes, but is not limited to, the following:

(1) Preventative, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to physical or mental condition or functional status of an Individual or that affects the structure or function of the body; and

(2) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

(g) "**Health Care Clearinghouse**" has the meaning set forth in 45 CFR Section 160.103 and includes a public or private entity, including a billing service, repricing company, community health management information system or community Health Information system, and "value-added" networks and switches, that performs either of the following functions:

(1) Processes or facilitates the processing of Health Information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.

(2) Receives a standard transaction from another entity and processes or facilitates the processing of Health Information into a nonstandard format or nonstandard data content for the receiving party.

(h) "**Health Care Component**" means a Component or combination of Components of a Hybrid Entity that are designated by the Hybrid Entity in accordance with 45 CFR Section 164.105(a)(2)(iii)(D) and from whom the PEBP receives Protected Health Information subject to HIPAA. The medical, dental, vision, and prescription drug benefits offered under the Plan are Health Care Components.

(i) "**Health Care Operations**" means any of the following activities of the Plan, to the extent such activities relate to the covered functions of the Plan, including, but not limited to:

(1) Conducting quality assessment and improvement activities including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities;

(2) Patient safety activities;

(3) Population-based activities relating to improving health or reducing Health Care costs, protocol development, case management and care coordination, disease management, contacting Health Care Providers and patients with information about Treatment alternatives and related functions that do not include Treatment;

(4) Reviewing the competence or qualifications of Health Care professionals, evaluating practitioner and Provider performance, rating Health Care Provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

(5) Underwriting (subject to the prohibition in this Article 11), premium rating and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, securing or placing a contract for reinsurance of risk relating to Health Care claims, including stop-loss insurance and excess of loss insurance;

(6) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(7) Business planning and development, such as conducting cost-management and planning- related analysis associated with managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;

(a) Business management and general administrative activities of the Plan, including, but not limited to:

(b) Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;

(c) Customer service, including the provision of data analysis for policyholders, Plan Sponsors, or other customers;

(d) Resolution of internal grievances;

(e) The sale, transfer, merger or consolidation of all or part of the Plan with another Covered Entity, or an entity that following such activity will become a Covered Entity, and due diligence related to such activity;

(f) Consistent with the applicable requirements of 45 CFR Section 164.514, creating de-identified Health Information or a limited data set, and fundraising for the benefit of the Covered Entity; and

(8) Any other activity that falls within the definition of the term "Health Care Operations" as set forth in 45 CFR Section 164.501.

(j) "**Health Care Provider**" has the meaning set forth in 45 CFR Section 160.103 and includes a provider of medical or health services, as well as any other person or organization that furnishes, bills, or is paid for Health Care in the normal course of business.

(k) "**Health Care Treatment**" means the provision, coordination, or management of Health Care and related services by one or more Health Care Providers, including the coordination or management of Health Care by a Health Care Provider with a third party, consultation between Health Care Providers relating to a patient, or the referral of a patient for Health Care from one Health Care Provider to another, and such other activities that may be included in the definition of "Treatment" as set forth in 45 CFR Section 164.501.

(l) "**Health Information**" has the meaning set forth in 45 CFR Section 160.103 and includes information (including Genetic Information), whether oral or recorded in any form or medium, including, but not limited to, verbal conversations, telephonic communications, electronic mail or messaging over computer networks, the Internet and intranets, as well as written documentation, photocopies, facsimiles and

electronic data, that is created or received by a Health Care Provider, a Health Plan, the PEBP, a life insurer, school or university, or a Health Care Clearinghouse that relates to

(1) The past, present, or future physical or mental health or condition of an Individual;

(2) The provision of Health Care to an Individual; or

(3) The past, present, or future payment for the provision of Health Care to an Individual.

(m) "**Health Insurance Issuer**" has the meaning set forth in 45 CFR Section 160.103 and includes an insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State law that regulates insurance. The term does not include a Group Health Plan (within the meaning of 45 CFR Section 160.103).

(n) "**Health Plan**" means an Individual or Group Health Plan that provides or pays the cost of medical care, and includes a Group Health Plan, a Health Insurance Issuer, an HMO and such other plans or arrangements as are set forth in the definition of a "Health Plan" in 45 CFR Section 160.103, including the Plan.

(o) "**HHS**" means the U.S. Department of Health and Human Services.

(p) "**HHS-Approved Technology**" means:

(1) With respect to data in motion, the encryption guidelines in Federal Information Processing Standard 140-2 (or successor guidelines).

(2) For data at rest, HHS-Approved Technology means the encryption guidelines in National Institute of Standards and Technology (NIST) Special Publication 800-111 (or successor guidelines).

(3) With respect to the destruction of data containing Protected Health Information, an HHS-Approved Technology requires the destruction of the media on which the Protected Health Information is stored such that, for paper, film, or other hard copy media, destruction requires shredding or otherwise destroying the media so that Protected Health Information cannot be read or reconstructed; for electronic media, destruction requires that the data be cleared, purged, or destroyed consistent with NIST Special Publication 800-88 (or successor guidelines) such that the information cannot be retrieved. HHS-Approved Technology may be updated from time to time based on guidance from the Secretary of HHS.

(q) "**HITECH**" means the Health Information Technology for Economic and Clinical Health Act.

(r) "**Hybrid Entity**" means a single legal entity that is a Covered Entity whose business activities include both covered functions and non-covered functions and that designates Health Care Components (in accordance with 45 CFR Section 164.105(a)(2)(iii)(D)) for purposes of fulfilling the Hybrid Entity requirements of HIPAA, as defined in 45 CFR Section 164.103. For purposes of this definition, "covered functions" means those functions performed by a Covered Entity that make the entity a Health Plan, Health Care Provider, or Health Care Clearinghouse. The Plan is a Hybrid Entity.

(s) "**Individual**" has the meaning set forth in 45 CFR Section 164.103 as the person who is the subject of Protected Health Information.

(t) "**Individually Identifiable Health Information**" has the meaning set forth in 45 CFR Section 160.103, and includes Health Information, including demographic information, collected from an Individual and created or received by a Health Care Provider, Health Plan, employer, or Health Care Clearinghouse that identifies the Individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual involved.

(u) "**Organized Health Care Arrangement**" has the meaning set forth in 45 CFR Section 160.103 and includes:

(1) A Group Health Plan (within the meaning of 45 CFR Section 160.103) and a Health Insurance Issuer or HMO with respect to such Group Health Plan, but only with respect to Protected Health Information created or received by such Health Insurance Issuer or HMO that relates to Individuals who are or who have been participants or beneficiaries in such Group Health Plan;

(2) A Group Health Plan and one or more other Group Health Plans each of which are maintained by the same PEBP; or

(3) The Group Health Plans described in the second bullet of this definition and Health Insurance Issuers or HMOs with respect to such Group Health Plans, but only with respect to Protected Health Information created or received by such Health Insurance Issuers or HMOs that relates to Individuals who are or have been participants or beneficiaries in any of such Group Health Plans.

(v) "**PEBP Workforce**" means the Executive Director, the agency staff, and the attorneys (for claim purposes).

(w) "**Plan Administration Functions**" means administrative functions performed by the PEBP on behalf of the Plan, excluding functions performed by the PEBP in connection with any other benefit or benefit Plan of the PEBP.

(x) "**Plan Sponsor**" means the State of Nevada. The HIPAA regulations incorporate the ERISA definition of "Plan Sponsor," which generally means the employer that establishes or maintains the employee benefit Plan.

(y) "**Privacy Notice**" means the notice of privacy practices that sets forth the uses and disclosures of Protected Health Information by the Plan that are required or permissible under HIPAA, as more fully described in 45 CFR Section 164.520.

(z) "**Privacy Official**" means the person appointed by the PEBP, or its delegate, on behalf of the Plan, who is responsible for developing and implementing policies and procedures for protecting the privacy and confidentiality of Protected Health Information that is held by or on behalf of the Plan, in accordance with 45 CFR Section 164.530.

(aa) "**Privacy Rule**" means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

(bb) "**Protected Health Information**" means Individually Identifiable Health Information that is transmitted by electronic media, maintained in electronic media, transmitted, or maintained in any other form or medium, including oral or written information. Protected Health Information excludes Individually Identifiable Health Information in education records covered by the Family Educational Rights and Privacy Act, as amended (within the meaning of 20 USC Section 1232g), employment records held by the Covered Entity in its role as an Employer, other records described in 20 USC Section 1232g(a)(4)(B)(iv), and information regarding a person who has been deceased for more than 50 years.

(cc) "**Required by Law**" means

(1) A mandate contained in law that compels a Covered Entity to make a use or disclosure of Protected Health Information and that is enforceable in a court of law including, but not limited to, a court order, a court-ordered warrant, subpoena, or summons issued by a court, grand jury, a governmental inspector general, or an administrative body authorized to require the production of information;

(2) A civil or an authorized investigative demand;

(3) Medicare conditions of participation with respect to Health Care Providers participating in the program; and

(4) Statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

(dd) "**Secured Protected Health Information**" means Protected Health Information to the extent that the information is protected by using an HHS-Approved Technology identified by HHS for rendering Protected Health Information unusable, unreadable, or indecipherable to unauthorized Individuals.

(ee) "**Security Official**" means the person appointed by the PEBP on behalf of the Plan who is responsible for the development, implementation, and maintenance of the HIPAA data security policies and procedures required for the Plan in accordance with 45 CFR Section 164.308(a)(2).

(ff) "**Security Standards"** means the Standards for the Security of Electronic Protected Health Information, as set forth in 45 CFR Parts 160 and 162 and Part 164, Subpart C.

(gg) "**Subcontractor**" means a person to whom a Business Associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of the Business Associate.

(hh) "**Summary Health Information**" has the meaning set forth in 45 CFR Section 164.504 and includes information that summarizes the claims history, claims expenses, or types of claims experienced by Individuals for whom the PEBP has provided benefits under the Plan, and from which the following information has been removed:

(1) Names;

(2) Geographical subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code (if permitted under 45 CFR Section 164.514(b)(2)(i)(B));

(3) All elements of dates (except year) directly relating to the Individual(s) involved (e.g., birth date) or their medical Treatment (e.g., admission, discharge date, or date of death), all ages over 89, and all elements of dates (including years) indicative of age, except that such ages and elements may be aggregated into a single category of age 90 or older);

(4) Other identifying numbers, such as Social Security, telephone, fax, account, or medical record numbers, e-mail, or Internet addresses, URLs, or Internal Protocol (IP) address numbers, vehicle identifiers and serial numbers;

(5) Facial photographs or biometric identifiers (e.g., fingerprints or voice prints);

(6) Any other unique identifying number, characteristic, or code; and

(7) Any information of which the PEBP has knowledge that could be used alone or in combination with other information to identify an Individual.

(ii) "**Unsecured Protected Health Information**" means Protected Health Information that is not rendered unusable, unreadable, or indecipherable to unauthorized Individuals using an HHS- Approved Technology.

11.3 Provision of Protected Health Information to the PEBP Workforce

Certain individuals who work for the PEBP have access to the Individually Identifiable Health Information of PEBP Participants for administration functions. These individuals are known as the PEBP Workforce and are identified in Schedule 2. When this Health Information is provided to the PEBP Workforce, it is Protected Health Information and, if it is transmitted by or maintained in electronic media, it is Electronic Protected Health Information. This Section 11.3 describes the circumstances under which Protected Health Information may be received, used, disclosed by the PEBP Workforce.

(a) **Permitted Disclosure of Enrollment/Disenrollment Information**. A Health Care Component of the PEBP (or a Health Insurance Issuer or HMO with respect to the PEBP) may disclose to the PEBP Workforce, information on whether an Individual is participating in the PEBP or is enrolled in or has disenrolled from a Health Insurance Issuer or HMO offered by the PEBP.

(b) **Permitted Uses and Disclosure of Summary Health Information**. A Health Care Component of the PEBP (or a Health Insurance Issuer or HMO with respect to the PEBP) may disclose Summary Health Information to the PEBP Workforce, provided that the PEBP Workforce requests the Summary Health Information for the purpose of:

(1) Obtaining premium bids for providing Health Insurance coverage under the PEBP; or

(2) Modifying, amending, or terminating the PEBP.

Summary Health Information means information that summarizes the claims history, claims expenses, or type of claims experienced by Individuals who have received health benefits under the PEBP; and from which the names and other personal identifiers described at 45 CFR Section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR Section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

(c) **Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes**. Unless otherwise permitted by law, a Health Care Component of the PEBP (or a Health Insurance Issuer or HMO with respect to the PEBP) may disclose Protected Health Information and Electronic Protected Health Information to the PEBP Workforce, provided that the PEBP Workforce uses or discloses the Protected Health Information and Electronic Protected Health Information only for Plan administration purposes.

Plan administration purposes means administration functions performed by the PEBP Workforce, a Health Care Component of the PEBP, or a Health Insurance Issuer or HMO with respect to the PEBP. Plan Administration Functions include quality assurance, claims processing, auditing, and monitoring. Enrollment and disenrollment of the participants and their covered dependents (beneficiaries) is performed by the PEBP Workforce. The PEBP Workforce also performs quality assurance, auditing and monitoring in

its role as the Plan Administrator. The Plan contracts with certain Health Care Components such as third party claims administrators and HMOs to perform claims administration, auditing, and monitoring. Plan Administration Functions do not include functions performed by the employer in connection with any other benefit or benefit plan (e.g., retirement) or any employment-related actions or decisions. Employment information held by the employer is held in its capacity as an employer and is not Protected Health Information. Enrollment and disenrollment functions performed by the PEBP Workforce are performed on behalf of participant and beneficiaries and are not Plan Administration Functions. Employment and enrollment and disenrollment information generally is not Protected Health Information.

The PEBP Workforce or any of its Health Care Components shall not use or disclose Protected Health Information or Electronic Protected Health Information in a manner that is inconsistent with 45 CFR Section 164.504(f).

With respect to any Protected Health Information, the PEBP Workforce or any of its Health Care Components shall:

(1) Not use or further disclose the Protected Health Information of a Plan Participant or their covered Dependent(s) other than as permitted or required by the PEBP or as Required by Law;

(2) Ensure that any agent, including a Subcontractor, to whom it provides Protected Health Information received from the PEBP Workforce agrees to the same restrictions and conditions that apply to the PEBP Workforce or any of its Health Care Components with respect to Protected Health Information;

(3) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit Plan of the employer;

(4) Report any use or disclosure of Protected Health Information in compliance with 45 CFR Section 164.400-414 of which it becomes aware that is inconsistent with the uses or disclosures;

(5) Make available Protected Health Information to comply with HIPAA's right to access in accordance with 45 CFR Section 164.524;

(6) Make available Protected Health Information for amendment, and incorporate any amendments to Protected Health Information, in accordance with 45 CFR Section 164.526;

(7) Make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;

(8) Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;

(9) If feasible, return or destroy all Protected Health Information that it still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(d) **Other Uses and Disclosures of Protected Health Information**. The PEBP may disclose Protected Health Information to such other persons or entities and under such circumstances as permitted under HIPAA,

HITECH, and the rules, regulations, and other guidance issued by the U.S. Department of Health and Human Services under HIPAA and HITECH.

(e) **Nondisclosure of Genetic Information for Underwriting Purposes**. The PEBP shall not use or disclose Protected Health Information that is Genetic Information (within the meaning of 45 CFR Section 160.103) for underwriting purposes as defined in 45 CFR Section 164.502(a)(5)(i).

(f) **Adequate Separation**. The Plan shall allow the HIPAA Privacy Official, HIPAA Security Official, the PEBP Board, the Executive Officer of the PEBP, or any person under the supervision of the Executive Officer of the PEBP who receives Protected Health Information relating to payment, Health Care Treatment, or Health Care Operations of, or other matters pertaining to, the PEBP in the ordinary course of business.

No other persons shall have access to Protected Health Information. These specified employees (or classes of employees) shall only have access to and use of Protected Health Information to the extent necessary to perform the Plan Administration Functions of the Plan. Please refer to Schedule 2 that describes adequate separation of PHI. If a specified employee does not comply with the provisions of this Article 11, the employee shall be subject to disciplinary action by the PEBP for non-compliance pursuant to the PEBP's employee discipline and termination procedures.

The PEBP shall ensure that the provisions of this Article 11 are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic Protected Health Information on behalf of the PEBP.

(g) **Organized Health Care Arrangement**. The Plan (including the Component Benefits), and the other fully insured and self-insured medical options offered or maintained by the PEBP, shall be deemed part of an Organized Health Care Arrangement, to the fullest extent permitted under the Privacy Rule.

(h) **Interpretation**. The Plan and this Section shall be interpreted and administered in accordance with the Privacy Rule, any applicable federal or state law, and any other applicable regulation or other official guidance issued thereunder. In the event of a conflict between this Section and the Privacy Rule, statute, regulation, or guidance, such Privacy Rule, statute, regulation, or guidance shall govern.

11.4 HIPAA Security Rule

(a) **PEBP Security Practices**. By law, PEBP is required to:

(1) Put in place administrative, physical, and technical safety measures to reasonably and appropriately protect the confidentiality, integrity, and availability of Participant personal medical information that is stored electronically, consistent with the requirements of the Security Standards;

(2) Make sure there are reasonable and appropriate security measures in place to protect and separate Participant personal medical information that is stored electronically from other agencies, Employees, or Employers who do not need access to it, consistent with the requirements of the Security Standards;

(3) Make sure that any agents, including a subcontractor, or vendors who help PEBP with its operations also have in place reasonable and appropriate security measures to protect PEBP personal medical information; and

(4) Report to the PEBP Security Officer any security problems or incidences resulting from unauthorized access, use or interference of systems operations in a system containing PEBP personal medical information, known by PEBP or any agent or vendor.

(b) **Interpretation**. The Plan and this Section shall be interpreted and administered in accordance with the Security Standards, any applicable federal or state law, and any other applicable regulation or other official guidance issued thereunder. In the event of a conflict between this Section and the Security Standards, statute, regulation, or guidance, such Security Standards, statute, regulation, or guidance shall govern. The Plan shall adopt written policies and procedures to implement the provisions of this Section.

11.5 HIPAA Breach Notification Standards

PEBP shall comply with the breach of unsecured protected health information notification provisions as set forth in HITECH and addressed under Notification in the Case of Breach of Unsecured Protected Health Information at 45 CFR Part 164, Subpart D.

11.6 Certification

The Plan Sponsor certifies that this Article incorporates the provisions set forth in 45 CFR Section 164.504(f)(2)(ii) and the Plan Sponsor agrees to such provisions in accordance with 45 CFR Section 164.504(f)(2)(ii).

11.7 Amendment of Schedule 2

The Plan Administrator may amend Schedule 2 to add or remove a PEBP position, access, or access level, or to update the Privacy Official, Security Official, and HIPAA contact office information. Any such modification shall not necessitate a formal amendment to this Plan document.

Schedule 1. Component Benefits

The Plan shall provide for the following Component Benefits, as provided for, and described in the applicable Incorporated Documents:

- Medical and Prescription Drugs
  - PEBP Premier (EPO) Plan, Low Deductible PPO Plan, Consumer Driven Health Plan, Health Maintenance Organization
- Dental
- Vision
- Basic Life Insurance
- Supplemental Life Insurance and Accidental Death and Dismemberment Insurance, and Dependent Life Insurance
- Short-Term Disability Insurance
- Health Reimbursement Arrangement

All Component Benefits are described in the applicable Incorporated Documents and, the applicable Summary of Coverage or Summary of Insurance. A Summary of Coverage or Summary of Insurance that describes benefits under this Plan will reference the name of the Plan as the PEBP Active Employee Health and Welfare Wrap Plan.

Schedule 2. HIPAA Privacy and Security Provisions

PEBP Position	Access	Access Level
PEBP Board		
PEBP Board Member	PHI, PII, Minimum Necessary	Level 1
PEBP Executives		
Executive Officer	PHI, PII, Minimum Necessary	Level 4
Executive Assistant	PHI, PII, Minimum Necessary	Level 2
Accounting		
Chief Financial Officer	PHI, PII, Minimum Necessary	Level 3
Administrative Services Officer II	PHI, PII, Minimum Necessary	Level 3
Management Analyst II	PHI, PII, Minimum Necessary	Level 2
Accounting Technician II	PHI, PII, Minimum Necessary	Level 2
Accounting Assistant II, III	PHI, PII, Minimum Necessary	Level 2
Information Technology		
Chief Information Officer	PHI, PII, Minimum Necessary	Level 3
IT Professional II, III	PHI, PII, Minimum Necessary	Level 2
Operations		
Operations Officer	PHI, PII, Minimum Necessary	Level 3
Management Analyst III	PHI, PII, Minimum Necessary	Level 2
Program Officer III	PHI, PII, Minimum Necessary	Level 2
Program Officer I	PHI, PII, Minimum Necessary	Level 2
Member Services Administrative Assistant II, III, IV	PHI, PII, Minimum Necessary	Level 2
Eligibility Administrative Assistant I, IV	PHI, PII, Minimum Necessary	Level 2
Education Information Officer	PHI, PII, Minimum Necessary	Level 2
Quality Control		
Quality Control Officer	PHI, PII, Minimum Necessary	Level 4
Management Analyst III	PHI, PII, Minimum Necessary	Level 4
Management Analyst I	PHI, PII, Minimum Necessary	Level 4

Access Level

- **Level 1:** Name, address, social security number, unique ID number, telephone number and other contact information such as email address of PEBP participants.

- **Level 2:** Name, address, social security number, unique ID number, telephone number and other contact information such as email address of PEBP participants. Credit Card, Debit Card and Financial Account information.

- **Level 3:** Name, address, social security number, unique ID number, telephone number and other contact information such as email address of PEBP participants. Credit Card, Debit Card and Financial Account information. Minimum necessary claims data as provided by PEBP Vendors (limited to special projects as authorized by the Executive Officer).

- **Level 4:** Name, address, social security number, unique ID number, telephone number and other contact information such as email address of PEBP participants. Physical and mental condition information (past, present, future) to include clinical reports regarding PEBP participants only when necessary to administer health care benefits.

HIPAA Privacy Officer, HIPAA Security Officer, HIPAA Contact Office

- **PEBP Privacy Officer:** If a Participant feels his/her privacy rights have been violated, he/she may file a complaint with the PEBP's Quality Control Officer or with the HHS Office for Civil Rights.
  PEBP Quality Control Officer
  901 S. Stewart St., Ste. 1001
  Carson City NV 89701
  (775) 684-7000 Phone
  (800) 326-5496
  (775) 684-7028 Fax

- **PEBP Security Officer:** The PEBP CIO is responsible for coordinating compliance with the HIPAA Security Rules as defined by the Code of Federal Regulations, 45 C.F.R. 160, 162 and 164.
  PEBP Chief Information Officer (CIO)
  901 S. Stewart St., Ste. 1001
  Carson City NV 89701
  (775) 684-7000 Phone
  (800) 326-5496
  (775) 684-7028 Fax

- **HIPAA Contact Office:** PEBP as the Plan Administrator
  PEBP
  901 S. Stewart St., Ste. 1001
  Carson City NV 89701
  (775) 684-7000 Phone
  (800) 326-5496
  (775) 684-7028 Fax

Schedule 3. Section 1557 Notice

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

The PEBP CDHP and Exclusive Provider Organization Plan for Medical and Prescription Drug Benefits:

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

If you need these services, contact PEBP at 775-684-7000 or 800-326-5496.

If you believe that the PEBP Consumer Driven Health Plan or the Premier Exclusive Provider Organization Plan for Medical and Prescription Drug Benefits has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: PEBP's Civil Rights Coordinator, 901 South Stewart Street, Suite 1001, Carson City, NV 89701, Phone: 775-684-7020 (TTY: 1-800-545-8279), Fax: 775-684-7028. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, contact PEBP's Civil Rights Coordinator.

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

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

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

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

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

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

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

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-326-5496 (TTY: 1-800-545-8279).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-326-5496 (**መስማት ለተሳናቸው**:1-800-545-8279).

เรียน: ถ้าคณุพดู ภาษา ไทยคณุสามารถ ใช้บริการชว่ ยเหลือทางภาษา ได้ฟรี โทร 1-800-326-5496 (TTY: 1-800-545-8279)

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

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-623-6945 (رقم هاتف الصم والبكم: 1-800-545-9728).

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

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

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

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

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

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