NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

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SECTION 125

HEALTH AND WELFARE BENEFITS PLAN DOCUMENT

PLAN YEAR 2022

(EFFECTIVE JULY 1, 2021 – June 30, 2022)

Public Employees' Benefits Program
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Table of Contents

AMENDMENT LOG **1**

PREAMBLE **2**

Accessing Other Benefit Information: 2

ARTICLE 1: DEFINITIONS **3**

1.1 ADMINISTRATOR 3
1.2 BENEFIT ACCOUNT 3
1.3 BENEFITS 3
1.4 CODE 3
1.5 PEBP 3
1.6 COMPONENT PLAN 3
1.7 DEPENDENT 3
1.8 EFFECTIVE DATE 3
1.9 ELECTION FORM 3
1.10 PARTICIPANT 3
1.11 PEBP 3
1.12 ERISA 3
1.13 INSURER 3
1.14 PARTICIPANT 3
1.15 PARTICIPANT ACCOUNT 4
1.16 PARTICIPATION DATE 4
1.17 PLAN 4
1.18 PLAN YEAR 4
1.19 PPACA 4
1.20 SALARY REDUCTION CONTRIBUTIONS 4
1.21 STATUS CHANGE 4

ARTICLE 2: ELIGIBILITY AND PARTICIPATION **5**

2.1 PARTICIPATION 5
2.2 TERMINATION OF PARTICIPATION 5

ARTICLE 3: ELECTION OF BENEFITS **5**

3.1 ELECTION OF BENEFITS 5
3.2 ELECTION FORM 5
3.3 INITIAL ELECTION PERIOD 5
3.4 ELECTION PERIODS AFTER INITIAL ELECTION PERIOD 5

3.5 STATUS CHANGE ELECTIONS; SPECIAL ENROLLMENT; OTHER ELECTION CHANGES. 6
ARTICLE 4: PARTICIPANT ACCOUNTS AND BENEFIT ACCOUNTS 17
4.1 PARTICIPANT ACCOUNTS AND BENEFIT ACCOUNTS 17
4.2 CREDITING AND ALLOCATING ACCOUNTS 17
4.3 DEBITING OF ACCOUNTS 17
4.4 ACCOUNTS AS BOOK ENTRIES ONLY 17
ARTICLE 5: CREDITS AND DEBITS TO ACCOUNTS 17
5.1 SALARY REDUCTION CONTRIBUTIONS 17
5.2 ALLOCATIONS TO AND DEBITING OF BENEFIT ACCOUNTS 18
5.3 CHANGES DURING PLAN YEAR 18
ARTICLE 6: BENEFITS 19
6.1 AVAILABLE BENEFIT ELECTIONS 19
6.2 INSURANCE CONTRACTS 20
6.3 SOURCE OF BENEFITS 20
6.4 MAXIMUM CONTRIBUTIONS AND BENEFITS 20
ARTICLE 7: HIPAA PRIVACY AND SECURITY OF PROTECTED HEALTH INFORMATION 21
7.1 INTRODUCTION 21
7.2 DEFINITIONS 21
7.3 PROVISION OF PROTECTED HEALTH INFORMATION TO THE PEBP WORKFORCE 28
7.4 HIPAA SECURITY RULES 31
7.5 HIPAA BREACH NOTIFICATION STANDARDS 32
7.6 CERTIFICATION 32
7.7 AMENDMENT 32
ARTICLE 8: ADMINISTRATION 32
8.1 THE ADMINISTRATOR 32
8.2 ADMINISTRATIVE RULES AND DETERMINATIONS 32
8.3 DELEGATION AND RELIANCE 33
8.4 INDEMNIFICATION AND INSURANCE 33
8.5 COMPENSATION, EXPENSES AND BOND 34
8.6 ADMINISTRATIVE EXPENSES PAID BY EMPLOYER 34
ARTICLE 9: AMENDMENT OR TERMINATION OF PLAN 35
9.1 AMENDMENT 35
9.3 REDUCTION OR TERMINATION OF BENEFITS 35
9.4 EFFECTIVE DATES 35

9.5 PROCEDURE 35
ARTICLE 10: GENERAL PROVISIONS 36
10.1 NO EMPLOYMENT CONTRACT 36
10.2 APPLICABLE LAW 36
10.3 NON-ALIENATION PROVISIONS 36
10.4 PAYMENTS TO INCOMPETENTS 36
10.5 EFFECT OF MISTAKE 36
10.6 INABILITY TO LOCATE RECIPIENT 36
10.7 PLAN COMMUNICATIONS 37
10.8 SOURCE OF BENEFITS 37
10.9 INTERPRETATION 37
10.10 MEDICARE, MEDICAID, AND TRICARE SECONDARY PAYER RULES 37
10.11 HEALTH CARE CONTINUATION COVERAGE RULES 37
10.12 HIPAA RULES 37
10.13 STATUTE OF LIMITATIONS 37
10.14 COORDINATION OF BENEFITS 37
10.15 CLAIMS SUBSTANTIATION REQUIREMENT 37
10.16 MENTAL HEALTH PARITY 38
10.17 GINA 38
10.18 HEALTH CARE REFORM 38
10.19 RESCISSION OF COVERAGE 38
ARTICLE 11: PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) 39

AMENDMENT LOG

Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.

PREAMBLE

This amendment and restatement of the State of Nevada Public Participants' Benefits (PEBP) Program Health and Welfare Benefits Plan (the Plan) is effective July 1, 2021.

The purpose of the Plan is to allow eligible PEBP Participants to choose benefits from among those benefits provided under the Plan.

The Plan includes provisions for a "cafeteria plan" meeting the requirements of §125 of the Internal Revenue Code of 1986, as amended, but some benefits offered under the Plan (or benefits offered to certain Participants) may not be offered pursuant to the Plan's cafeteria plan feature.

Accessing Other Benefit Information:

Review the following documents for information related to dental, life, enrollment and eligibility, COBRA, third-party liability and subrogation, HIPAA and Privacy and Security and mandatory notices. These documents are available on your member E-PEBP portal account which can be accessed www.pebp.state.nv.us and clicking on the orange log in icon, or by contacting PEBP at 775-684-7000 or 800-326-5496.

- State of Nevada PEBP Active Employee Health and Welfare Wrap Plan Document
- State of Nevada PEBP Retiree Health and Welfare Wrap Plan Document
- Consumer Driven Health Plan (CDHP) Master Plan Document
- CDHP Summary of Benefits and Coverage for Individual and Family
- Low Deductible PPO Plan (LD PPO) Master Plan Document; LD PPO Summary of Benefits and Coverage for Individual and Family
- PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document
- Premier Plan Master Plan Document
- Premier Plan Summary of Benefits and Coverage for Individual and Family
- Health Plan of Nevada Evidence of Coverage (EOC) and Summary of Benefits and Coverage
- PEBP Enrollment and Eligibility Master Plan Document
- Flexible Spending Accounts (FSA) Summary Plan Description
- Section 125 Health and Welfare Benefits Plan Document
- Medicare Retiree Health Reimbursement Arrangement Summary Plan Description

ARTICLE 1: DEFINITIONS

The following terms have the meanings indicated unless the context clearly requires otherwise:

1.1 ADMINISTRATOR means the Plan Administrator referred to in Article 8.

1.2 BENEFIT ACCOUNT is defined in Section 4.1.

1.3 BENEFITS mean those benefits or coverage available for election by a Participant under Article 6.

1.4 CODE means the Internal Revenue Code of 1986, as amended, together with applicable regulations and other authoritative guidance issued thereunder.

1.5 PEBP means the State of Nevada Public Employees' Benefits Program and any successor entity.

1.6 COMPONENT PLAN means any plan or program referred to Participants in Article 6 and any other plan or program designated by PEBP as a Component Plan.

1.7 DEPENDENT means the definition of Dependent as set forth in the Master Plan Document for the PEBP Enrollment and Eligibility.

1.8 EFFECTIVE DATE means July 1, 2021.

1.9 ELECTION FORM means the form provided by or process designated by the Administrator by which a Participant enrolls or re-enrolls in the Plan and elects Benefits in accordance with Article 3.

1.10 PARTICIPANT means a person who is identified as eligible in the PEBP Master Plan Document for the PEBP Enrollment and Eligibility.

1.11 PEBP means the State of Nevada Public Employees' Benefits Program.

1.12 ERISA means the Employee Retirement Income Security Act of 1974, as amended, together with applicable regulations and other authoritative guidance issued pursuant to that Act.

1.13 INSURER means any insurance company to which premiums are paid and which provides benefits with respect to a Participant in accordance with Article 6.

1.14 PARTICIPANT means a Participant who becomes a Participant pursuant to Article 2.

1.15 PARTICIPANT ACCOUNT is defined in Section 4.1.

1.16 PARTICIPATION DATE is the first date on which a Participant may participate in the Plan (or a Component Plan, if applicable), as set forth in Section 2.1.

1.17 PLAN means, collectively, the State of Nevada Public Employees' Benefit Program Health and Welfare Benefits Plan, as described in this document and as amended from time to time, and the Component Plans.

1.18 PLAN YEAR means the twelve-month period beginning each July 1st and ending each June 30th.

1.19 PPACA means the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010 and any subsequent legislation, together with applicable regulations and other authoritative guidance issued pursuant to that Act.

1.20 SALARY REDUCTION CONTRIBUTIONS mean contributions made under the Plan based on an election by a Participant pursuant to Section 5.1 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 Plan or to contribute to a Health Savings Account.

1.21 STATUS CHANGE means, and is limited to:

(a) an event that changes a Participant's legal marital status, including marriage, death of spouse, or divorce;

(b) an event that changes a Participant's number of Dependents, including the birth, adoption, placement for adoption (as defined in regulations under C.F.R. § 146.117) or death of a Dependent;

(c) an event that changes the employment status of a Participant or the Participant's Dependent resulting in a loss or gain of coverage such as the termination or commencement of employment, Participant moving outside the HMO coverage area, the reduction or increase in hours of employment (including a switch between part-time and full-time employment, or commencement or return from an unpaid leave of absence) of the Participant and any change in the employment status of a Participant or the Participant's Dependent that results in that person becoming (or ceasing to be) eligible under a plan sponsored by that person's employer;

(d) an event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age or any similar circumstance;

(e) for purposes of a Component Plan offering dependent care assistance benefits, an event that changes the number of Qualifying Individuals, as defined in Section 6.1(f)

(f) for any election that is not accomplished on a pre-tax basis, any other event

that, in the Administrator's sole discretion, qualifies as a Status Change.

ARTICLE 2: ELIGIBILITY AND PARTICIPATION

2.1 PARTICIPATION. Each Participant is eligible to participate in the Plan as set forth in the PEBP Master Plan Document for the PEBP Enrollment and Eligibility. However, individual Component Plans may impose different or additional eligibility and participation requirements as provided in each Component Plan.

Notwithstanding any other provision of this Plan, no person may participate in the Plan's Code §125 cafeteria plan feature at any time when he or she does not qualify as a Participant of the Plan (as determined by PEBP in accordance with Code §125(d)(1)(A) and other applicable guidance).

2.2 TERMINATION OF PARTICIPATION.

(a) Termination of Coverage for Participants. A Participant's participation in the Plan terminates as set forth in the PEBP Master Plan Document for the PEBP Enrollment and Eligibility.

ARTICLE 3: ELECTION OF BENEFITS

3.1 ELECTION OF BENEFITS: IN GENERAL. A Participant may elect and in accordance with the following provisions of this Article, any one or more of the Benefits available under Article 6.

3.2 ELECTION FORM. A Participant's Election Form (electronic or paper form) shall contain such information as the Administrator may deem appropriate.

3.3 INITIAL ELECTION PERIOD.

(a) IN GENERAL. A Participant who becomes eligible to become a Participant shall follow the guidelines as set forth in the Enrollment Processes section of the Master Plan Document for the PEBP Enrollment and Eligibility. The elections made by the Participant on this initial Election Form shall be effective, subject to Section 2.2 (Termination of Participation), for the period beginning on the Participant's Participation Date and ending on the last day of the Plan Year during which the Participant changes his or her initial elections pursuant to Section 3.4 or Section 3.5; provided, however, that a Participant's initial election of coverage under a *Health Care Flexible Spending Account* or *Dependent Care Flexible Spending Account* will expire no later than the end of the initial Plan Year for which the initial election applies.

3.4 ELECTION PERIODS AFTER INITIAL ELECTION PERIOD. A Participant

may change his or her initial elections for any subsequent Plan Year by requesting, completing and submitting a new Election Form for the applicable Plan Year during the period preceding the applicable Plan Year that is identified by the Administrator as the Plan's annual "election period". The elections made by the Participant on each such Election Form shall be effective, subject to Sections 2.2 and 3.5, beginning on the first day of the Plan Year following the applicable election period and continuing until such elections are changed pursuant to this Section. Notwithstanding the preceding, coverage under any Component Plan for which the Participant becomes ineligible will not remain in effect beyond the date on which the Participant becomes ineligible under that Component Plan.

3.5 STATUS CHANGE ELECTIONS; SPECIAL ENROLLMENT; OTHER ELECTION CHANGES.

(a) Status Change Rules. Within 60 days after a Status Change occurs, a Participant may, with the approval of and pursuant to guidelines established by the Administrator, change his or her election of Benefits, and any Salary Reduction Agreement referenced in Section 5.1, in a manner which is Consistent (as defined in Section 3.5(b)) with the Status Change.

With the approval of and pursuant to guidelines established by the Administrator, a Participant who is eligible to become a Participant but has failed to complete an Election Form may become a Participant and file an Election Form within 60 days after a Status Change occurs, provided that the Participant's commencement of participation and election of Benefits is Consistent (as defined in Section 3.5(b)) with the Status Change.

Elections made under this Section after being approved by the Administrator will take effect on the date specified by the Administrator and remain in effect until the earlier of (i) the end of the Plan Year in which the Participant makes an election pursuant to Section 3.4 (or, for elections relating to a *Health Care Flexible Spending Account* or a *Dependent Care Flexible Spending Account*, the end of the Plan Year in which the election is made), (ii) the date on which the Participant becomes ineligible for coverage under any Component Plan, or (iii) the date the Participant again changes his or her election in accordance with the Plan's procedures. Except for a change permitted under Section 3.5(c)(ii) because of a birth, adoption or placement for adoption, any change permitted by this Section 3.5 to a Participant's Salary Reduction Agreement under Section 5.1 may be made on a prospective basis only and may not be used to pay costs of coverage provided before the effective date of such a change.

Notwithstanding any provision of this Plan to the contrary, for any Component Plan that provides coverage through an insurance policy, elections of benefits, including any new election or change in elections that would otherwise be permitted under this Section 3.5(a) will not be permitted unless the election or change is also permitted under the terms of the applicable insurance contract.

"Consistent" Defined. Except as otherwise provided in this Section 3.5(b), an election change is "Consistent" with a Status Change only if the election change is on account of and corresponds with a Status Change that affects the Participant's or the Participant's Dependent's eligibility for coverage under an employer's plan. An election change to decrease or cancel coverage under a Component Plan is not Consistent with a Status Change because of a Participant or a Dependent becoming eligible for coverage under an employer's plan unless the Participant or Dependent elects such coverage. In determining whether an election change is Consistent for purposes of the preceding sentence, PEBP will request required documentation as outlined in the PEBP Enrollment and Eligibility Master Plan Document that alternative coverage has been or will be obtained.

An election change with respect to a *Dependent Care Flexible Spending Account* is also Consistent with a Status Change if the election change is on account of and corresponds with a Status Change that affects expenses covered under that Component Plan.

Notwithstanding any other provision of this Plan to the contrary, no Participant may change or initiate an election of Benefits or a Salary Reduction Agreement under the Plan regarding contributions to a *Health Care Flexible Spending Account* under this Plan solely because the Participant or a Dependent gains eligibility for coverage under any other employer's health plan or *Health Care Flexible Spending Account* plan, and no Participant may change an election of Benefits or a Salary Reduction Agreement under the Plan to stop or decrease contributions to a *Health Care Flexible Spending Account* under this Plan solely because of a loss of coverage for the Participant or a Dependent under any other employer's health plan or Health Care Flexible spending account plan.

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

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

If you request a change due to a special enrollment event within the 60-day timeframe, coverage will be effective the date of birth, adoption, or placement for adoption. For all other events, coverage will be effective the first day of the month following the qualifying event date or the first day of the month following the date the participant notifies the plan of the qualifying event, whichever is later.

Some examples of Special Enrollment events include:

- You or your eligible dependent(s) lose eligibility for coverage under a group health plan or other insurance coverage (such as an employee and his/her dependents' loss of coverage under the spouse's plan) or when an employer terminates contributions toward health coverage;
- An individual loses coverage under a group health plan covered through COBRA continuation due to the exhaustion of the COBRA period;
- An individual becomes a new dependent through marriage, birth, adoption, or being placed for adoption; and
- An individual loses coverage under a State Children's Health Insurance Program (CHIP) or Medicaid or becomes eligible to receive premium assistance under those programs for group health plan coverage.

Special enrollment rights are subject to certain circumstances. If you are a State or non-State retiree, special enrollment does not apply to you, but it does apply to your dependents if you are covered under the Plan. If you are a surviving spouse or surviving domestic partner, special enrollment does not apply to you or your dependents.

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

(b) Special Enrollment Rights. This Section 3.5(c) applies notwithstanding any other provision of this Plan to the contrary. For purposes of the remainder of this Section 3.5(c) only, "Plan" refers only to coverage under any Component Plan that offers medical benefits that are subject to Code §9801(f) (as determined by the Administrator). This Section 3.5(c) is included in the Plan to comply with the requirements of Code §9801 and any regulations or other authoritative guidance issued pursuant to those provisions and will be construed to provide only those enrollment rights that are required by those provisions, regulations, or other authoritative guidance.

The Benefit options available to a Participant under a Component Plan during a Special Enrollment Period will be the same Benefit options that would be available to such a Participant during an initial election period or, if applicable, during an annual election period (but limited to Benefit options that are subject to C.F.R. § 146.117(f)), regardless of whether the Participant or any Dependent was enrolled in a different Benefit option or no coverage under such a Component Plan at the time of the Special Enrollment election.

Notwithstanding any provision of this Plan to the contrary, for purposes of this Section 3.5(c), "Participant" is defined as described in Section 1.10, except that "Participant" does not include any person who is not, at the applicable time, a current Participant of PEBP (as determined by PEBP).

(i) Special Enrollment Rights Because of Loss of Alternative Coverage. A Participant or a Dependent who is otherwise eligible for coverage under the Plan

(including, for a Participant's Dependent, any requirement that the Participant also be enrolled in the Plan) is eligible to enroll in the Plan during a Special Enrollment Period, as described in this Section 3.5(c)(i), if,

(A) when coverage under the Plan was previously offered (e.g., during an initial enrollment period, a Special Enrollment Period or, if applicable, an open enrollment period), the Participant or Dependent had coverage under another group health plan or health insurance coverage (Alternative Coverage), and

(B) the Participant or the Dependent satisfies one of the following conditions:

(1) the Alternative Coverage is not COBRA continuation coverage, and the Alternative Coverage terminates because of a "Loss of Eligibility" (as described later in this Section 3.5(c)(i));

(2) the Alternative Coverage is not COBRA continuation coverage and employer contributions (including contributions by any current or former employer of the Participant or Dependent) toward the Participant's or Dependent's Alternative Coverage terminate; or

(3) the Alternative Coverage is COBRA continuation coverage, and the Alternative Coverage terminates because the COBRA continuation coverage is exhausted (as described later in this Section 3.5(c)(i)).

"Loss of Eligibility" includes, but is not limited to, a loss of eligibility because of divorce, cessation of dependent status, death of a Participant, termination of employment or a reduction in the number of hours of employment. For Alternative Coverage offered through an HMO or another arrangement that does not provide benefits to individuals who no longer reside or work in a service area, "Loss of Eligibility" also includes a loss that occurs because the Participant or Dependent no longer lives or works in the applicable service area (unless the HMO or other arrangement is part of a group plan that makes another benefit option available to the affected Participant or Dependent). In addition, a "Loss of Eligibility" occurs if the Alternative Coverage no longer offers any benefits to the class of similarly situated individuals that includes the Participant or Dependent.

"Loss of Eligibility" for purposes of this Section 3.5(c)(i) does not include a loss of coverage because of a failure of the Participant or Dependent to pay for coverage on a timely basis or a loss of coverage for cause (such as for making a fraudulent claim or a misrepresentation of a material fact in connection with the Alternative Coverage).

For purposes of this Section 3.5(c)(i), exhaustion of COBRA coverage occurs when COBRA coverage ceases for any reason other than a failure of the Participant or Dependent to pay premiums on a timely basis or for cause. Exhaustion of COBRA coverage occurs when COBRA coverage ceases because an employer or other responsible party fails to remit premiums on a timely basis. For COBRA coverage provided through an HMO or another

arrangement that does not provide benefits to individuals who no longer reside or work in a service area, exhaustion of COBRA coverage also occurs if coverage ceases because the Participant or Dependent no longer lives or works in the applicable service area (unless other COBRA coverage is available).

If a Participant loses eligibility for Alternative Coverage (or exhausts COBRA Alternative Coverage), the Participant (and each otherwise eligible Dependent) is eligible for Special Enrollment during the Special Enrollment Period. If a Dependent loses eligibility for Alternative Coverage (or exhausts COBRA Alternative Coverage), only the Participant and any Dependent who loses eligibility for Alternative Coverage (or exhausts COBRA Alternative Coverage) is eligible for Special Enrollment. In any case, Special Enrollment rights are subject to any Plan eligibility rules that condition Dependent eligibility on enrollment of the Participant.

A Participant or a Dependent who is eligible for a Special Enrollment under this Section 5.1 may be enrolled in the Plan, and the Participant may make a corresponding change in a salary reduction agreement under Section 5.1, if any, during the Participant's or Dependent's Special Enrollment Period. The Special Enrollment Period under this Section 3.5(c)(i) ends 60 days after the termination of the Alternative Coverage.

Following an election by a Participant under this Section 3.5(c)(i), the Participant's or Dependent's coverage will become effective no later than the first day of the first month following the month the Participant's or Dependent's loss of coverage occurred. A Special Enrollment Period election will be treated as an initial election of coverage pursuant to Section 3.3 and is subject to all Plan provisions that apply to initial elections, except that coverage begins only as described in this paragraph.

(ii) Special Enrollment Rights Following Marriage, Birth or Adoption. Following the marriage of a Participant or a Participant, the birth of a child, or the adoption or placement for adoption of a child, the Participant, the Participant's Dependent or the Participant's Dependent, as applicable, may enroll in the Plan during a Special Enrollment Period, as follows:

(A) An otherwise eligible Participant may enroll himself or herself in the Plan and make a corresponding change to a salary reduction agreement under Section 5.1, if any, during the Special Enrollment Period described in this Section 3.5(c)(ii) if an individual becomes a Dependent of the Participant through marriage, birth, adoption or placement for adoption.

(B) An active Participant may enroll an individual who becomes or is his or her spouse (determined under federal law) and make a corresponding change to a salary reduction agreement under Section 5.1, if any, during the Special Enrollment Period described in this Section 3.5(c)(ii) if either (I) the individual becomes the Participant's spouse or (II) the individual is the Participant's spouse and a child becomes a Dependent of the Participant through birth, adoption or placement for adoption.

(C) An otherwise eligible Participant may elect to enroll in the Plan the Participant and an individual who becomes or is his or her spouse (determined under federal law) and make a corresponding change to a salary reduction agreement under Section 5.1, if any, during the Special Enrollment Period described in this Section 3.5(c)(ii) if (I) the Participant and the individual become married or (II) the Participant and the individual already are married and a child becomes a Dependent of the Participant through birth, adoption or placement for adoption.

(D) An active Participant may enroll an individual in the Plan and make a corresponding change to a salary reduction agreement under Section 5.1, if any, during the Special Enrollment Period described in this Section 3.5(c)(ii) if the individual becomes a Dependent of the Participant through marriage, birth, adoption, or placement for adoption.

(E) An otherwise eligible Participant may elect to enroll the Participant and an individual who becomes a Dependent of the Participant in the Plan and make a corresponding change to a salary reduction agreement under Section 5.1, if any, during the Special Enrollment Period described in this Section 3.5(c)(ii) if the individual becomes a Dependent of the Participant through marriage, birth, adoption, or placement for adoption.

The Special Enrollment Period under this Section 3.5(c)(ii) begins on the date of the marriage, birth, adoption, or placement for adoption that gives rise to the Special Enrollment Period (or, if later, on the Participant's Participation Date) and ends 60 days after that date. Following an election during a Special Enrollment Period for coverage under the Plan, the coverage will be effective, (A) for a marriage, on a date specified by the Administrator that is no later than the first day of the first month beginning after the date the Participant submits to the Administrator an Election Form electing coverage for the Participant or Dependent under the Plan, (B) for a Dependent's birth, on the date of birth, and, (C) for a Dependent's adoption or placement for adoption, on the date of the adoption or placement for adoption. A Special Enrollment Period election will be treated as an initial election of coverage pursuant to Section 3.3 with respect to medical coverage or any other coverage that is subject to the Special Enrollment requirements of C.F.R. § 146.117(f)and is subject to all Plan provisions that apply to initial elections, except that coverage begins only as described in this paragraph.

For purposes of this Section 3.5(c)(ii), "marriage" is limited to a marriage that is recognized as a marriage for purposes of federal law.

(iii) Special Enrollment Rights Relating to Medicaid or CHIP Coverage (see ARTICLE 11: Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)) To the extent required by C.F.R. § 146.117(f), a Participant or a Participant's Dependent who is eligible but not enrolled may enroll in the Plan by requesting enrollment during a Special Enrollment Period described in this Section 3.5(c)(iii) in either of the following situations:

(A) Termination of Medicaid or CHIP Coverage. The Participant or the Participant's Dependent was covered under a Medicaid plan under Title XIX of the Social Security Act or under a state child health plan (CHIP) under Title XXI of the Social Security Act and coverage of the Participant or the Participant's Dependent under that Medicaid or CHIP plan is terminated as a result of loss of eligibility for that coverage.

(B) Eligibility for Financial Assistance under Medicaid or CHIP. The Participant or the Participant's Dependent becomes eligible for financial assistance for coverage under the Plan, through a Medicaid plan or a state CHIP plan (including under any waiver or demonstration project conducted under or in relation to such a plan).

The Special Enrollment Period described in this Section 3.5(c)(iii) is the 60-day period that begins on the date of the termination of coverage described in (A) above or the date the Participant or the Participant's Dependent is determined by the appropriate government agency to be eligible for the financial assistance described in (B) above. Enrollment that is properly requested during that Special Enrollment Period will become effective no later than the first day of the first month following the month the Participant or the Participant's Dependent loses Medicaid or CHIP eligibility or the first day of the month the Participant or the Participant's Dependent gains eligibility for financial assistance for coverage through a Medicaid plan or a state CHIP plan. Enrollment under this Section 3.5(c)(iii) is permitted for each Participant and the Participant's Dependent who experiences an event described in (A) or (B) above. Enrollment for any person, other than the Participant or the Participant's Dependent, who has not experienced such an event will be permitted under this Section 3.5(c)(iii) only to the extent required by applicable law, as determined by PEBP.

(c) Significant Changes in Cost or Coverage. Any election change permitted under this Section 3.5(d) must be requested, pursuant to procedures established by the Administrator, within 60 days after the date of the event giving rise to the right to make the election change (as determined by the Administrator).

Notwithstanding any provision of this Plan to the contrary, for any Component Plan that provides coverage through an insurance policy, elections of benefits, including any new election or change in elections that would otherwise be permitted under this Section 3.5(d) will be permitted unless the election or change is also permitted under the terms of the applicable insurance contract.

(i) Significant Cost Changes. If the cost payable by a Participant for coverage offered under a Benefit option significantly changes during a Plan Year, as determined by PEBP, the Participant may make corresponding changes to his or her election of Benefits and to a salary reduction agreement under Section 5.1. If the change is an increase in the Participant's cost of that coverage, a Participant may elect to replace his or her coverage with coverage available under another Benefit option, if any, that offers similar coverage, as determined by PEBP, or, if no other similar Benefit option is available, a Participant may drop the coverage. If the change is a decrease in the Participant's cost of coverage under a Benefit option, a Participant or a Participant who is eligible to become a Participant may revoke a current election of similar coverage and elect the coverage with the decreased cost.

For purposes of the preceding paragraph, a cost increase or decrease means an increase or decrease in the amount of the Participant's cost for a Benefit option only if the increase or decrease results from an action taken by the PEBP (or, for elections involving a *Dependent Care Flexible Spending Account*, from a change in costs imposed by a dependent care provider).

Notwithstanding anything else in this Section 3.5(d)(i), for any change in costs associated with a *Dependent Care Flexible Spending Account*, a Participant may not change a salary reduction agreement or election of Benefits if the cost change is imposed by a dependent care provider who, with respect to the Participant, is a parent, grandparent, child, grandchild, brother, sister, niece, nephew, stepparent, stepchild, stepbrother, stepsister, son-in-law, daughter-in-law, mother-in-law, father-in-law, sister-in-law or brother-in-law.

(ii) Coverage Changes.

(A) Curtailment Without Loss of Coverage. If a Participant experiences a significant curtailment of coverage under a Benefit option that is not a loss of coverage (under applicable law, as determined by PEBP), the Participant may elect to revoke his or her election of that Benefit option and, in lieu of that coverage, elect to receive coverage under another Benefit option, if any, that offers similar coverage, as determined by PEBP, and may make corresponding changes to a salary reduction agreement under Section 5.1. Coverage

under a Benefit option is significantly curtailed only if there is an overall reduction in coverage that constitutes reduced coverage to Participants generally, as determined by PEBP.

(B) Loss of Coverage. If a Participant experiences a significant curtailment of coverage under a Benefit option that is a loss of coverage (under applicable law, as determined by PEBP), the Participant may elect to revoke his or her election of that Benefit option and, in lieu of that coverage, elect to receive coverage under another Benefit option, if any, that offers similar coverage, as determined by PEBP, and may make corresponding changes to a salary reduction agreement under Section 5.1. If no similar coverage is available to replace the Benefit option for which a loss of coverage occurred, a Participant may elect to drop the coverage.

For purposes of this Section 3.5(d)(ii), "loss of coverage" means a complete loss of coverage under a Benefit option and includes, for example, the elimination of a Benefit option, the loss of availability of an HMO option in the area where the Participant or Dependent resides, a Participant's or Dependent's loss of coverage under a health plan option because expenses exceed an annual limit and other similar events, as determined by PEBP. In addition, PEBP, in its discretion, may elect to treat as a loss of coverage any of the following: (1) a substantial decrease in the medical care providers available under the Benefit option; (2) with regard to a specific Participant or Dependent, a reduction in benefits provided under a health plan for a specific type of medical condition or treatment with respect to which the Participant or Dependent is currently in a course of treatment; or (3) any similar fundamental loss of coverage.

(C) Addition of Option. If PEBP adds a new Benefit option or if coverage under an existing Benefit option is significantly improved during a Plan Year, as determined by PEBP, a Participant who elected a Benefit option for the Plan Year that provides similar coverage, as determined by PEBP, may change his or her election of Benefits to replace that Benefit option with the new or improved Benefit option and may make corresponding changes to a salary reduction agreement under Section 5.1, if applicable. Any Participant, or any Participant who is eligible to become a Participant, who did not elect any Benefit option for the Plan Year that provides coverage similar to that offered under a new or improved Benefit option, as determined by PEBP, may change his or her election of Benefits to elect the new or improved Benefit option and may make corresponding changes to a salary reduction agreement under Section 5.1, if applicable.

(iii) Changes Under Another Employer's Plan. A Participant, or a Participant who is eligible to become a Participant, may change his or her election of Benefits and Salary Reduction Agreement under Section 5.1 on account of and corresponding to (A) an election change made under another employer-sponsored plan (including another plan of PEBP), if the change is one that is permitted under that other plan under provisions similar to the provisions in this Section 3.5, or (B) an election change made under another employer-sponsored plan (including another plan of PEBP) that corresponds to a period of coverage that is different from the Plan Year.

(iv) Loss of Other Group Health Coverage. If a Participant or a Participant's Dependent, or a Participant who is eligible to become a Participant, or his or her Dependent loses coverage under any group health coverage sponsored by a governmental entity or educational institution, the Participant or Participant may change his or her election of Benefits and Salary Reduction Agreement under Section 5.1 to elect coverage for the affected individual.

Nothing in this Section 3.5(d) shall be construed to permit a change to a Participant's election of Benefits or Salary Reduction Agreement under Section 5.1 with respect to a *Health Care Flexible Spending Account* or to permit a change of election with respect to any Component Plan because of cost or coverage changes associated with a *Health Care Flexible Spending Account* sponsored by any employer of a Participant or a Dependent.

(d) Other Election Changes. Any election change permitted under this Section 3.5(e) must be requested, pursuant to procedures established by the Plan Administrator, within 60 days after the date of the event giving rise to the right to make the election change (as determined by the Administrator) or as otherwise provided in this Section 3.5(e).

Notwithstanding any provision of this Plan to the contrary, for any Component Plan that provides coverage through insurance policies, elections of benefits, including any new election or change in elections that would otherwise be permitted under this Section 3.5(e) will be permitted unless the election or change is also permitted under the terms of the applicable insurance contract.

(i) Judgment, Decree or Order. If a Participant is subject to a judgment, decree or order (Order) resulting from a divorce, annulment, or change in legal custody (including a qualified medical child support order) for accident or health coverage for the Participant's child, the Participant, or if required by the Order, PEBP or the Administrator, may change the Participant's election of Benefits and Salary Reduction Agreement under Section 5.1, if any, to provide coverage for the child if the Order requires coverage under the Plan. If the Order requires the Participant's spouse, former spouse or another individual to provide coverage for the child, the Participant may change his or her election of Benefits and Salary Reduction Agreement under Section 5.1, if any, to cancel coverage for the child, if the Participant provides adequate proof, as determined by the Administrator, that the coverage required by the Order is actually being provided.

(ii) Medicare/Medicaid Eligibility. If a Participant or a Participant's Dependent who is enrolled in a Component Plan that offers accident or health coverage, becomes enrolled under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under §1928 of the Social Security Act (the program for distribution of pediatric vaccines), the Participant may make an election change to cancel or reduce coverage of that Participant, or his or her Dependent, under the Component Plan that offers accident or health coverage, and may change a Salary Reduction Agreement under Section 5.1 accordingly. If a Participant or a Participant's Dependent, who was previously enrolled under Medicare or Medicaid as described

in the previous sentence, loses eligibility for such coverage, the Participant may elect coverage for that individual under a Component Plan that offers accident and/or health coverage. A change described in this Section 3.5(e)(ii) must be requested within 60 days after the gain or loss of eligibility for Medicare or Medicaid coverage.

(iii) Family and Medical Leave Act. A Participant taking unpaid leave under the Family and Medical Leave Act of 1993 (FMLA) may revoke an existing election of group health coverage and, upon return from FMLA leave, may make other elections concerning group health coverage that are permitted by FMLA. A Participant may make corresponding changes to a Salary Reduction Agreement under Section 5.1 to reflect these special FMLA-permitted changes.

(iv) Health Savings Account Contributions. A Participant who is making Salary Reduction Contributions to a Health Savings Account under the Plan or a Participant who is eligible to make such contributions may make changes to a Salary Reduction Agreement under Section 5.1 to increase, decrease or stop such contributions on at least a monthly basis, subject to reasonable administrative rules and procedures, established by the Administrator. A Participant who ceases to be an eligible individual for purposes of Code §223 may change his or her Salary Reduction Agreement at any time to cease Health Savings Account contributions. Changes in Salary Reduction Contribution elections will become effective on a prospective basis only.

(v) Revoking Medical Coverage to Enroll in Marketplace Coverage. A Participant who has an enrollment opportunity to enroll in a Qualified Health Plan through an exchange or marketplace established under PPACA §1311 ("Marketplace") may change his or her election of Benefits and Salary Reduction Agreement under Section 5.1, if any, to revoke coverage under a Component Plan that provides medical coverage that qualifies as minimum essential coverage under Code §5000A(f)(1) (not including any Health Care FSA Component Plan) but only if the revocation corresponds to the intended enrollment in Marketplace coverage by the Participant and all Dependents whose coverage under this Plan is being revoked. A revocation of coverage pursuant to the preceding sentence will be treated as corresponding to enrollment in Marketplace coverage only if the Marketplace coverage (for all covered persons whose coverage would be terminated because of the revocation) is effective no later than the next day after coverage under the Plan would terminate because of the revocation of coverage under this Plan. The Plan Administrator may rely on the Participant's reasonable representation that all covered persons whose coverage is to be revoked have enrolled in or will enroll in Marketplace coverage to be effective no later than the deadline indicated in the previous sentence. This paragraph will be interpreted to be consistent with guidance provided by the Internal Revenue Service in Notice 2014-55 and any applicable guidance, including regulations or proposed regulations that replace or supplement that guidance, as interpreted by the Plan Administrator.

ARTICLE 4: PARTICIPANT ACCOUNTS AND BENEFIT ACCOUNTS

4.1 PARTICIPANT ACCOUNTS AND BENEFIT ACCOUNTS. PEBP or Administrator shall maintain records reflecting a Participant Account for each Participant. The Participant Account shall be divided into sub-accounts (Benefit Accounts) for each Benefit elected by the Participant.

4.2 CREDITING AND ALLOCATING ACCOUNTS. Amounts shall be credited to Participant Accounts as provided in Section 5.1 and allocated to Benefit Accounts as provided in Section 5.2.

4.3 DEBITING OF ACCOUNTS. Benefit Accounts shall be debited as provided in Section 5.2.

4.4 ACCOUNTS AS BOOK ENTRIES ONLY. Participant Accounts and Benefit Accounts shall be maintained by PEBP and/or the Administrator as entries on its books. No money shall be paid into any Participant Account or Benefit Account. No assets or funds shall be paid to, held in, or invested in any separate trust. No interest will be credited to or paid on amounts credited to any Participant Account or Benefit Account.

ARTICLE 5: CREDITS AND DEBITS TO ACCOUNTS

5.1 SALARY REDUCTION CONTRIBUTIONS. During the applicable election period determined under Article 3, a Participant may enter into a Salary Reduction Agreement with PEBP which directs that the Participant's compensation for the period to which the election relates shall be reduced each payroll period and that the amount of such reduction will be credited to the Participant's Participant Account. For Participants who are eligible to participate in the Plan's Code §125 cafeteria plan feature, Salary Reduction Contributions will be made on a pre-tax basis to the extent permitted under Code §125 (as determined by PEBP) and only from compensation that would otherwise be payable to the Participant as a Participant (within the meaning of Code §125(d)(1)(A)). For certain Benefits and to the extent permitted by PEBP, a Participant may make contributions on an after-tax basis and that amount will be credited to his or her Participant Account.

Except as otherwise provided in this Plan or a Component Plan, a Participant's pre-tax Salary Reduction Contributions for any period will be limited only by the amount of compensation payable to the Participant as a Participant for that period (or the total Participant cost of pre-tax benefits elected by the Participant, if less). For purposes of the preceding sentence, "Participant" has the same meaning that applies for purposes of Code §125(d)(1)(A). Notwithstanding the preceding, the elected salary reduction, as applicable to any Participant, is subject to reduction by the Administrator to the extent deemed necessary by the Administrator to avoid the Plan being discriminatory for purposes of Code §125.

Pre-tax Salary Reduction Contributions will be deducted from a Participant's compensation on a uniform basis throughout the applicable Plan Year or other period of coverage, with deductions made for each pay period or some other interval that is specified by PEBP. Pre-tax Salary Reduction Contributions deducted from a Participant's compensation during a Plan Year may not be used to pay for coverage or benefits provided during a later Plan Year except to the extent permitted under applicable regulations issued under Code §125. As permitted by applicable regulations, in accordance with uniform and consistent administrative and payroll procedures, Salary Reduction Contributions deducted from a Participant's compensation during the last month of a Plan Year may be used to pay for health or accident coverage provided during the first month of the next Plan Year.

A Participant's elected Salary Reduction Contribution for coverage under a Component Plan is subject at all times to PEBP's right to automatically increase or decrease the amount of a Participant's contribution to correspond to a change in the amount that a Participant is required to pay for coverage under that Component Plan. Any automatic changes made based on the preceding sentence will apply prospectively only but otherwise may become effective on any date determined by PEBP. Such automatic changes will be made only on a reasonable and consistent basis.

Except as otherwise expressly permitted under the Plan and applicable law, a Participant who is not an active Participant shall make contributions on an after-tax basis. Also, any contributions made by or on behalf of a Participant to pay for coverage for any Dependent who is not a Code Section 152 dependent (as defined in Section 1.7), spouse (as determined for purposes of federal law) or child of the Participant will be made on an after-tax basis or, if PEBP in its discretion and in accordance with uniform and consistent administrative procedures, permits such contributions to be made on a pre-tax basis, will be treated as resulting in imputed income for the Participant, to the extent required under applicable law. For purposes of the preceding sentence, "child" means any individual who qualifies as a child of the Participant under Code §152(f)(1) who will not reach age 27 before the end of the Participant's tax year.

5.2 ALLOCATIONS TO AND DEBITING OF BENEFIT ACCOUNTS. Amounts credited to a Participant's Participant Account shall be allocated, on the date credited, to the Benefit Accounts of the Participant. Such allocation shall be made pursuant to the election made by the Participant in accordance with Section 6.1. However, in no event may an amount in excess of the total amount credited to a Participant's Participant Account be credited to the Participant's Benefit Accounts. All payments of Benefit amounts under the Plan shall be debited against the appropriate Benefit Account.

5.3 CHANGES DURING PLAN YEAR. Except as provided in Sections 3.5 or 5.1 and to the extent permitted under applicable law, a Participant shall not change (a) amounts to be credited to a Participant Account during a Plan Year pursuant to Section 5.1 or (b) the allocation of such amounts to Benefit Accounts during the Plan Year pursuant to Section 5.2.

ARTICLE 6: BENEFITS

6.1 AVAILABLE BENEFIT ELECTIONS. The benefits available for election pursuant to Article 3 shall be those provided through the Component Plans. The Participant cost of the Benefits will be determined by PEBP and will be communicated to Participants from time to time.

Pursuant to a Participant's election of a Benefit provided under a Component Plan, the compensation of the Participant will be reduced by the amount necessary to provide that Benefit, and PEBP shall credit the amount of the salary reduction to the Component Plan on behalf of the Participant.

The Plan's Benefit options are listed below. Further details are set forth in the Master Plan Document for the PEBP Consumer Driven Health Plan for Medical, Vision and Prescription Drug Benefits.

(a) Consumer Driven Health Plan (CDHP). Each eligible Participant may elect to have sufficient Salary Reduction Contributions made pursuant to Section 5.1 for one of the medical, dental, vision, or prescription drug coverage options designated by PEBP.

(b) Basic Life Insurance Each Eligible Participant may elect to have sufficient Salary Reduction Contributions made pursuant to Section 5.1 credited to his or her Basic Life Insurance under a basic life insurance coverage option designated by PEBP.

(c) Health Savings Account. Each eligible Participant who participates in a High Deductible Health Plan (as defined in Code §223(c)(2)) offered under the Plan and who qualifies as an "eligible individual" for purposes of Code §223(c)(1) may be credited with PEBP contributions to a Health Savings Account, if any, and may elect on his or her Election Form to have sufficient Salary Reduction Contributions made pursuant to Section 5.1 credited to his or her Health Savings Account. A Participant is eligible to be credited with Employer contributions or to make Salary Reduction Contributions to a Health Savings Account only for months during which the Participant is an "eligible individual" for purposes of Code §223(c)(1). The total amount credited to a Participant's Health Savings Account through PEBP contributions or Participant Salary Reduction Contributions for a calendar year may not exceed the applicable limit that applies under Code §223. PEBP may limit contributions to a Participant's Health Savings Account as needed to ensure that the applicable limit is not exceeded, but PEBP is not responsible for monitoring contributions that are made to a Participant's Health Savings Account from outside the Plan. All contributions to a Health Savings Account become the property of the Participant in accordance with applicable law. A Participant's Health Savings Account that is funded through this Plan is not a Component Plan and is not a Participant benefit plan for purposes of ERISA or Nevada law. If PEBP elects to make contributions to Health Savings Accounts, those contributions will be made only for individuals who are determined to be eligible individuals for purposes of Code §223(c)(1) and who, at the applicable time, are

participating in the CDHP Component Plan based on an affirmative election of that coverage. No person will be eligible for PEBP contributions to an HSA for any period when that person is participating in the Health Savings Plan based solely on an automatic election as described in Section 6.1(a) (as determined by PEBP).

(d) Flexible Spending Accounts (FSA). Each eligible Participant may elect to have Salary Reduction Contributions made pursuant to Section 5.1 credited to his or her Health Care FSA, Dependent Care FSA, and/or Limited Purpose/Scope FSA according to guidelines established by the Administrator and set forth in the FSA Summary Plan Description, which shall set forth the amount of Salary Reduction Contributions that may be credited to a Participant's Health FSA for a Plan Year. No Participant is an eligible Participant for purposes of the Plan's Health Care FSA feature for any period when he or she is a Participant in the HSA.

(e) Buy-up Vision Plan: Each eligible Participant may elect to have sufficient Salary Reduction Contributions made pursuant to Section 5.1 credited to his or her Buy-up Vision Plan voluntary coverage option designated by PEBP.

(f)

6.2 INSURANCE CONTRACTS. PEBP has the right to enter into contracts with one or more insurance companies for providing any Benefits under the Plan and to replace any such insurance company from time to time. If any Benefit is intended to be provided under an insurance contract, a Participant may look only to the insurance company for payment of that benefit.

Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any insurance contracts used to provide Benefits shall be the property of, and shall be retained by, PEBP, except to the extent, if any, that the Administrator determines that a portion of the payment is required to be treated as Plan assets under applicable law. To the extent that any portion of such a payment is required to be treated as Plan assets, that amount will be used to pay reasonable Plan expenses or to provide Benefits or will be used for any other purpose that is consistent with applicable law regarding the use of such assets.

6.3 SOURCE OF BENEFITS. PEBP will pay any Benefits intended to be self-funded from its general assets.

6.4 MAXIMUM CONTRIBUTIONS AND BENEFITS. The maximum amount of contributions and Benefits made available under the Plan to any Participant in any Plan Year shall be limited as provided in the Code.

ARTICLE 7: 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.

7.1 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 the 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.

7.2 DEFINITIONS. The following are definitions of specific terms and words used in this section. 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 form 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 160.103.

(f) "**Health Care**" means care, services, or supplies related to the health of an Individual within the meaning of 45 CFR 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:

(a) 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;

(b) Patient safety activities;

(c) 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;

(d) 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;

(e) 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;

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

(g) 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;

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

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

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

(4) Resolution of internal grievances;

(5) 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;

(6) 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

(7) 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 Publications 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.

7.3 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 administrative functions. These individuals are known as the PEBP Workforce. 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 7.3 describes the circumstance under which Protected Health Information may be received, used, or 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. PEBP 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. If a specified employee does not comply with the provisions of this Article, 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 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.

7.4 HIPAA SECURITY RULES.

(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.

7.5 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.

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

7.7 AMENDMENT. The Plan Administrator may amend the PEBP Workforce 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.

ARTICLE 8: ADMINISTRATION

8.1 THE ADMINISTRATOR. Except as to those functions reserved within the Plan or a Component Plan to PEBP, or an Insurer, the Administrator controls and manages the operation and administration of the Plan. The Administrator is PEBP or any other person or committee appointed by PEBP to administer the Plan. The Administrator or any person who is a member of a committee that is appointed to be the Administrator may or may not be a Participant in the Plan.

8.2 ADMINISTRATIVE RULES AND DETERMINATIONS. Subject to the limitations of the Plan, the Administrator shall establish rules for the administration of the Plan and the transaction of its business. The Administrator has the exclusive right (except as to matters reserved to PEBP or an Insurer by the Plan or a Component Plan) to interpret the Plan and to decide all matters arising thereunder, including the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Administrator or PEBP in respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator has the following powers and duties:

(a) To require any person to furnish such information, including, but not limited to, the execution of any agreements, as the Administrator may request for the purpose of

the proper administration of the Plan as a condition to receiving any Benefits under the Plan;

(b) To make and enforce such rules and regulations and prescribe the use of such forms as the Administrator deems necessary for the efficient administration of the Plan;

(c) To decide on questions concerning the Plan and the eligibility of any Participant to participate in the Plan, in accordance with the provisions of the Plan; and

(d) To determine the amount of Benefits which shall be payable to any person in accordance with the provisions of the Plan, to inform PEBP of the amount of such Benefits and to provide a full and fair review to any Participant whose claim for Benefits has been denied in whole or in part.

In carrying out its duties herein, the Administrator shall have discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it, and its determinations shall be given deference and shall be final and binding on all interested parties.

Benefits under the Plan will be paid only if the Administrator decides in its discretion that the applicant is entitled to them. Because of this reservation of discretionary power to Plan fiduciaries, any judicial review of a Plan fiduciary's decision would not be made on a "de novo" basis but would be made under the deferential "arbitrary and "capricious" standard of review.

8.3 DELEGATION AND RELIANCE. The Administrator, subject to approval of PEBP, may employ the services of such firms or persons as it may deem necessary or desirable in connection with the Plan. The Administrator may delegate any of its powers or duties to another person or persons. Without limiting the generality of the preceding sentence, the Administrator shall specifically have the power to delegate to any Insurer the power and responsibility to determine claims and benefits under any policy issued by such Insurer, and the Administrator shall be protected in relying upon such Insurer's determinations. The Administrator and PEBP (and any person to whom the Administrator may delegate any duty or power in connection with the administration of the Plan) and all persons connected therewith may rely upon all tables, valuations, certificates, reports and opinions furnished by any duly appointed actuary, accountant (including Participants of PEBP who are actuaries or accountants) or legal counsel, or other specialist, and they shall be fully protected in respect to any action taken or permitted in good faith in reliance thereon. All actions so taken or permitted shall be conclusive upon all persons.

8.4 INDEMNIFICATION AND INSURANCE. To the extent permitted by law, neither the Administrator, nor any other person performing duties hereunder, shall incur any liability for any act done, determination made or failure to act, if in good faith, and PEBP shall indemnify the Administrator, its members and such other persons against any and all liability which is incurred as a result of the good faith performance or non-performance of their duties hereunder. Nothing in this Plan shall preclude PEBP from purchasing liability insurance to protect such persons with respect to their duties under this Plan.

8.5 COMPENSATION, EXPENSES AND BOND. Unless otherwise agreed to by PEBP, the Administrator shall serve without compensation for its services as such, but all reasonable expenses incurred in the performance of its duties shall be paid by PEBP. Unless otherwise determined by PEBP or unless required by any federal or state law, the Administrator shall not be required to give any bond or other security in any jurisdiction.

8.6 ADMINISTRATIVE EXPENSES PAID BY EMPLOYER. All administrative expenses incurred in connection with the Plan, including but not limited to administrative expenses and compensation and other expenses and charges of any actuary, counsel, accountant, specialist or other person who shall be employed by the Administrator in connection with the Plan, shall be paid by PEBP or from Participant contributions, as determined by PEBP.

ARTICLE 9: AMENDMENT OR TERMINATION OF PLAN

9.1 AMENDMENT. PEBP reserves the power at any time and from time to time, and retroactively if deemed necessary or appropriate, to modify or amend, in whole or in part, any or all of the provisions of the Plan or the insurance contracts maintained to provide Benefits under the Plan. All amendments to the Plan will be in writing.

Notwithstanding the preceding, to the extent that any amendment affects the Plan's Code §125 cafeteria plan feature, the amendment will be effective no earlier than the date the written amendment is adopted by PEBP, except to the extent an earlier effective date is permitted under applicable guidance from the Internal Revenue Service or the Department of the Treasury. For any amendment that adds a new Component Plan or a new benefit under an existing Component Plan to the Plan, to the extent that the new benefit is made available under the Plan's cafeteria plan feature, the Plan will not pay or reimburse any expenses relating to that benefit, unless the expenses were incurred after the later of the amendment's adoption date or effective date.

9.2 TERMINATION. PEBP reserves the power to discontinue or terminate the Plan at any time. In the event of the dissolution, merger, consolidation, or reorganization of PEBP, the Plan shall terminate unless it is continued by a successor to PEBP.

9.3 REDUCTION OR TERMINATION OF BENEFITS. Participants in the Plan, including future retirees and retirees who have already retired, if any, have no right to Plan Benefits after a Plan termination or a partial Plan termination affecting them, and have no right to Plan Benefits to the extent that they are eliminated or reduced by a Plan amendment, except that such Participants are entitled to Benefits with respect to covered events giving rise to Benefits and occurring before the effective date of the Plan termination or applicable Plan amendment.

9.4 EFFECTIVE DATES. Any such amendment or termination shall be effective at such date as PEBP shall determine.

9.5 PROCEDURE. An amendment or termination under this Article shall be valid only if it is approved by PEBP's Board of Directors at a duly called meeting at which a quorum thereof is present or by written consent of the members of PEBP's Board of Directors executed in accordance with applicable state law. Notwithstanding the preceding, the Board of Directors, in its discretion, may designate an officer of PEBP or other individual to approve an amendment or termination under this Article. If so, an amendment or termination will be valid if it is approved by the authorized designee of the Board in writing, provided the designee is operating within the scope of his or her authority in approving the amendment or termination.

ARTICLE 10: GENERAL PROVISIONS

10.1 NO EMPLOYMENT CONTRACT. Nothing contained in this Plan shall be construed as a contract of employment between PEBP and any Participant, or as a right of any Participant to be continued in the employment of PEBP, or as a limitation of the right of PEBP to discharge any of its Participants with or without cause.

10.2 APPLICABLE LAW. The provisions of the Plan shall be construed, administered, and enforced according to the laws of the State of Nevada. The Plan is not established under and/or subject to the federal law known as the Employee Retirement Income Security Act of 1974, as amended (ERISA).

10.3 NON-ALIENATION PROVISIONS. No Benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No Benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements, or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order (QMCSO) which provides for Plan coverage for an Alternate Recipient the Plan's QMCSO Procedures.

10.4 PAYMENTS TO INCOMPETENTS. If the Administrator knows that any person entitled to payments under the Plan is incompetent by reason of physical or mental disability, age or some other cause, it may cause all payments thereafter becoming due to such person to be made to the person's legal guardian for the person's benefit, without responsibility to follow the application of amounts so paid. Payments made pursuant to this Section shall completely discharge the Administrator and PEBP.

10.5 EFFECT OF MISTAKE. In case of a mistake as to the eligibility or participation of any person in the Plan, or the allocations made to the Benefit Account of any Participant, or Benefits paid or provided for a Participant, Dependent or any other person, the Administrator may, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to the Participant or other person the credits to the account or distributions to which he or she is entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or PEBP from compensation payable by PEBP, to the extent permitted under applicable law.

10.6 INABILITY TO LOCATE RECIPIENT. If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person (including a notice of the payment so due mailed to the last known address of such Participant or other person as shown on the records of PEBP), such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited 18 months after the date such payment first became due or after such period as is provided in the applicable insurance contract.

10.7 PLAN COMMUNICATIONS. All communications in connection with the Plan made by a Participant will become effective only when duly executed on forms provided by and filed with the Administrator.

10.8 SOURCE OF BENEFITS. PEBP (and any insurance contracts purchased or held by PEBP) shall be the sole source of Benefits under the Plan. No Participant or other person shall have any right to, or interest in, any assets of PEBP upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the Benefits payable under the Plan to such Participant or other person.

10.9 INTERPRETATION. This Plan is to be interpreted so as to be consistent in all respects with the requirements of the Code and the laws of the State of Nevada.

10.10 MEDICARE, MEDICAID, AND TRICARE SECONDARY PAYER RULES. The Plan at all times will be operated in accordance with any applicable Medicare and Medicaid secondary payer and non-discrimination rules, including, but not limited to the rules of §1144(a) of the Social Security Act. These rules include, where applicable, but are not necessarily limited to, rules concerning individuals with end stage renal disease, rules concerning active Participants age 65 or over, and rules concerning working disabled individuals. In addition, the Plan at all times will be operated in accordance with any applicable TRICARE secondary payer and non-discrimination rules issued by the Department of Defense.

10.11 HEALTH CARE CONTINUATION COVERAGE RULES. Notwithstanding any provision of the Plan to the contrary, PEBP shall provide Participants and Dependents with all health care continuation coverage rights to which they are entitled under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and any other similar, applicable state law.

10.12 HIPAA RULES. Notwithstanding any provision of the Plan to the contrary, the Plan shall always be administered in accordance with all applicable requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

10.13 STATUTE OF LIMITATIONS. Notwithstanding any otherwise applicable statutory statute of limitations, no legal action may be commenced or maintained to recover benefits under this Plan more than 12 months after the final review decision by the Administrator has been rendered (or deemed rendered).

10.14 COORDINATION OF BENEFITS. The coordination of benefits provisions specified in the Master Plan Document for the PEBP Consumer Driven Health Plan for Medical, Vision, and Prescription Drug benefits, as interpreted by the Administrator in its discretion, shall control coordination of benefits situations involving the Plan and other payers. Notwithstanding any provision of this Plan to the contrary, in any case where a claimant receives benefits under a Component Plan that could have been paid in part under another plan, the Administrator has the right to seek reimbursement from that other plan.

10.15 CLAIMS SUBSTANTIATION REQUIREMENT. All claims for Benefits offered through the Plan's Code §125 cafeteria plan feature must be substantiated by information

provided by an independent third party in accordance with applicable regulations before benefits may be paid. However, the Plan is not responsible for substantiating claims for reimbursement from a Participant's Health Savings Account.

10.16 MENTAL HEALTH PARITY. Notwithstanding any provision of the Plan to the contrary, mental health and substance abuse benefits provided under any Component Plan will comply in all respects with all applicable requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

10.17 GINA. Notwithstanding any provision of the Plan to the contrary, the Plan, including all Component Plans, will comply with the applicable requirements of the Genetic Information Nondiscrimination Act of 2008.

10.18 HEALTH CARE REFORM. Notwithstanding any provision of the Plan to the contrary, the Plan, including all Component Plans, will comply with any applicable requirement of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 beginning on the applicable effective date.

10.19 RESCISSION OF COVERAGE. Notwithstanding any provision of the Plan to the contrary, the Plan may rescind coverage under any Component Plan for any individual (or a Participant or Dependent covered under the same coverage as that individual) who engages in fraud with respect to the Plan, or who makes an intentional misrepresentation of material fact. Except as otherwise prohibited by law, the Plan may rescind coverage under a Component Plan for other reasons in accordance with the terms of the applicable Component Plan.

The Plan will not rescind coverage under any Component Plan that is subject to PPACA, for any individual covered under that Component Plan, unless the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud with respect to the Plan, or unless the individual makes an intentional misrepresentation of material fact. In cases where rescission is permitted, the Plan will provide at least thirty days advance written notice to each Participant or Dependent who would be affected before coverage will be rescinded under this Section. This paragraph is included in the Plan to comply with the requirements of PPACA and applicable regulations, including Treasury Regulations §54.9815-2712T (and any subsequent regulations that amend or replace those regulations) and shall be interpreted to be consistent with such regulations and to permit rescissions to the extent permitted under those regulations.

For purposes of this Section, a rescission is a cancellation or discontinuance of coverage under a Component Plan that has retroactive effect. A cancellation or discontinuance of coverage is not a rescission if (i) it is effective retroactively only to the extent it is attributable to a failure to timely pay required Participant contributions towards the cost of coverage or (ii) the Administrator determines the Plan is not required by law to treat the retroactive termination as a rescission under applicable law.

ARTICLE 11: PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 71

ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.myflfamilies.com/service-programs/access/medicaid.shtml Phone: 1-850-300-4323
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-362-8312
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

LOUISIANA – Medicaid	NEW HAMPSHIRE – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"] Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604 CHIP Website: https://www.nd.gov/dhs/services/medicalserv/chip/ Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669

OREGON – Medicaid	VERMONT– Medicaid
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: https://dss.sd.gov/medicaid/ Phone: 605-773-4678	Website: https://www.dhs.wisconsin.gov/medicaid/index.htmPhone: 1-800-947-3529
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

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

under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.
OMB Control Number 1210-0137 (expires 1/31/2023)