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TRUCKEE MEADOWS WATER AUTHORITY
Section §115 Other Post-Employment Benefit Plan & Trust
Trustee Meeting
AGENDA
Tuesday, November 21, 2017 at 1:30 p.m.
Independence Room
1355 Capital Boulevard, Reno, NV 89502

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1. Roll call*
2. Public comment — limited to no more than three minutes per speaker*
3. Approval of the agenda **(For Possible Action)**
4. Approval of the August 15, 2017 minutes**. (For Possible Action)**
5. Review and approval of Other Post-Employment Benefits Trust benefit calculation for TMWA Retiree(s) –Jessica Atkinson **(For Possible Action)**
6. Review of proposal for Tier 2 calculations going forward – Jessica Atkinson **(For Possible Action)**
7. Presentation of GASB 74 Update –Michele Sullivan
8. Review of Retirement Benefits Investment Fund (RBIF) performance review—Michele Sullivan **(For Possible Action)**
9. Discussion and possible Trustee direction regarding meeting times and dates for 2018 – Jessica Atkinson **(For Possible Action)**
10. Trustee comments and requests for future agenda items*
11. Public comment — limited to no more than three minutes per speaker*
12. Adjournment **(For Possible Action)**

NOTES:
1. The announcement of this meeting has been posted at the following locations: Truckee Meadows Water Authority (1355 Capital Blvd., Reno), Reno City Hall (1 E. First St., Reno), Sparks City Hall (431 Prater Way, Sparks), Sparks Justice Court (1675 E. Prater Way, Sparks), Washoe County Courthouse (75 Court St., Reno), Washoe County Central Library (301 South Center St., Reno), Washoe County Administration (1001 East Ninth St., Reno), and at http://www.tmwa.com.
2. In accordance with NRS 241.020, this agenda closes three working days prior to the meeting. We are pleased to make reasonable accommodations for persons who are disabled and wish to attend meetings. If you require special arrangements for the meeting, please call 834-8002 before the meeting date.
3. The Board may elect to combine agenda items, consider agenda items out of order, remove agenda items, or delay discussion on agenda items. Arrive at the meeting at the posted time to hear item(s) of interest.
4. Asterisks (*) denote non-action items.
5. Public comment is limited to three minutes and is allowed during the public comment periods. The public may sign-up to speak during the public comment period or on a specific agenda item by completing a "Request to Speak" card and submitting it to the clerk. In addition to the public comment periods, the Chairman has the discretion to allow public comment on any agenda item, including any item on which action is to be taken.

Section 115 Post-Retirement Medical Plan & Trust

a single employer plan sponsored by
Truckee Meadows Water Authority

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DRAFT AUGUST 15, 2017 MINUTES

The meeting of the TMWA Section 115 Post-Retirement Medical Plan and Trust (Trust) Trustees was held on Tuesday, August 15, 2017 in the Truckee Meadows Water Authority Independence Room, 1355 Capital Blvd., Reno, Nevada.

Michele Sullivan, Chairman, called the meeting to order at 1:37 p.m.

1. ROLL CALL AND DETERMINATION OF PRESENCE OF A QUORUM.

A quorum was present.

Voting Members Present:	Voting Members Absent:
Michele Sullivan	George Gaynor
Charles Atkinson	
Sandra Tozi	

Members Present	Members Absent:
Rosalinda Rodriguez	Pat Waite
Gus Rossi	Jessica Atkinson

2. PUBLIC COMMENT

There was no public comment.

3. APPROVAL OF THE AGENDA

Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved the agenda.

4. APPROVAL OF THE MAY 16, 2017 MINUTES

Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved the May 16, 2017 meeting minutes.

5. REVIEW OF CURRENT PEBPS SUBSIDY CALCULATIONS AND DISCUSS OPTIONS FOR CALCULATING BENEFITS FOR TIER 2 RETIREES GOING FORWARD.

In the absence of Jessica Atkinson, HR Manager, this item was presented by Rosalinda Rodriguez, HR Coordinator.

Ms. Rodriguez advised that when the trust was originally formed after the Merger in 2015 with Washoe County, they adopted the subsidy calculations being used by the 2015 Public Employees' Benefits Program (PEBP) at the time for Tier 2 retiree's. Since then the PEBP's has changed their subsidy calculations. The new calculations are vastly different then what was originally adopted. Ms. Atkinson wanted the Trustees to consider options going forward, which would be to adopt the 2018 subsidy calculation PEBP's is using, or possibly adopt the current Washoe County Schedule, or if possible, continue with the PEBP's schedule that was adopted at the time of the merger.

Discussion ensued and Trustee's ultimately decided that a proposal should be brought to the next scheduled meeting for review in adopting Washoe County's subsidy schedule. Mr. Rossi advised that the language in the document would need to be revised regardless of what option is selected to use for Tier 2 retiree's. The Washoe County schedule was used for the audit and actuarial evaluation assumptions.

Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved a draft proposal be brought to the next scheduled meeting with adopting the Washoe County's current subsidy schedule.

6. REQUIRED COMMUNICATION FROM EXTERNAL TRUST AUDITORS EIDE BAILLY

This was for informational purposes no motion for approval needed.

7. PRESENTATION OF TRUCKEE MEADOWS WATER AUTHORITY POST-RETIREMENT MEDICAL PLAN AND TRUST'S AUDITED FINANCIAL STATEMENTS FOR THE YEARS ENDED DECEMEBER 31, 2016 AND 2015.

Ms. Sullivan reviewed the Financial statements. The account has increased by $152,000 in the last year. Investment income is $35,000 and former employer contributions were $127,000 in 2016. TMWA funds the Annual Required Contribution (ARC) on a biannual basis, to ensure funds are accumulated on a regular and systematic basis.

Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved the audited Financial Statements for the years ended December 31, 2016 and 2015.

8. PRESENTATION OF GASB 74 UPDATE

Ms. Sullivan advised she wanted to have an update for the Trustee's regarding GASB 74, which defines whether or not the Trust would meet the qualification as a standalone financial statement or whether the Trust's financials would roll up into the parent company's financial statements. Previously, this Trust has functioned as a standalone Trust and has been audited separate from the TMWA financials. At this time, Ms. Sullivan did not have any updates to present as Trust auditors are waiting on guidance from the regulatory body as well as waiting to see what the City of Reno does with their plan as this would likely be the model our auditors would recommend we follow. If it is determined that it should continue to be treated as its own separate plan then it is possible the Annual Required Contribution (ARC) rate could increase. This does not affect any plan member, but would affect the financials for the Trust. This should be clarified and finalized by December, and Ms. Sullivan advised she would present that formally once completed.

9. REVIEW OF RETIREMENT BENEFITS INVESTMENT FUND (RBIF) PERFORMANCE REVIEW

Ms. Sullivan advised the fiscal year to date return on investments is 8.81% and 8.39% over the last five years and based on TMWA's actuarial assumption of 6% return, the Trust investments have been performing better than expected.

Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved RBIF performance review.

10. TRUSTEE COMMENTS AND REQUESTS FOR FUTURE AGENDA ITEMS

GASB 74 update

RBIF investment/return analysis next quarter.

11. PUBLIC COMMENT – LIMITED TO NO MORE THAN THREE MINUTES PER SPEAKER

There was no public comment.

12. ADJOURNMENT

With no further business to discuss, Chairperson Sullivan adjourned the meeting at 2:05 p.m.

Minutes were approved by the Trustees in session on _____.

Respectfully Submitted,

_____
Rosalinda Rodriguez, Recording Secretary

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STAFF REPORT

TO: Trustees of the §115 Other Post Employment Benefits (OPEB) Trust
THRU: Jessica Atkinson, TMWA Human Resources Manager
DATE: November 14, 2017
SUBJECT: **Review and approval of Post-Retirement Medical Trust benefit calculation(s) for TMWA Retiree(s)**

Recommendation

TMWA staff recommends the §115 Trustee's approve the retirement health insurance benefit calculation for the following TMWA retiree(s):

CY2017: Doretta Umscheid

Summary

The Trustees move to approve the benefit calculations, as presented, for retiree(s).

Background

Based on the §115 plan document, TMWA Human Resources has completed the benefit calculation for the declared retiree(s). Please refer to the enclosed benefit calculation worksheet(s) for specific details.

TMWA Human Resources has met to discuss calculation(s) with retiree(s) and provided a copy of the §115 Plan Document. Retiree(s) are aware that these calculation(s) are based off of current plan year (CY17) medical costs. These costs are subject to change (increase or decrease) in accordance with annual open enrollment periods.

Retiree(s) have been made aware that in order to qualify for the Post-Retirement Medical Benefits. They must enroll in and pay the cost of Medicare A and Medicare Part "B" or Medicare Part "C."

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STAFF REPORT

TO: Trustees of the §115 Other Post Employment Benefits Trust
THRU: Jessica Atkinson, TMWA Human Resources Manager
DATE: November 15, 2017
SUBJECT: **Review of proposal for Tier II Subsidy Schedule**

Recommendation

1. Approve the subsidy schedule for §115 tier II retirees under the age of 65 as presented in attachment 3 for fiscal year 2018.
2. Approve Exchange -HRA Table for §115 tier II retirees age 65 and older as presented in attachment 4 for fiscal year 2018.

Summary

Beginning in fiscal year 2016, the Public Employee Benefit Program (PEBP) changed their methodology for determining non-state retiree subsidies. As a result, trustees need to determine the appropriate base subsidy amount to be used in determining the total allowable subsidy for §115 tier II retirees under age 65 and approve the subsidy schedule for the current fiscal year.

The PEBP has continued to publish a Medicare Exchange HRA Contribution Table. Trustees should review and approve the contribution table for the current fiscal year.

Background

By way of background, the 2003 Nevada Legislature passed legislation (AB286) that afforded public employees of Nevada political subdivisions the opportunity to enroll, upon their retirement, in the Public Employee Benefit Program (PEBP) retiree health plan. The 2003 legislation also obligated the public employers of said retirees who enrolled in the plan to pay a portion of the medical premium on the retiree's behalf (the "Subsidy"). The current §115 trust document provides tier II retirees under age 65 with an amount equal to the "Subsidy" for non-state retirees to be applied towards their coverage under TMWA's benefit plans rather than the PEBP Retiree Health Plan.

Instead of receiving the "Subsidy," tier II retires age 65 and older, receive the equivalent of the State of Nevada's Medicare Exchange Retiree HRA contribution based upon the combined number of years of service with Washoe County and/or TMWA and must elect Medicare coverage.

The following is noted in the trust document for tier II retirees:

> PEBP non-state retiree subsidy and Medicare Exchange Retiree HRA Contribution subsidy amounts are revised annually by the state of Nevada and in the event that these benefits are discontinued by the State of Nevada, then tier II retirees shall continue to receive the same premium amount that they were entitled to receive during the last year that these benefits remained in effect.

At the time of the merger with Washoe County (FY2015) the Non-State Retiree Subsidy Schedule (attachment 1 page 24) and Medicare Exchange Retire HRA Contribution Table (attachment 1 page 25) were in place and provided for a straight subsidy or contribution amount based solely on years of service.

At the beginning of fiscal 2016 and continuing to current, the PEBP changed the way subsidies were calculated. Since FY2016 there is no longer a straight subsidy schedule based on years of service for those under age 65. Instead, the PEBP has implemented a Non-State Retiree Subsidy Adjustment Table (attachment 2 page 2). To calculate the subsidy using the adjustment table, a base subsidy amount is identified according to enrollment in either the Statewide PPO Consumer Driven Health Plan, Standard HMO Plan or the Alternate HMO Plan. After determining the appropriate base subsidy amount, an adjustment is then made using the adjustment table based on years of service (base subsidy – adjustment = total subsidy.)

The impact of the change from the subsidy schedule to the subsidy adjustment table is such that a straight subsidy amount can no longer be calculated using years of service as the only factor for consideration. §115 retirees don't enroll in any of the plans offered by the PEBP, which makes it difficult to immediately determine the appropriate base subsidy amount to apply the adjustment table to. Because of this, and to ensure §115 tier II retirees under age 65 receive the maximum subsidy available, it is recommended that the trust recognize the highest base subsidy amount for retiree only coverage (FY18 $404.76 for the Standard HMO Plan) as the amount that the adjustment table will be applied to. The total subsidy schedule based on years of service using a base subsidy of $404.76 is included as attachment 3 and it is recommended that trustees approve this subsidy schedule for §115 Tier II retirees under the age of 65 for fiscal year 2018.

For §115 tier II retirees age 65 and older, the PEBP has continued to publish annually an Medicare Exchange – HRA Contribution Table. The FY2018 Exchange – HRA Contribution Table is included as attachment 4 and it is recommended that trustees approve this subsidy schedule for §115 tier II retirees age of 65 and older for fiscal year 2018.

As it is anticipated that tier II retirees will begin receiving trust benefits within the next year and because the amounts are anticipated to change each fiscal year for both the "Subsidy" schedule and HRA Contribution table, a presentation of this information will be made to trustees each fiscal year for their adoption/approval.

Plan Year 2015 Open Enrollment

***P**ublic*
***E**mployees'*
***B**enefits*
***P**rogram*

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM
PEBP
Health Matters.

Take time to:

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

Making changes? Don't wait—Open Enrollment ends May 31, 2014

Public Employees' Benefits Program
901 S. Stewart St., Suite 1001
Carson City, NV 89701
(775) 684-7000 . (800) 326-5496 . Fax: (775) 684-7028
www.pebp.state.nv.us
mservices@peb.state.nv.us
Twitter.com/NVPEBP

Effective July 1, 2014 - June 30, 2015

Plan Year 2015 Open Enrollment

Welcome to the Public Employees' Benefits Program Open Enrollment for Plan Year 2015. Open Enrollment gives you the opportunity to review your benefit options and make changes to your coverage based on your current needs. **Please read this document carefully to ensure you are choosing the option to meet your health care needs.**

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Revised 03/17/2014

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

Approved 4.11.14

Introduction to Open Enrollment

To begin the enrollment process, first review your personal coverage letter that you received in the mail. Next, review this guide carefully.

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

- ☐ Change your current plan election (e.g., CDHP to/from HMO)
- ☐ Add or delete your dependent(s)
- ☐ Decline coverage
- ☐ Enroll in a voluntary product (e.g., Flexible Spending, Voluntary Life Insurance, Short-Term Disability Insurance)
- ☐ Enroll in PEBP dental coverage (this option is only available to individuals enrolled in medical coverage through OneExchange)
- ☐ Decline PEBP dental coverage (this option is only available to retirees and their covered dependents enrolled in medical coverage through OneExchange)

You DO NOT need to take further action if you:

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

Open Enrollment is May 1 - May 31, 2014

Plan Year 2015, Effective July 1, 2014 - June 30, 2015

Complete enrollment changes online at www.pebp.state.nv.us (except for retirees enrolled in OneExchange (formerly Extend Health)) or complete the Open Enrollment Form available by request at 775-684-7000, 800-326-5496 or email mservices@peb.state.nv.us.

Elections made during Open Enrollment must be received by the PEBP office by May 31st (or postmarked by May 31st)

Public Employees' Benefits Program
901 South Stewart Street, Suite 1001
Carson City, NV 89701
775-684-7000 or 800-326-5496
Fax: 775-684-7028
www.pebp.state.nv.us
Email: mservices@peb.state.nv.us
Twitter.com/NVPEBP

Allowable Changes

Important
Spouses and domestic partners who are eligible for coverage through their own employer may not be covered as a dependent.

Coverage changes that can be made online:

- ☐ Change health plan options
- ☐ Add or delete a dependent
- ☐ Beneficiary designation(s) for Health Savings Account (HSA)
- ☐ Modify employee annual HSA contribution amount
- ☐ Establish an HSA (if changing coverage from HMO to CDHP effective July 1, 2014)
- ☐ Establish a Health Reimbursement Arrangement (if changing coverage from HMO to the CDHP and the participant is not eligible for the HSA)
- ☐ Update address/contact information

Changes that cannot be made online:

- ☐ Enroll in Flexible Spending (medical and/or dependent care)
- ☐ Enroll in a voluntary product
- ☐ Cancel a voluntary product
- ☐ Initial enrollment in retiree coverage
- ☐ COBRA enrollment
- ☐ Participant name change
- ☐ Coverage changes related to the Medicare Exchange

Your Responsibilities

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

- If you do not make any changes during Open Enrollment, your current coverage will continue after July 1, 2014 and you will be responsible for paying the Plan Year 2015 premium rates for coverage.
- Changes made during open enrollment must be completed online or through the submission of a completed Open Enrollment Form by May 31, 2014.
- To add dependent(s) to your coverage, PEBP must receive the required supporting eligibility documents by June 30, 2014.
- If you experience a change of address, you must submit your new address to PEBP within 30 days of the change.
- If you experience a mid-year qualifying family status change that affects your benefits, you must notify PEBP within 60 days (e.g., birth, divorce, marriage, etc.)
- Declining PEBP medical coverage (CDHP, HMO, and medical coverage through OneExchange) will result in termination of Basic Life, HRA funding, Long Term Disability, Voluntary Life and Short Term Disability insurance (if applicable) and you will not be eligible to enroll in a medical plan until the next Open Enrollment period (unless you have a qualifying family status change). Additionally, if you are retiree, you may permanently lose the option to re-enroll in PEBP.
- It is your responsibility to contact Standard Insurance within 31 days following the date medical coverage ends to learn about your rights to convert or port your Basic Life and Voluntary Life coverage (if applicable).

How to Enroll

Complete your enrollment by doing one of the following:

1. Enroll Online

- Go to www.pebp.state.nv.us and click **e-PEBP Portal**. Follow the instructions to complete your enrollment before May 31, 2014.

2. Complete the Open Enrollment Form

- Open Enrollment Forms may be requested by calling 775-684-7000 or 800-326-5496 or via email to mservices@peb.state.nv.us
- Completed forms must be received in the PEBP office by May 31, 2014 or postmarked by May 31, 2014.

Documentation to Add Dependent(s)

To *add* a spouse or domestic partner, submit a copy of your marriage certificate or a copy of the domestic partner certificate issued from the Nevada Secretary of State's office.

To cover children from birth to age 26, submit a copy of the child's birth certificate. If the dependent is a stepchild or the child of a domestic partner, PEBP will also require a copy of the marriage or domestic partner certificate. Note: Child(ren) under a permanent legal guardianship are eligible for coverage to age 19 or to age 26 if the child meets certain requirements. Refer to the PEBP Master Plan Document for eligibility requirements.

Supporting documents must be received in the PEBP office by June 30, 2014. Documents may be faxed to 775-684-7028. For more information regarding supporting document requirements, please visit www.pebp.state.nv.us or call 775-684-7000, 800-326-5496 or email to mservices@peb.state.nv.us.

Health Savings Account (HSA)

Employees who contribute money to their HSA through automatic payroll deductions will continue with the same contribution amount for Plan Year 2015. Exception: ANY change made to an employee's coverage during Open Enrollment (via online or paper form) will automatically reset the employee's HSA election to zero. However, employees may enter a new HSA election online when submitting the Open Enrollment change.

Note: HSA elections after Open Enrollment must be made through HealthSCOPE Benefits.

Overview of Plan Changes

Plan Year 2015

Consumer Driven Health Plan (CDHP)

- The coinsurance rate on the CDHP will change from the current 75% (Plan) and 25% (participant) to 80% (Plan) and 20% (participant) after the plan year deductible is satisfied.
- The Plan will cover one annual preventive vision screening exam paid at 100% under the wellness benefit.
- The CDHP deductible will be reduced from $1,900 to $1,500 for individual coverage (participant only) and from $3,800 to $3,000 for family coverage (participant plus one or more covered family members).

Dental Plan

- The annual dental maximum per covered member will increase from the current $1,000 to $1,500 per covered member.

Basic Life Insurance

- Increase the Basic Life Insurance for eligible active employees from the current $10,000 to $25,000 and from $5,000 to $12,500 for eligible retirees.

Base Consumer Driven Health Plan HSA and HRA Funding

- Continue base HSA and HRA funding of $700 for primary CDHP participants and $200 for each covered dependent (maximum 3 dependents).

One-Time Supplemental HSA/HRA Contribution For Participants *Consumer Driven Health Plan (CDHP)* Enrolled July 1, 2014	
State Employee/ Retiree	$400 (Employee/Retiree)
	$100 per dependent (maximum 3 dependents)
Non-State Employee	$400 (Employee)
	$100 per dependent (maximum 3 dependents)
Non-State Retiree	$800 (Retiree)
	$200 per dependent (maximum 3 dependents)

Overview of Plan Changes

Plan Year 2015

Lump-Sum Contribution for Retirees Enrolled in a Medical Plan Through OneExchange on July 1, 2014

Retirees with a retirement date before January 1, 1994 will continue to receive the 15-year ($165) base contribution per month. Additionally, these retirees will also receive a *one-time, lump-sum* contribution of $2 per month per year of service ($360 for pre-1994 retires with 15 years of service).

Retirees with a retirement date on or after January 1, 1994 will continue to receive $11 per month per year of service beginning with 5 years ($55) and a maximum of 20 years ($220). Additionally, these retirees will receive a *one-time, lump-sum* contribution equal to $2 per month per year of service beginning with 5 years ($120) and a maximum of 20 years ($480).

Health Plan of Nevada

Plan design changes for HPN include the following:

- Specialist Office Visit copayment will increase from $15 to $25
- Urgent Care copayment will increase from $15 to $30
- Emergency Room copayment will increase from $75 to $150
- Inpatient Hospital Admission copayment will increase from $200 to $300
- *NowClinic Telemedicine Visit: $5 copayment
- *Convenient Care Clinic Visit: $5 copayment

* HPN members can use *NowClinic* to connect with Southwest Medical and *NowClinic* providers via secure webcam, chat, phone or mobile application anytime, 24/7/365. *NowClinic* lets you talk just like you would in an exam room with providers who can diagnose, provide care recommendations and prescribe, if appropriate, for simple care needs such as flu, sinusitis, insomnia, and pink eye. It's the same copay as a convenient care clinic visit, so it's both less expensive and easier than a typical trip to your family doctor.

Hometown Health Plan

Plan design changes for HHP include the following:

- Decrease Inpatient Hospital Admission copayment from $1,500 to $500
- Decrease Out-Patient Surgery Admission copayment from $1,000 to $350

Overview of Plan Changes

Plan Year 2015

Voluntary Life Insurance - Special Enrollment Period: May 1 – 31, 2014

Life and Disability insurance can give you a greater sense of financial security by enabling you to protect your income now and in the future from an unexpected event. Standard Insurance is offering a special enrollment opportunity for Voluntary Life and Voluntary Short Term Disability (STD) insurance to all eligible active participants. Any benefits elected during this enrollment period will take effect July 1, 2014, subject to the active work requirement.

During the enrollment period, you may be able to enroll in or increase your coverage without answering medical questions and in certain cases, the late enrollment penalty will be waived. Full details are available online at www.standard.com/mybenefits/nevada.

You may enroll for Voluntary Life and AD&D insurance up to the Guarantee Issue Amount of $100,000 for yourself without answering medical questions if you meet the following criteria:

- You are an active participant
- You are currently not enrolled or are enrolled for less than $100,000 of coverage
- You have not been previously declined Voluntary Life coverage by Standard Insurance

Voluntary Short-Term Disability Insurance

If you are eligible but not enrolled in Voluntary STD insurance, you may enroll for Option C without answering medical questions and you will not be subject to the late enrollment penalty.

- Option A: 7-day Benefit Waiting Period and a 15% rate reduction vs. 2013
- Option B: 14-day Benefit Waiting Period with the same rates as 2013
- Option C: 30-day Benefit Waiting Period and a 6% rate reduction vs. 2013

Retiree Voluntary Life Insurance

Life Insurance may be elected to a maximum of $50,000. Requests for increases require you to provide evidence of insurability.

→Retirees are not eligible for guarantee issue Voluntary Life Insurance.

→Reinstated retirees are not eligible for Basic or Voluntary Life Insurance.

→Participants who decline PEBP-sponsored coverage (CDHP, HMO, or medical coverage through OneExchange) will lose Basic and Voluntary Life Insurance.

Health Plan Options

Consumer Driven Health Plan (CDHP)

The CDHP is an insurance plan that allows participants to pay for eligible health care expenses with available funds from a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA).

Plan Features	In-Network (participating provider benefit)	Out-of-Network Benefit
Annual Deductible *Copayments for physician's office visits and prescription drug coverage do not apply to this plan.*	$1,500 Individual $3,000 Family[1] • $2,500 Individual Family Member Deductible	$1,500 Individual $3,000 Family[1] • $2,500 Individual Family Member Deductible
Annual Out-of-Pocket Maximum (Participant pays)	$3,900 Individual[2] $7,800 Family[2]	$10,600 Individual[3] $21,200 Family[3]
Includes annual deductible and coinsurance; excludes any charges in excess of Usual and Customary (U&C)[3] charges when accessing services from out-of-network providers.		

Each plan year, before the plan begins to pay benefits, you are responsible for paying your eligible medical and prescription drug expenses up to the plan year deductible. Deductibles accumulate on a plan year basis and reset to zero at the start of each new plan year.

[1] Family Deductible: The $3,000 Family Deductible applies when there are two or more people from the same family unit covered by the plan. The plan operates so that one person in the family unit will never pay more than $2,500 toward the $3,000 Family Deductible. Once the $2,500 Individual Family Member is met, the plan will pay coinsurance for that one person. The balance of the Family Deductible ($500) may be met by any combination of eligible health care expenses from the remaining family members.

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

[3] Services received from out-of-network providers are subject to U&C provisions, meaning charges are subject to the maximum allowance under the plan and covered individuals will be responsible for any amount the providers charge in excess of the maximum allowance. The cost of services received out-of-network do not accumulate toward the in-network deductible or in-network out-of-pocket maximum. The Plan has separate deductibles and out-of-network maximums when using out-of-network providers.

Health Plan Options

Consumer Driven Health Plan (CDHP)

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

Family member #1

Family member #1 incurs $2,600 in eligible in-network medical expenses, of which $2,500 is applied to the *individual in-network deductible* and $2,500 is also applied to the $3,000 family deductible. The Plan pays 80% of the remaining $100 ($100 x 80%=$80). Individual pays $20. Total applied to the family deductible: $2,520

Family member #2

Family member #2 incurs $2,000 in eligible in-network medical expenses: $480 is applied toward the remaining *family in-network deductible*, which satisfies the $3,000 family deductible. The Plan pays 80% of the remaining $1,520 ($1,520 x 80%= $1,216). Participant pays remaining $304 which is applied to the Annual Out-of-Pocket Maximum.

Health Plan of Nevada (HPN) HMO

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

Health Plan Options

Hometown Health Plan (HHP) HMO

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

HMO Reciprocity

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

Summary of Benefits and Coverage Document (SBC)

The SBC provides a summary of the key features of the benefits of each health plan option such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. To view the SBC for the Consumer Driven Health Plan, Hometown Health Plan or Health Plan of Nevada visit www.pebp.state.nv.us or contact PEBP for a hardcopy at 775-684-7000 or 800-326-5496 or by email at mservices@peb.state.nv.us.

Medical Plan Comparison

Benefit Category	Consumer Driven Health Plan Amount You Pay In-Network	Health Plan of Nevada Amount You Pay In-Network	Hometown Health Plan Amount You Pay In-Network
Medical Deductible	$1,500 individual $3,000 family • $2,500 Individual -when two or more family members covered	No deductible	No deductible
Annual Out-of-pocket Maximum	$3,900 person (plan year) $7,800 family (plan year)	$6,800 person (calendar year)	$6,200 person (plan year) $12,400 family (plan year)
Hospital Inpatient	20% coinsurance after deductible	$300 copayment per admission	$500 copayment per admission
Outpatient Same Day Surgery	20% coinsurance after deductible	$50 copayment per admission	$350 copayment per admission
Primary Care Visit	20% coinsurance after deductible	$15 copayment	$25 copayment
Specialist Visit	20% coinsurance after deductible	$25 copayment	$45 copayment
Urgent Care Visit	20% coinsurance after deductible	$30 copayment	$50 copayment
Emergency Room Visit	20% coinsurance after deductible	$150 copayment	$300 copayment
General Laboratory Services	20% coinsurance after deductible	No charge	No charge for outpatient or hospital
Chiropractic Services	20% coinsurance after deductible	$15 copayment	$45 copayment $1,000 plan year max
Wellness/Prevention	No charge for eligible wellness benefits provided in-network	No charge	No charge
Vision Exam*	Covered at 100% (subject to U&C, see below) (one exam per plan year)	$10 copayment every 12 months	$15 copayment every 12 months
Hardware (frames, lenses, contacts)	No benefit	$10 copayment lenses or frames ($100 allowance) or contacts in lieu glasses ($115 allowance)	20% discount off doctor's U&C fee for prescription glasses when a complete pair is purchased. 15% off contact lens fitting

*PEBP does not maintain a network specific to vision care; however, the PPO Network does have a list of some vision providers. Providers selected from the in network provider search will be paid at 100% PPO. Out of network providers will be paid at U&C under Preventive Wellness.

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

Pharmacy Plan Comparison			
Benefit Category	**Consumer Driven Health Plan** Amount You Pay In-Network	**Health Plan of Nevada** Amount You Pay In-Network	**Hometown Health Plan** Amount You Pay In-Network
Plan Deductible	$1,500 individual $3,000 family • $2,500 Individual -when two or more family members covered	No deductible	No deductible
Annual Out-Of-Pocket (OOP) Maximum*	$3,900 person $7,800 family (per plan year)	Contact HPN for pharmacy OOP* maximum	Contact HHP for pharmacy OOP* maximum
Retail Pharmacy - 30 day supply			
Preferred Generic (Tier 1)	20% after deductible	$7 copayment	$7 copayment
Preferred Brand (Tier 2)	20% after deductible	$35 copayment	$40 copayment
Non-Formulary (Tier 3)	100% of contracted price - does not apply to deductible or OOP*	$55 copayment	Greater of $75 copayment per script or 40%
Mail Order - 90 day supply			
Preferred Generic (Tier 1)	20% after deductible	$14 copayment	$14 copayment
Preferred Brand (Tier 2)	20% after deductible	$70 copayment	$80 copayment
Non-formulary (Tier 3)	100% of contracted price - does not apply to deductible or OOP*	Not available through mail order	Greater of $150 copayment per script or 40%
Specialty Medications Mail Order - 30 day supply			
Specialty Medications	20% after deductible - available in 30 day supply only through BriovaRx	Applicable retail pharmacy copayment will apply	30% coinsurance

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

Dental Plan *All PPO and HMO Eligible Participants*		
Benefit Category	**In-Network**	**Out-of-Network**
Individual Plan Year Maximum	$1,500 per person	$1,500 per person
Plan Year Deductible (applies to Basic and Major services only)	$100 per person or $300 per family (3 or more)	$100 per person or $300 per family (3 or more)
Preventive Services Four cleanings/plan year, exams, bitewing X-rays (2/plan year) Preventive Services are not subject to the $1,500 Individual Plan Year Maximum	100% of allowable fee schedule, no deductible	80% of the in-network provider fee schedule for the Las Vegas service area. For services received out-of-network outside of Nevada, the plan will reimburse at the U&C
Basic Services Periodontal, fillings, extractions, root canals, full-mouth X-rays	80% of allowable fee schedule, after deductible	50% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the plan will reimburse at the U&C
Major Services Bridges, crowns, dentures, tooth implants	50% of allowable fee schedule, after deductible	50% of the in-network provider fee schedule for the Las Vegas service area. For services received out-of-network outside of Nevada, the plan will reimburse at the U&C

- **Family Deductible: May be met by any combination of eligible dental expenses of three or more members of the same family coverage tier**. No one single family member would be required to contribute more than the equivalent of the individual deductible toward the family deductible. Both in-network and out-of-network deductibles are combined to meet your deductible each plan year.
- **Under no circumstances will the combination of PPO and Non-PPO benefit payments exceed the plan year maximum benefit $1,500.**

HSA Contributions for State and Non-State Employees Enrolled in the Consumer Driven Health Plan July 1, 2014

State and Non-State Employees with Coverage Effective July 1, 2014	Base Contribution	One-time Supplemental Contribution	Total Contribution
Participant Only	$700	$400	$1,100
Per Dependent (maximum 3 dependents)	$200	$100	$300

Calendar Year 2014 Maximum Contribution Allowed by the Internal Revenue Service (IRS)	Individual	Family (two or more family members)
The maximum shown is for eligible HSA individuals with high deductible health coverage through December 31, 2014[1]	$3,300	$6,550[2]

IRS Calendar Year 2014 HSA Contribution Limits

[1]The total calendar year 2014 contributions (combined employee/employer) cannot exceed the limits shown above.

[2]The Family maximum is based on your family as reported to the IRS on your federal tax return and applies regardless of whether two employees are married and eligible for the HSA. For example, if one employee is covering a dependent and the other employee is covered as self-only, the maximum for the entire family is $6,550. The total combined contributions between both employees and PEBP's contribution cannot exceed $6,550.

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

Note: If an employee is covering a dependent and that dependent has other coverage that is not considered a high deductible health plan, the maximum contribution allowed by IRS for the employee is based on an Individual or $3,300.

HRA Contributions for Consumer Driven Health Plan

State and Non-State Employees with Coverage Effective July 1, 2014	Base Contribution	One-time Supplemental Contribution	Total Contribution
Participant Only	$700	$400	$1,100
Per Dependent (maximum 3 dependents)	$200	$100	$300

State Retirees with Coverage Effective July 1, 2014	Base Contribution	One-time Supplemental Contribution	Total Contribution
Participant Only	$700	$400	$1,100
Per Dependent (maximum 3 dependents)	$200	$100	$300

Non-State Retirees with Coverage Effective July 1, 2014	Base Contribution	One-time Supplemental Contribution	Total Contribution
Participant Only	$700	$800	$1,500
Per Dependent (maximum 3 dependents)	$200	$200	$400

Health Savings Account (HSA) and Health Reimbursement Arrangement (HRA)

2014 HSA Limits

The IRS limits how much you can deposit into your HSA each year. The 2014 limits are:

- $3,300 for individual coverage
- $6,550 for family coverage

Are You 55 Years Old or Older?

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

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

HSA Eligibility

- You must be an active employee covered under the CDHP;
- You cannot have other coverage (Medicare, Tricare, Tribal, HMO, etc.) unless the other coverage is also a high deductible health plan;
- You *cannot* be claimed on someone else's tax return (excludes joint returns), or you or your spouse have a Medical FSA that can be used to pay for your medical expenses; and
- You cannot be covered under COBRA.
- You cannot have any Health Care FSA money in your account after June 30, 2014.

How the plans works

Your plan has an annual deductible. The deductible must be paid before your plan will help pay for eligible health care expenses (except eligible benefits for preventive care which are paid 100% when using in-network providers).

The following explains how the plan works before and after you meet your deductible.

1. **Your Deductible - You pay out-of-pocket until you reach the deductible.**
   When you have an eligible expense, like a doctor's visit, the entire cost of the visit will apply to your deductible. You will pay the full cost of your health care expenses until you meet your deductible.

2. **Your coverage - The CDHP pays a percentage of your expenses**
   Once the deductible is reached, the CDHP has coinsurance. With coinsurance, the plan shares the cost of expenses with you. The plan will pay a percentage of each eligible expense, and you will pay the rest. For example, if the plan pays 80% of the cost, you will pay 20%.

3. **Your out-of-pocket maximum - You are protected from major expenses**
   An out-of-pocket maximum protects you from major expenses. The out-of-pocket maximum is the most you will have to pay in the plan year for covered services. The plan will then pay 100 percent of covered expenses for the rest of the plan year. Your deductible and coinsurance will go toward your out-of-pocket maximum.

Health Reimbursement Arrangement (HRA)

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

Basic Life Insurance *All Eligible Primary Retirees and Employees*	
Employee Basic Life Insurance	Employees enrolled in a PEBP-sponsored medical plan receive $25,000 Basic Life Insurance coverage. Refer to the Life Insurance Certificate at http://*www*.standard.com/mybenefits/nevada for more information about this benefit or call The Standard at 888-288-1270.
Long-Term Disability for Active Employees	Long Term Disability Insurance is provided to active employees enrolled in a PEBP-sponsored medical plan. This benefit is designed to help protect you against a loss of income in the event you become disabled and are unable to work for an extended period of time. If your LTD claim is approved, benefits become payable at the end of the 180-day Benefit Waiting Period (no benefits are paid during the Benefit Waiting Period). The monthly LTD benefit is based on your earnings from the State of Nevada or participating public agency. Your monthly LTD benefit is 60 percent of the first $12,500 of your monthly earnings, as defined by the group insurance policy, reduced by deductible income. For more information about the LTD benefit, see the LTD Certificate of Insurance at http://www.standard.com/mybenefits/nevada/
Retiree Basic Life Insurance	Retirees enrolled in the CDHP, HMO plan or a qualifying medical plan through OneExchange receive $12,500 Basic Life insurance coverage. Refer to the Life Insurance Certificate at http://*www*.standard.com/mybenefits/nevada for more information about this benefit.
Medex Travel Assist for Active Employees and Retirees enrolled in the CDHP, HMO Plan or a qualifying medical plan through OneExchange.	Medex Travel Assist is designed to respond to most medical care situations and many other emergencies you and your family experience when you travel 100 miles or more from your home. Medex provides a wide-ranging program of information, referral, coordination and assistance services. These services include pre-trip assistance, medical assistance, emergency transportation, travel and technical assistance, legal services and medical supplies. Assistance is available 24 hours a day, 365 days a year whether you are 100 or 10,000 miles away from your home. Simply print out and carry the Medex Travel Assist Card available at http://www.standard.com/mybenefits/nevada/life_add.html#ben

Flexible Spending Account

Health Care and Dependent Care FSA

Available to State Employees Only

Health Care FSA

The Health Care Flexible Spending Account is a tax-free account that allows you to pay for qualified health care expenses that are not covered, or are partially covered, by your medical plan. Health Care FSAs can save you from 25% to 30% on the cost of eligible expenses you are already incurring.

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

For calendar year 2014, the maximum contribution limit for the Health Care FSA is $2,500. Note: This is a per employee limit, not a household limit. If an employee and his or her spouse are also eligible for the Health Care FSA, each individual can establish their own Health Care FSA with a $2,500 Calendar Year maximum.

Limited Purpose FSA

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

Dependent Care FSA

Dependent Care Flexible Spending Accounts create a tax break for dependent care expenses (typically child care or day care expenses) that enable you to work. If you are married, your spouse must be working, looking for work or be a full-time student. If you have a stay-at-home spouse, you should not enroll in the Dependent Care Flexible Spending Account. The IRS allows no more than $5,000 per household ($2,500 if you are married and file a separate tax return) be set-aside in the Dependent Care Flexible Spending Account in a calendar year.

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

You will pay a small fee of $3.25 per month to participant in one or both of the FSAs. To enroll in an FSA, contact HealthSCOPE Benefits to complete your enrollment before May 31, 2013 at 888-763-8232.

Options for Retirees and/or Dependents with Medicare Parts A and B

	Medicare Status (Retiree and/or Dependent)		Enrollment Options
1.	Retiree has Medicare Parts A and B; and no covered dependents	→	Retiree must enroll in a medical plan offered through OneExchange.
2.	Retiree has Medicare Parts A and B; and covers a non-Medicare dependent	→	• Retiree may enroll in a medical plan through OneExchange; and • the non-Medicare dependent(s) may retain the CDHP or HMO coverage; or • Retiree and dependent(s) may retain CDHP or HMO coverage
3.	Retiree and spouse/domestic partner both have Medicare Parts A and B; and no other covered dependents	→	Both must enroll in a medical plan offered through OneExchange
4.	Retiree under age 65 (without Medicare); and covers a spouse/ domestic partner with Medicare Parts A and B	→	• Retiree may retain coverage CDHP or HMO coverage; and • Spouse/domestic partner may enroll in medical coverage through OneExchange; or • Retiree and spouse/domestic partner may retain coverage under the CDHP or HMO plan

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

Note: At age 65, PEBP requires all retirees and their covered dependents to purchase Medicare Part B regardless of their eligibility for premium-free Part A.

State Employee Rates

Effective July 1, 2014 - June 30, 2015

** State ** Employee Rates	Statewide PPO	Statewide HMO
	Consumer Driven Health Plan	**Hometown Health Plan and Health Plan of Nevada**
	Participant Premium	Participant Premium
Employee Only	39.26	158.43
Employee + Spouse	156.45	436.96
Employee + Child(ren)	86.08	287.27
Employee + Family	203.05	565.80

** State Employee ** with Domestic Partner Rates	Statewide PPO		
	Consumer Driven Health Plan		
	Participant Premium	Pre-Tax Deduction	Post-Tax Deduction
Employee + DP	156.45	39.26	117.19
Employee + DP's Child(ren)	86.08	39.26	46.82
Employee + Children of both	86.08	86.08	0.00
Employee + DP + EE's Child(ren)	203.05	86.08	116.97
Employee + DP + DP's Child(ren)	203.05	39.26	163.79
Employee + DP + Children of both	203.05	86.08	116.97

** State Employee ** with Domestic Partner Rates	Statewide HMO		
	Hometown Health Plan and Health Plan of Nevada		
	Participant Premium	Pre-Tax Deduction	Post-Tax Deduction
Employee + DP	436.96	158.43	278.53
Employee + DP's Child(ren)	287.27	158.43	128.84
Employee + Children of both	287.27	287.27	0.00
Employee + DP + EE's Child(ren)	565.80	287.27	278.53
Employee + DP + DP's Child(ren)	565.80	158.43	407.37
Employee + DP + Children of both	565.80	287.27	278.53

State Rates For Employees on Leave without Pay, Military Leave, and State Active Legislators

Effective July 1, 2014 - June 30, 2015

**State Active Legislators, Employees on Leave Without Pay, and Military Leave **	Statewide PPO	Statewide HMO
	Consumer Driven Health Plan	**Hometown Health Plan and Health Plan of Nevada**
	Participant Premium	Participant Premium
Employee Only	560.80	720.12
Employee + Spouse/DP	994.87	1,383.30
Employee + Child(ren)	734.23	1,026.88
Employee + Family	1,167.46	1,690.06

Legislators, employees on Leave without Pay and Military leave do not receive a subsidy towards their health insurance premium.

**** State ** Retiree**	Statewide PPO	Statewide HMO
	Consumer Driven Health Plan	**Hometown Health Plan and Health Plan of Nevada**
	Participant Premium	Participant Premium
Retiree only	195.81	358.65
Retiree + Spouse	438.89	829.51
Retiree + Child(ren)	289.85	576.45
Retiree + Family	535.54	1,047.30
Surviving/Unsubsidized Dependent	543.91	703.23
Surviving/Unsubsidized Spouse + Child(ren)	711.84	1,009.99

To determine your final premium, turn to page 22.

State Retiree Rates

Effective July 1, 2014 - June 30, 2015

State Retiree with Domestic Partner Rates	Statewide PPO	Statewide HMO
	Consumer Driven Health Plan	**Hometown Health Plan and Health Plan of Nevada**
	Participant Premium	Participant Premium
Retiree + DP	438.89	829.51
Retiree + DP's Child(ren)	289.85	576.45
Retiree + Children of both	289.85	576.45
Retiree + DP + Retiree's Child(ren)	535.54	1,047.30
Retiree + DP + DP's Child(ren)	535.54	1,047.30
Retiree + DP + Children of both	535.54	1,047.30

To determine your final premium, turn to page 22.

State Retirees Without Subsidy

Effective July 1, 2014 - June 30, 2015

State Retirees Without Subsidy Refer to note below	**Statewide PPO**	**Statewide HMO**
	Consumer Driven Health Plan	**Hometown Health Plan and Health Plan of Nevada**
	Participant Premium	**Participant Premium**
Retiree only	543.91	703.23
Retiree + Spouse	977.98	1,366.41
Retiree + Child(ren)	711.84	1,009.99
Retiree + Family	1,150.57	1,673.17
Surviving/Unsubsidized Dependent	543.91	703.23
Surviving/Unsubsidized Spouse + Child (ren)	711.84	1,009.99

Note: State Retirees Without Subsidy Rates apply to retirees with an initial hire date of hire on or after January 1, 2012.

State Retiree Years of Service Subsidy

** State Retiree ** Subsidy For Retirees Enrolled in the **CDHP/HMO** Plan	
YOS	**Subsidy**
5	+346.65
6	+311.98
7	+277.32
8	+242.65
9	+207.99
10	+173.33
11	+138.66
12	+104.00
13	+69.33
14	+34.67
15 (Base)	0.00
16	-34.67
17	-69.33
18	-104.00
19	-138.66
20	-173.33

- For participants who retired before January 1, 1994, the participant premium for the selected plan and tier is shown on page 21.
- For participants who retired *on or after* January 1, 1994, *add or subtract* the appropriate subsidy based on the number of years of service *to or from* the participant premium for the selected plan and tier shown on page 21.
- Those retirees with less than 15 Years of Service, who were hired by their last employer on or after January 1, 2010 and who are not disabled do not receive a Years of Service Subsidy or Base Subsidy.
- Those retirees who were hired on or after January 1, 2012 do not receive a Years of Service Subsidy or Base Subsidy.
- If you are a retiree (or survivor) enrolled in the CDHP or an HMO plan and you pay for Medicare Part B, **deduct $104.90** from your premium cost.

Non-State Employee and Retiree Rates

Effective July 1, 2014 - June 30, 2015

** Non-State ** Employee Rates	Statewide PPO	Statewide HMO
	Consumer Driven PPO High Deductible Health Plan	**Hometown Health Plan and Health Plan of Nevada**
	Participant Premium	Participant Premium
Employee Only	916.05	750.06
Employee + Spouse	1,705.33	1,443.18
Employee + Child(ren)	1,602.37	1,102.14
Employee + Family	2,390.82	1,795.26

** Non-State ** Retiree Rates	Statewide PPO	Statewide HMO
	Consumer Driven Health Plan	**Hometown Health Plan and Health Plan of Nevada**
	Participant Premium	Participant Premium
Retiree only	899.16	733.17
Retiree + Spouse/DP	1,688.44	1,426.29
Retiree + Child(ren)	1,585.48	1,085.25
Retiree + Family	2,373.93	1,778.37
Surviving/Unsubsidized Dependent	899.16	733.17
Surviving/Unsubsidized Spouse/DP + Child(ren)	1,585.48	1,085.25

To determine your final premium, turn to page 24.

Non-State Retiree Years of Service Subsidy

Non-State Retiree Subsidy For Retirees Enrolled in the CDHP/HMO Plan	
YOS	**Subsidy**
5	-115.55
6	-150.22
7	-184.88
8	-219.55
9	-254.21
10	-288.88
11	-323.54
12	-358.21
13	-392.87
14	-427.54
15 (Base)	-462.20
16	-496.87
17	-531.53
18	-566.20
19	-600.86
20	-635.53

- For participants who retired *before* January 1, 1994, subtract the 15 year (base) subsidy from the participant premium in the selected plan and tier shown on page 23.
- For participants who retired *on or after* January 1, 1994, *subtract* the appropriate subsidy from the participant premium in the selected plan and tier shown on page 23.
- Those retirees with less than 15 Years of Service, who were hired by their last employer *on or after* January 1, 2010, and who are not disabled, do not receive a Years of Service Subsidy or Base Subsidy.
- Employees initially hired on or after January 1, 2012 will not receive the Years of Service subsidy.
- If you are a retiree (or survivor) enrolled in the CDHP or an HMO plan and you pay for Medicare Part B, **deduct $104.90** from your premium cost. Dependents do not qualify for the Part B credit.

Exchange-HRA Years of Service Contribution

Retirees Enrolled in OneExchange

Exchange-HRA Contribution for Medicare Retirees Enrolled in OneExchange	
Years of Service	**Contribution**
5	+55.00
6	+66.00
7	+77.00
8	+88.00
9	+99.00
10	+110.00
11	+121.00
12	+132.00
13	+143.00
14	+154.00
15 (Base)	+165.00
16	+176.00
17	+187.00
18	+198.00
19	+209.00
20	+220.00

- Participants who retired before January 1, 1994 receive the 15-year ($165) base contribution.
- For participants who retired on or after January 1, 1994, the contribution is $11 per month per year of service beginning with 5 years ($55) and a maximum of 20 years ($220).
- Those retirees with less than 15 years of service, who were hired by their last employer *on or after* January 1, 2010, and who are not disabled, do not receive a Years of Service contribution.
- Those retirees who were hired by their last employer on or after January 1, 2012 do not receive a years of service contribution.

Optional PEBP Dental Coverage

Retirees and Covered Dependents Enrolled in OneExchange

** Voluntary PEBP Dental Coverage ** Optional dental coverage for retirees enrolled in an OneExchange Medical Plan		
Voluntary Dental Coverage	**State Retiree Rate**	**Non-State Retiree Rate**
Retiree only	34.51	33.55
Retiree + Spouse/DP	69.03	67.09
Surviving/Unsubsidized Spouse/DP	34.51	33.55
Retirees and their spouses or domestic partners enrolled in a medical plan through OneExchange may enroll or decline PEBP dental coverage during Open Enrollment. To enroll in PEBP dental or to decline PEBP dental coverage, complete the Open Enrollment Form. Retirees and covered dependents electing PEBP dental are responsible for canceling dental coverage through OneExchange (if applicable).		

Unsubsidized Dependent Rates

For Dependents of Retirees Enrolled in OneExchange

Effective July 1, 2014 - June 30, 2015

** STATE ** Unsubsidized Dependent	CDHP	HMO
Spouse/Domestic Partner or Child	543.91	703.23
Child(ren)	711.84	1,009.99
Spouse/DP + Child(ren)	711.84	1,009.99

** NON-STATE ** Unsubsidized Dependent	CDHP	HMO
Spouse/Domestic Partner or Child	899.16	733.17
Children	1,585.48	1,085.25
Spouse/DP + Child(ren)	1,585.48	1,085.25

COBRA Rates

State and Non-State Employee and Retiree

State COBRA	Statewide PPO	Statewide HMO
	Consumer Driven Health Plan	**Hometown Health Plan & Health Plan of Nevada**
****Employee****	**Premium**	**Premium**
Participant	572.02	734.52
Participant + Spouse/DP	1,014.77	1,410.97
Participant + Child(ren)	748.91	1,047.42
Participant + Family	1,190.81	1,723.86
Spouse/DP Only	572.02	734.52
Spouse/DP + Child(ren)	748.91	1,047.42
****Retiree****		
Participant	544.79	717.29
Participant + Spouse/DP	997.54	1,393.74
Participant + Child(ren)	726.08	1,030.19
Participant + Family	1,173.58	1,706.63
Spouse/DP Only	544.79	717.29
Spouse/DP + Child(ren)	726.08	1,030.19
-- COBRA participants do not qualify for Life Insurance and Long-Term Disability. -- Participants on COBRA do not receive a subsidy.		

Non-State COBRA	Statewide PPO	Statewide HMO
	Consumer Driven Health Plan	**Hometown Health Plan & Health Plan of Nevada**
****Employee****	**Premium**	**Premium**
Participant	934.37	765.06
Participant + Spouse/DP	1,739.44	1,472.04
Participant + Child(ren)	1,634.42	1,124.18
Participant + Family	2,438.64	1,831.17
Spouse/DP Only	934.37	765.06
Spouse/DP + Child(ren)	1,634.42	1,124.18
****Retiree****		
Participant	917.14	747.83
Participant + Spouse/DP	1,722.21	1,454.82
Participant + Child(ren)	1,617.19	1,106.96
Participant + Family	2,421.41	1,813.94
Spouse/DP Only	917.14	747.83
Spouse/DP + Child(ren)	1,617.19	1,106.96
-- COBRA participants do not qualify for Life Insurance and Long-Term Disability. -- Participants on COBRA do not receive a subsidy.		

PEBP Important Notices

HIPAA Privacy Practices

The Privacy Rule provides federal protection for personal health information and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other purposes. For more information, please visit the following website: http://www.hhs.gov/ocr/office/index.html

Women's Health and Cancer Rights Act of 1998

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services. This includes all stages of reconstruction and surgery to achieve symmetry between the breasts, prosthesis, and complications resulting from a mastectomy, including lymphedema.

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

- Consumer Driven PPO High Deductible Health Plan: 888-7NEVADA (888-763-8232)
- Health Plan of Nevada: (702) 242-7300 or (800) 777-1840
- Hometown Health Plan: (775) 982-3232 or (800) 336-0123

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). For more information, please visit the following website http://www.dol.gov/index.htm.

Vendor Contact List

CDHP Medical and PPO Dental Claims Administrator • Claim status inquiries • Plan benefit information • HSA/PPO-HRA Administration • Network Providers • ID cards	**HealthSCOPE Benefits** P.O. Box 91603 Lubbock, TX 79490-1603 Customer Service: 888-7NEVADA 888-763-8232 Group Number: NVPEB www.healthscopebenefits.com
In-State PPO Medical Network • Network Providers • Provider directory • Additions/deletions of providers	**PEBP Statewide PPO Network** Administered by Hometown Health Partners and Sierra Healthcare Options Customer Service: (800) 336-0123 www.pebp.state.nv.us
National Provider Network For participants who reside outside Nevada or who reside in Nevada and access healthcare services outside of Nevada	**First Health Network** P.O. Box 91603 Lubbock, TX 79490-1603 Customer Service: 800-226-5116 www.myfirsthealth.com
Dental PPO Network • Statewide dental PPO providers • Dental provider directory	**Diversified Dental Services** Northern Nevada: (866) 270-8326 Southern Nevada: (800) 249-3538
CDHP Pharmacy Plan Administrator • Prescription drug information • Retail network pharmacies • Prior authorization • Non-network retail claims payment • Price and Save Tool • Mail order service and mail order forms Specialty Drug Services: Brioval Rx Diabetic Supplies - Catamaran/Liberty Medical	**Retail Pharmacy Services: Catamaran** (800) 799-1012 www.catamaranrx.com **Walgreens Mail Order Services** 866) 845-3590 **Briova Rx (Specialty pharmacy)** (866) 618-6741 **Diabetic Sense - Liberty Medical** (877) 852-3512
Hometown Health • Pre-certification • Case Management	**Hometown Health** Pre-certification and Customer Service (775) 982-3232 (800) 336-0123 www.apshealthcare.com
U.S. Preventive Medicine • NVision Health & Wellness Program • Diabetes Care Management • Obesity Care Management Program	**U.S. Preventive Medicine (USPM)** **NVision Health & Wellness Program** (877) 800-8144 NVision.PEBP.state.nv.us

Vendor Contact List

Northern HMO Plan • Provider network • Provider directories • Appeals • Benefit Information • Additions/deletions of providers • Pharmacy Benefits	**Hometown Health Plan** Customer Service: (775) 982-3232 or (800) 336-0123 MedImpact Retail Pharmacy (888) 266-7481 Mail Order: Postal Prescription Services (PPS) (800) 552-6694 Costco Mail Order Pharmacy (800) 607-6861 www.pharmacy.costco.com
Southern HMO Plan • Provider network • Provider directories • Benefit Information/Appeals • Additions/deletions of providers	**Health Plan of Nevada** Customer Service: (702) 242-7300 (800) 777-1840 www.stateofnvhpnbenefits.com or www.pebp.state.nv.us
Life and AD&D Insurance • Life insurance benefits information • Claim filing • MEDEX travel assistance • Beneficiary designation forms	**Standard Insurance Company** Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html or www.pebp.state.nv.us
Medicare Exchange Medicare supplemental plan/HRA administrator for retirees	**Towers Watson's OneExchange** Customer Service: (888) 598-7545 www.ExtendHealth.com/PEBP
Life Insurance • Voluntary Life Insurance • Voluntary Short-Term Disability Insurance	**Standard Insurance Company** Customer Service: (888) 288-1270 www.standard.com/mybenefits/nevada/index.html or www.pebp.state.nv.us
Flexible Spending • Medical • Dependent Care	**HealthSCOPE Benefits** Customer Service: (888)763-8232 Fax: (877) 240-0135 P.O. Box 3627 Little Rock, AR 72203 Email: pebphsahra@healthscopebenefits.com www.healthscopebenefits.com
Home and Auto Insurance	**Liberty Mutual** Customer Service: (800) 637-7026 gary.bishop@libertymutual.com

Open Enrollment Webinars and Recorded Plan Component Presentations

Open Enrollment Webinars

To learn about plan changes for Plan Year 2015, attend a live webinar. Registration is required and each session is limited to 1,000 registrants. To register, visit www.pebp.state.nv.us.

Date	Time	Region	Plan Type
May 6, 2014	9:00 am - 10:30 am	Northern Nevada	CDHP and HHP
May 6, 2014	2:30 pm - 4:00 pm	Southern Nevada	CDHP and HPN
May 7, 2014	9:00 am - 10:30 am	Southern Nevada	CDHP and HPN
May 7, 2014	2:30 pm - 4:00 pm	Northern Nevada	CDHP and HHP
May 13, 2014	9:00 am - 10:30 am	Southern Nevada	CDHP and HPN
May 13, 2014	12:00 pm - 1:30 pm	Northern Nevada	CDHP and HHP
May 15, 2014	9:00 am - 10:30 am	Northern Nevada	CDHP and HHP
May 15, 2014	11:00 am - 12:30 pm	Southern Nevada	CDHP and HPN
May 20, 2014	9:00 am - 10:30 am	Southern Nevada	CDHP and HPN
May 20, 2014	12:00 pm - 1:30 pm	Northern Nevada	CDHP and HHP
May 22, 2014	9:00 am - 10:30 am	Northern Nevada	CDHP and HHP
May 22, 2014	12:00 pm - 1:30 pm	Southern Nevada	CDHP and HPN

Recorded Plan Component Presentations

Recorded instructional videos relating to various plan components are also available at www.pebp.state.nv.us.

NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

State and Non-State Retirees– Plan Year 2018 Rates

State and Non-State Retirees	Statewide PPO				Standard HMO Plan				Alternate HMO Plan			
	PPO Consumer Driven High Deductible Health Plan				Hometown Health Plan & Health Plan of Nevada				Hometown Health Plan & Health Plan of Nevada			
	Rate	Base Subsidy	Supp Subsidy	Participant Premium	Rate	Base Subsidy	Supp Subsidy	Participant Premium	Rate	Base Subsidy	Supp Subsidy	Participant Premium
Retiree only	581.78	372.70	-	209.08	802.75	404.76	-	397.99	771.53	391.01	-	380.52
Retiree + Spouse	1,067.37	589.51	-	477.86	1,585.19	642.79	-	942.40	1,483.81	615.29	-	868.52
Retiree + Child(ren)	771.82	459.22	-	312.60	1,175.77	518.24	-	657.53	1,113.90	496.44	-	617.46
Retiree + Family	1,258.81	676.03	-	582.78	1,958.21	756.27	-	1,201.94	1,848.13	720.72	-	1,127.41
Surviving/Unsubsidized Dependent	581.78	-	-	581.78	802.75	-	-	802.75	771.53	-	-	771.53
Surviving/Unsubsidized Spouse + Child(ren)	771.82	-	-	771.82	1,175.77	-	-	1,175.77	1,113.90	-	-	1,113.90

- The State retiree rates listed on this page are subsidized rates for those who retired prior to January 1, 1994
- For those who retired on or after January 1, 1994, refer to the Plan Year 2018 State and Non-State retiree Years of Service Subsidy Table on page 2. Locate your years of service and subtract the corresponding subsidy from the participant premium.
- Those retirees with less than 15 years of service, who were hired by their last employer on or after January 1, 2010 and who are not disabled do not receive a years of service subsidy or base subsidy.
- Those retirees who were hired by their last employer on or after January 1, 2012 do not receive a years of service subsidy or base subsidy.
- For those retirees on the PEBP CHDP or HMO plan who are enrolled in Medicare Part B, subtract an additional $134 from the participant premium.

Plan Year 2018 State and Non-State Retiree Years of Service Subsidy

YOS	State/Non-State
5	+333.77
6	+300.39
7	+267.02
8	+233.64
9	+200.26
10	+166.89
11	+133.51
12	+100.13
13	+66.75
14	+33.38
15	-
16	-33.38
17	-66.75
18	-100.13
19	-133.51
20	-166.89

- For participants who retired before January 1, 1994, subtract the 15 year (base) subsidy from the participant premium in the selected plan and tier.
- For participants who retired on or after January 1, 1994 add or subtract the appropriate subsidy above to the participant premium in the selected plan and tier. Do not add more than the base subsidy in the selected plan and tier.
- Those retirees with less than 15 years of service, who were hired by their last employer on or after January 1, 2010 and who are not disabled do not receive a years of service subsidy or base subsidy.
- Those retirees who were hired by their last employer on or after January 1, 2012 do not receive a years of service subsidy or base subsidy.

State and Non-State Retirees - Plan Year 2018 Rates

Base Subsidy Retiree Only Standard HMO Plan **$ 404.76**

YOS	ADJUSTMENT	TOTAL SUBSIDY
5	$ 333.77	$ 70.99
6	$ 300.39	$ 104.37
7	$ 267.02	$ 137.74
8	$ 233.64	$ 171.12
9	$ 200.26	$ 204.50
10	$ 166.89	$ 237.87
11	$ 133.51	$ 271.25
12	$ 100.13	$ 304.63
13	$ 66.75	$ 338.01
14	$ 33.38	$ 371.38
15	$ -	$ 404.76
16	$ (33.38)	$ 438.14
17	$ (66.75)	$ 471.51
18	$ (100.13)	$ 504.89
19	$ (133.51)	$ 538.27
20	$ (166.89)	$ 571.65

MENU

Exchange HRA Contributions

- - Exchange HRA Contribution

Health Reimbursement Arrangement (HRA)

To help cover the cost of medical expenses, the Exchange Health Reimbursement Arrangement (or Exchange-HRA) is a PEBP-owned account for eligible retirees enrolled in a medical plan through the Medicare Exchange. Eligible retirees receive a monthly contribution to their Exchange-HRA based on their date of hire, date of retirement, and total years of service credit earned with each Nevada public employer.

For detailed information regarding the Exchange HRA, view the Summary Plan Description for Plan Year 2018 Health Reimbursement Arrangement (HRA) Document.

To receive an Exchange-HRA contribution:

An eligible retiree must obtain and maintain medical coverage through the Medicare Exchange (Tricare for Life retirees are not required to enroll in a medical plan; however, they must provide PEBP with a copy of their Tricare for Life and Medicare Parts A and B card).

Retirees can use the Exchange-HRA for reimbursement of qualified health care expenses including premiums for Medicare Part B coverage. Exchange-HRAs may also be used to request reimbursement of qualified health care expenses for eligible tax dependents, such as a spouse.

HRA Contribution:

The monthly tax-exempt contribution for Plan Year 2018 is $12 per month per year of service, beginning with five years ($60) to a maximum of twenty years of service ($240). Individuals who retired before January 1, 1994, will receive a flat $180 per month to the Exchange-HRA.

Dependents do not receive their own Exchange-HRA and no additional funds are contributed for dependents.

Exchange-HRA Contribution for Medicare Retirees Enrolled in the Medicare Exchange

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

- Participants who retired before January 1, 1994 receive the 15- year ($180) base contribution.
- For participants who retired on or after January 1, 1994, the contribution is $12 per month per year of service beginning with 5 years ($60) and a maximum of 20 years ($240).
- Spouses/domestic partners and surviving spouses /domestic partners enrolled in the Medicare Exchange are not eligible for an HRA contribution.
- Those retirees with less than 15 Years of Service, who were hired by their last employer on or after January 1, 2010 and who are not disabled do not receive a Years of Service contribution.
- Those retirees who were hired by their last employer on or after January 1, 2012 do not receive a Years of Service contribution.

Establishing the Exchange-HRA

PEBP will automatically establish the Exchange-HRA once a retiree has enrolled in a medical plan through the Medicare Exchange. Once established, the Medicare Exchange will send the retiree an HRA Welcome Kit with information on how to use the HRA and claim forms.

Examples of Eligible Medical Expenses for Exchange HRA Retirees

- Medical insurance premium
- Dental premium
- Pharmacy plan premium
- Dental expenses (e.g., dentures, crowns, fillings)
- Hearing Aids
- Doctor visit copays, prescription copays
- Prescription eyeglasses/contact lenses

Please refer to IRS Publication 502 for detailed information about Medical and Dental Expenses.

**Note: In the event the retiree dies, the Exchange-HRA account of the eligible retiree is immediately forfeited; provided, however, that his or her estate or representatives may submit claims for eligible medical expenses incurred by the eligible retiree and his or her dependents prior to the eligible retiree's death, as long as such claims are submitted no later than one-hundred eighty (180) days after the eligible retiree's death.

Contact Us

Our first priority is you. We want to be sure the process of securing high-quality health benefits through the State of Nevada is as easy as possible. Need help? Contact us!

CONTACT US

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STAFF REPORT

TO: Trustees of the §115 Other Post Employment Benefits (OPEB) Trust
FROM: Jessica Atkinson**,** TMWA Human Resources Administrator
DATE: 11/21/2017
SUBJECT: **Discussion and direction regarding meeting times and dates for 2018**

Recommendation

TMWA staff recommends that the Board of Trustees provide input on the schedule proposed for the TMWA Other Post-Employment Benefits §115 Trust meetings as well as confirmation of meeting times.

Discussion

The regular schedule for the TMWA Other Post-Employment Benefits §115 Trust meetings has traditionally been quarterly on the third Tuesday of the month beginning in February of each calendar year.

Staff recommends changing the trustee meetings for the two different post-retirement medical benefit trusts to allow for approval and processing of reimbursement requests according to the reimbursement payment schedule.

2018 Trustee Meeting Dates Proposed

Tuesday, January 16	1:30 p.m.
Tuesday, April 17	1:30 p.m.
Tuesday, July 17	1:30 p.m.
Tuesday, October 16	1:30 p.m.