DOUGLAS COUNTY SCHOOL DISTRICT

BENEFIT PLAN DOCUMENT & SUMMARY PLAN DESCRIPTION
OF THE
MEDICAL, PRESCRIPTION, DENTAL AND VISION BENEFITS
RESTATED JANUARY 1, 2025

Contract Administrator:
Hometown Health
10315 Professional Circle
Reno, NV 89521

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DIRECTORY OF SERVICE PROVIDERS

The following providers render services on behalf of the Plan. A Plan participant can contact the appropriate office when he or she has a question or needs help

TYPE OF SERVICE	SERVICE PROVIDER
Contract Administrator / Third Party Administrator **The service provider that handles the processing of your medical claims in accordance with the District's Preferred Provider Organization Plan. You may contact the TPA to obtain additional information about your Plan coverage and claims procedures**	**Hometown Health** **10315 Professional Circle** **Reno, Nevada 89521** **(775) 982-3232** **(800) 336-0123** **www.hometownhealth.com**
Pre-certification /Utilization Management/Case Management **The service provider that provides Pre-Certification and Utilization Management services described under the Plan's Utilization Management Program.**	**Hometown Health Services** **(775) 982-3232** **(800) 336-0123**
Preferred Provider Organization for Medical **The service provider that provides the network of medical Preferred Providers that have agreed to negotiated discounted rates.**	**Hometown Health** **(775) 982-3232** **(800) 336-0123** **www.hometownhealth.com** **click "Provider Directory"**
Preferred Provider Organization for Dental **The service provider that provides the network of dental Preferred Providers that have agreed to negotiated discounted rates.**	**Diversified Dental** **www.ddsppo.com** **Southern Nevada: (702) 869-6200 or** **(800) 249-3538 (toll-free)** **Northern Nevada: (775) 337-1180** **(866) 270-8326 (toll free)**
Prescription Drug Vendor **The service provider that provides a network of participating retail pharmacies to obtain prescription drugs by using your Plan identification card.**	**MaxorPlus** **(800) 687-0707** **www.maxorplus.com**
Telemedicine Service	**Teladoc** **(800) 835-2362** **www.teladoc.com**

Provides access to US board-certified doctors, dermatologist, and therapists by phone or video, 24hrs/day, 365 days/year.	
Vision Service Provider	**Vision Service Plan** **(800) 877-7195** **www.vsp.com**

IMPORTANT INFORMATION

WHOM TO CONTACT FOR ADDITIONAL INFORMATION

A Plan participant can obtain additional information about Plan coverage of a specific drug, treatment, procedure, preventive service, etc. from the office who handles claims on behalf of the Plan, the Contract Administrator. See the first page of the GENERAL PLAN INFORMATION section for the name, address and phone number of the Contract Administrator.

COBRA NOTICE PROCEDURES

In some circumstances, an Employee or a Qualified Beneficiary is the first to know that a COBRA Qualifying Event has occurred (e.g., in the case of a divorce or legal separation, or where a child reaches a maximum age limit and is no longer eligible). In such instances, it is the Employee's or the COBRA Qualified Beneficiary's responsibility to provide notice to the Plan that a COBRA Qualifying Event has occurred.

The procedures for providing notice of a COBRA Qualifying Event are included in the Employer's COBRA notice communication piece that is provided to newly-hired employees. The procedures (current as of the date of this document) are also included herein and are located immediately following the COBRA CONTINUATION COVERAGE section (see COBRA NOTIFICATION PROCEDURES section). Please review that section for additional details or contact the Plan Administrator for the most current notice procedures.

NOTE: It is important that the Plan Administrator be kept informed of the current addresses of all Plan participants or beneficiaries who are or may become Qualified Beneficiaries.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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 to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean delivery. 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).

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under Federal law, group health plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending physician and the patient: (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce symmetrical appearance, (3) breast prostheses, and (4) physical complications of all stages of mastectomy, including lymphedemas.

Plan participants must be notified, upon enrollment and annually thereafter, of the availability of benefits required due to the Women's Health and Cancer Rights Act (WHCRA).

DEFINITIONS

Some of the terms used in this document begin with a capital letter. These terms have special meanings and are included in the DEFINITIONS section. When reading this document, it will be helpful to refer to that section. Becoming familiar with the terms defined therein will provide a better understanding of the benefits and provisions.

GENETIC INFORMATION AND NON-DISCRIMINATION ACT

GINA (Genetic Information and Non-Discrimination Act, effective 1/1/2010) prohibits group health plans from collecting genetic information and discriminating in enrollment and cost of coverage based on an individual's genetic information – which includes family medical information.

MENTAL HEALTH PARITY

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Sponsor.

NON-GRANDFATHERED PLAN

The Plan Sponsor believes that this Plan is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act).

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Douglas County School District, the Plan Sponsor, at 775-782-7177. The Plan participant may also contact the Employee Benefits Security administration U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa.

UTILIZATION MANAGEMENT PROGRAM

The Plan includes a Utilization Management Program as described below. The purpose of the program is to encourage Covered Persons to obtain quality medical care while utilizing the most cost-efficient sources.

The Plan Administrator may require utilization management review to determine medical necessity of the services by a non-PPO provider.

The Plan Sponsor has contracted with an independent organization to provide pre-service review. The phone number of the organization is (800) 336-0123. The name and phone number of the organization is also shown on the Employee's coverage identification card.

HOSPITAL & OUTPATIENT SURGERY PRE-SERVICE REVIEW REQUIREMENTS

Compliance Procedures
Except as noted, at least 48 hours prior to any non-emergency admission to a hospital or Skilled Nursing Facility, Covered Person or someone acting on his behalf must contact the Utilization Management Organization for pre- service review. For an emergency admission, the Utilization Management Organization must be contacted within two
(2) working days of the first business day after admission.

For a proposed admission for surgery, or a surgery to be performed on an Outpatient basis when performed in a free- standing Ambulatory Surgical Center or when done in a hospital facility, the Utilization Management Organization may require that a Second (& 3rd) Surgical Opinion be obtained.
If, in the opinion of the patient's Physician, it is necessary for the patient to receive additional services or to be confined for a longer time than initially authorized, the Physician may request that additional days or services be authorized by contacting the Utilization Management Organization no later than the last authorized day.

NOTE: Pre-service review will not be required for an Inpatient admission for Pregnancy delivery that does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. However, if/when the Pregnancy confinement for the mother or newborn is expected to exceed these limits, prior authorization for such extended confinement is required.

Penalty for Non-Compliance
If the above pre-service review requirements are not completed or if a surgical opinion is required but not obtained, all facility (e.g., Hospital or Skilled Nursing Facility) expenses will be reduced by 50% before Plan benefits are determined.

Any additional share of expenses that becomes Covered Person's responsibility for failure to comply with these requirements will not be considered eligible medical expenses and thus will not apply to any deductibles, coinsurance or out-of-pocket maximums of the Plan.

See Pre-Service Claims in the CLAIMS PROCEDURES section for more information, including information on appealing an adverse decision (e.g., a benefit reduction) under this program.

NOTE: The Plan will not reduce or deny a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the patient (e.g., the patient is unconscious and is in need of immediate care at the time medical treatment is required).

MORE INFORMATION ABOUT PRE-SERVICE REVIEW

It is the Employee's or Covered Person's responsibility to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an Employee should contact the review organization to make certain that the facility or attending Physician has initiated the necessary processes.

Pre-service review and authorization are not a guarantee of coverage. The Utilization Management Program is designed ONLY to determine whether or not a proposed setting and course of treatment is Medically Necessary and appropriate. Benefits under the Plan will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions. Nothing in the Utilization Management Program will increase benefits to cover any confinement or service that is not Medically Necessary or that is otherwise not covered under the Plan.

CASE MANAGEMENT SERVICES

In situations where extensive or ongoing medical care will be needed, the Utilization Management Organization may, with the patient's and Plan Sponsor's consent, provide case management services. Such services may include contacts with the patient, his family, the primary treating Physician, other caregivers and care consultants, and the hospital staff as necessary.

The Utilization Management Organization will evaluate and summarize the patient's continuing medical needs, assess the quality of current treatments, coordinate alternative care when appropriate and approved by the Physician and Plan Sponsor, review the progress of alternative treatment after implementation, and make appropriate recommendations to the Plan Sponsor.

The Plan Sponsor expressly reserves the right to make modifications to Plan benefits on a case-by-case basis to assure that appropriate and cost-effective care can be obtained in accordance with these services.

NOTE: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Also, each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

GENERAL PLAN INFORMATION

Name of Plan	**Douglas County School District**
Plan Sponsor / Plan Administrator	**Douglas County School District**
Mailing Address:	1638 Mono Avenue Minden, NV 89423
Business Services Phone:	(775) 782-5131
Benefits Coordinator Phone:	(775) 782-7177
Participating Employer	**Douglas County School District**
Plan Sponsor ID Number (EIN)	**88-6000034**
Plan Year	**January 1 through December 31**
Plan Benefits Described Herein	**Medical, Prescription, Dental & Vision Benefits**
Contract Administrator	**Hometown Health**
Mailing Address	10315 Professional Circle Reno, NV 89521
Phone	(775) 982-3232 or (800) 336-0123

FUNDING - SOURCES AND USES

Employee & Employer Obligations
Plan benefits described herein are paid from the general assets of the Plan Sponsor. The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed, if any, by each Employee or Plan participant.

COBRA costs are fully the Employee's or Qualified Beneficiary's responsibility and are generally 102% of the full cost of coverage for active (non-COBRA) enrollees, except in special circumstances where a greater cost is allowed by law. See COBRA CONTINUATION COVERAGE section for more information.

For active Employees, the Employee's share of the cost(s) will be deducted on a regular basis from his wages or salary. In other instances, the Employee or Plan participant will be responsible for remitting payment to the Employer in a timely manner as prescribed by the Employer. If Plan benefits are part of an Employer-sponsored cafeteria plan under Section 125 of the Internal Revenue Code, such coverage costs may be deducted on a pre-tax basis.

Taxes
Any premium or other taxes that may be imposed by any state or other taxing authority and that are applicable to the coverages of the Plan will be paid by the Plan Sponsor.

NOTE: To provide benefits, purchase insurance protection, pay administrative expenses and any necessary taxes, the contributions that are paid by Employees will be used first and any remaining Plan obligations will be paid by Employer contributions. Should total Plan liabilities in a Plan Year be less than total Employee contributions, any excess will be applied to reduce total Employee contribution requirements in the subsequent Plan Year or, at Plan Sponsor's discretion, may be used in any other manner that is consistent with applicable law.

ADMINISTRATIVE PROVISIONS

Administration (type of)
The Plan benefits described herein are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator. The Contract Administrator is not an insurance company.

Alternative Care
In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan Sponsor elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to provide benefits thereafter in strict accordance with the provisions of the Benefit Plan Document.

Amendment or Termination of the Plan
Since future conditions affecting the Plan Sponsor or Employer (s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any participant or beneficiary:

- reduce, modify or terminate retiree health care benefits under the Plan, if any;
- alter or postpone the method of payment of any benefit;
- amend any provision of these administrative provisions;
- make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a Plan meeting the requirements of the applicable sections of the Internal Revenue Code or ERISA; and
- terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those benefits to which he has become entitled under the Plan.

NOTE: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's Board of Trustees, or by written amendment that is signed by at least one Fiduciary of the Plan. Employees will be provided with notice of the change within the time allowed by federal law.

Anticipation, Alienation, Sale or Transfer

Except for assignments to providers of service (see CLAIMS PROCEDURES section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any

like or unlike claims.

Clerical Error
Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Discrepancies
In the event that there may be a discrepancy between any documentation provided to Employees and the Benefit Plan Document, the Benefit Plan Document will prevail.

Facility of Payment
Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or

claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Plan.

Fiduciary Responsibility, Authority and Discretion
Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the Reasonable expenses of administering the Plan.

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan participants rights; and to determine all questions of fact and law arising under the Plan.

Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to, provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third-party Reasonable compensation. The Fiduciaries may delegate

to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

Force Majeure
Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

Gender and Number
Except when otherwise indicated by the context, any masculine terminology will include the feminine (and vice versa) and any term in the singular will include the plural (and vice versa).

Illegality of Particular Provision
The illegality of any particular provision of the Benefit Plan Document will not affect the other provisions and the Benefit Plan Document will be construed in all respects as if such invalid provision were omitted.

Indemnification
To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and held harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions
No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Benefit Plan Document.

No legal action may be brought to recover on the Plan: (1) more than three years from the time written proof of loss is required to be given, or (2) until the Plan's mandatory claim appeal(s) are exhausted. See CLAIMS PROCEDURES section for more information.

Loss of Benefits
To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or beneficiary might otherwise reasonably expect the Plan to provide based on the description of benefits:
an employee's cessation of active service for the employer;

- a Plan participant's failure to pay his share of the cost of coverage, if any, in a timely manner;

- a dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces);

- a Plan participant is injured and expenses for treatment may be paid by or recovered from a third party; a claim for benefits is not filed within the time limits of the Plan.

Material Modification
In the case of any modification or change to the Plan that is a Material Modification in covered services or benefits, Plan participants and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days.

Material Modifications are those which would be construed by the average Plan participant as being important reductions in coverage and generally would include any Plan modification or change that: (1) eliminates or reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations, (2) increases premiums, deductibles, coinsurance, copays, or other amounts to be paid by a Plan participant or beneficiary, or (3) establishes new conditions or requirements (e.g., preauthorization requirements) to obtaining services or benefits under the Plan.

Misstatement / Misrepresentation
If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on Covered Person's true status.

If marital status, Dependent status, or age is a factor in determining eligibility or the amount of a benefit, and there has been a misstatement of such status with regard to an individual on an enrollment form or claim’s filing, his eligibility, benefits, or both, will be adjusted to reflect his true status.

A misstatement of marital status, Dependent status, or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

Misuse of Identification Card
If an Employee or covered Dependent permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

Non-Discrimination Due to Health Status
An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A health status-related factor means any of the following:

- a medical condition (whether physical or mental and including conditions arising out of acts of domestic violence)
- claims experience
- receipt of health care
- medical history
- evidence of insurability

- disability
- genetic information

Physical Examination
The Plan Sponsor, at the Plan's expense, will have the right and opportunity to have a Physician of its choice examine Covered Person when and as often as it may reasonably require during the pendency of any claim.

Plan Administrator Discretion & Authority
The Plan Administrator has the exclusive authority, in its sole and absolute discretion, to take any and all actions necessary to or appropriate to interpret the terms of the Plan in order to make all determinations thereupon. The Plan Sponsor shall make determinations regarding coverage and eligibility. The Plan Administrator (or the delegated Contract Administrator acting within the scope of its delegated authority on behalf of the Plan) shall make determinations regarding Plan benefits.

Privacy Rules & Security Standards & Intent to Comply
To the extent required by law, the Plan Sponsor certifies that the Plan will: (1) comply with the Standards for Privacy of Individually Identifiable Health Information (see PRIVACY RULES section) of the Health Insurance Portability and Accountability Act (HIPAA) and (2) comply with HIPAA Security Standards with respect to electronic protected health information.

The Plan, as required by law, will notify Covered Person in the event of breach to unsecured protected health information.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

Purpose of the Plan
The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents.

Reimbursements
Plan's Right to Reimburse Another Party - Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Payment in Error - When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from Covered Person or the provider of service in the event it is determined that such care or services are not covered.

Covered Person (or parent or legal guardian if Covered Person is a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Rights Against the Plan Sponsor or Employer
Neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

The Plan may remove or further modify this provision at the Plan's discretion.

Titles or Headings
Where titles or headings precede explanatory text throughout the Benefit Plan Document, such titles or headings are

intended for reference only. They are not intended and will not be construed to be a substantive part of the Benefit Plan Document and will not affect the validity, construction or effect of the Benefit Plan Document provisions.

Termination for Fraud
An individual's Plan coverage or eligibility for coverage may be terminated if:

- the individual submits any claim that contains false or fraudulent elements under state or federal law;

- a civil or criminal court finds that the individual has submitted claims that contain false or fraudulent elements under state or federal law;

- an individual has submitted a claim that, in good faith judgment and investigation, he knew or should have known, contained false or fraudulent elements under state or federal law.

Type of Plan
This Plan is not a plan of insurance. This Plan is a self-funded nonfederal governmental group health plan that, for the most part, is exempt from the requirements of the Employee Retirement Income Security Act (ERISA). However, governmental plans are not automatically excluded from the following amendments to ERISA: The Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns' and Mothers' Health Protection Act (NMHPA), and the Women's Health and Cancer Rights Act (WHCRA). To be exempt from certain requirements of these laws, the Plan must make an

affirmative written election to be excluded. Such election must be filed with the Centers for Medicare and Medicaid Services (CMS) prior to the beginning of each Plan Year, with notice provided to each Plan participant. Unless such written election is filed and participant notices are made, this Plan intends to fully comply with the above-stated federal laws.

Workers' Compensation

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

DEFINITIONS

When capitalized herein, the following items will have the meanings shown below.

Accidental Injury – Any accidental bodily injury that is caused by external forces under unexpected circumstances and that is not excluded due to being employment-related (see **GENERAL EXCLUSIONS** section). Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Accidental Injury for purposes of benefit determination. Accidental injury shall not include any Sickness.

Affordable Care Act – The comprehensive health care reform law enacted March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is used to refer to the final, amended version of the law.

Ambulatory Surgical Center – Any public or private establishment that:

- complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;
- has an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
- provides continuous Physician services and registered professional nursing services whenever a patient is in the facility; and
- does not provide services or other accommodations for patients to stay overnight.

American Dental Association (ADA) – A nonprofit professional association whose membership is dental professionals in the United States. Its purpose is to assist its members in providing the highest professional and ethical care to the citizens of the United States and to serve as an advocate for the advancement of the profession.

American Hospital Association (AHA) – A national organization that represents and serves individuals, institutions, and organizations that work to improve health services for all people. The AHA publishes several journals and newsletters.

American Medical Association (AMA) – A professional association whose membership is made up of the largest group of physicians and medical students in the United States, including practitioners in all recognized medical specialties, as well as general primary care physicians. The AMA is governed by a board of trustees and house of delegates who represent various state and local medical associations and U.S. government agencies such as the Public Health Service and medical departments of the army, navy, and air force. The AMA maintains directories of all
U.S. licensed physicians (including nonmembers) in the United States, including graduates of foreign medical colleges; researches prescription and Non-Prescription Drugs; advises congressional and state legislators regarding proposed health care laws; and publishes a variety of journals that report on scientific and socioeconomic developments in the field of medicine.

Assignment of Benefits – An arrangement whereby the Plan participant assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Plan participant, and are limited by the terms of this Plan Document. A

provider that accepts this arrangement indicates acceptance of an Assignment of Benefits as consideration in full for services, supplies, and/or treatment rendered.

Autism Spectrum Disorder – Screening for and diagnosis of autism spectrum disorders and applied behavior analysis treatment of autism spectrum disorders under the age of 18 (or if enrolled in high school, until the person reaches the age of 22) and is:

- prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and
- provided for a person diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician,
- psychologist or behavior analyst.

Evidence-based research means research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.

Habilitative or rehabilitative care means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the function of a person.

Licensed assistant behavior analyst means a person who holds current certification or meets the standards to be certified as a board-certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Board of Psychological Examiners and who provides behavioral therapy under the supervision of a licensed behavior analyst or psychologist.

Licensed behavior analyst means a person who holds current certification or meets the standards to be certified as a board-certified behavior analyst or a board-certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and who is licensed as a behavior analyst by the Board of Psychological Examiners.

Prescription care means medication prescribed by a licensed physician and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications.

Psychiatric care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

Psychological care means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

Screening for autism spectrum disorders means Medically Necessary assessments, evaluations or test to screen and diagnose whether a person has an autism spectrum disorder.

Therapeutic care means services provided by licensed or certified speech pathologists, occupational therapists and physical therapists.

Treatment plan means a plan to treat an autism spectrum disorder that is prescribed by a licensed physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst.

NOTE: Nothing in this section shall be construed as requiring an insurer to provide reimbursement to an early intervention agency or school for services delivered through early intervention or school services.
Benefit Plan Document – This document which describes the benefits of the Plan.

Calendar Year – The period of time commencing at 12:01 A.M. on January 1 of each year and ending at 12:01 A.M. on the next succeeding January 1. Each succeeding like period will be considered a new Calendar Year.

CHIP – Refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

CHIPRA – Refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

Claimant – Any Covered Person on whose behalf a claim is submitted for benefits under the Plan.

Clean Claim – Is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, claims under review as Medically Necessary , Usual & Customary, or for Reasonableness, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

Contract Administrator – A company that performs all functions reasonably related to the general management, supervision and administration of the Plan in accordance with the terms and conditions of an administration agreement between the Contract Administrator and the Plan Sponsor.

The Contract Administrator is not a fiduciary of the Plan and does not exercise any discretionary authority with regard to the Plan. The Contract Administrator is not an insurer of Plan benefits, is not responsible for Plan financing, and does not guarantee the availability of benefits under the Plan.

Convalescent Hospital – see Skilled Nursing Facility

Covered Person – A covered Employee or retiree, a covered Dependent, and a Qualified Beneficiary (COBRA).
See **ELIGIBILITY AND EFFECTIVE DATES, EXTENSIONS OF COVERAGE**, and **COBRA CONTINUATION COVERAGE** sections for further information.

NOTE: In enrolling an individual as a Covered Person or in determining or making benefit payments to or on behalf of a Covered Person, the eligibility of the individual for state Medicaid benefits will not be taken into account.

Covered Provider – Any practitioner of the healing arts who:

- is licensed and regulated by a state or federal agency and is acting within the scope of his license; or
- in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association;

and includes, but is not limited to a/an:

Audiologist
Certified or Registered Nurse Midwife
Certified Registered Nurse Anesthetist (CRNA)
Chiropractor (DC)
Dentist (DDS or DMD)
Licensed Clinical Psychologist (PhD)
Licensed Clinical Social Worker (LCSW)
Licensed Practical Nurse (LPN)
Licensed Professional Counselor (LPC)
Licensed Vocational Nurse (LVN)
Nurse Practitioner Occupational Therapist (OTR)
Optometrist (OD)
Physical Therapist (PT or RPT)
Physician- see Physician
Podiatrist or Chiropodist (DPM, DSP, or DSC) Psychiatrist (MD)
Registered Nurse (RN)
Respiratory Therapist
Speech Pathologist

A Covered Provider will also include the following when appropriately-licensed and providing services that are covered by the Plan:

facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, etc.; licensed Outpatient mental health facilities;
freestanding public health facilities;
hemodialysis and Outpatient clinics under the direction of a Physician (MD);
enuresis control centers;
home infusion therapy providers;
durable medical equipment providers;
prosthetists and prosthetist-orthotists;
portable X-ray companies;
independent laboratories and lab technicians;
diagnostic imaging facilities;
blood banks;
speech and hearing centers;
and ambulance companies.

NOTE: A Covered Provider does not include: (1) a Covered Person treating himself or any relative or person who resides in Covered Person's household - see Relative or Resident Care in the **GENERAL EXCLUSIONS** section, or (2) any Physician, nurse or other provider who is an employee of a hospital or other Covered Provider facility and who is paid by the facility for his services.
Dependent – see **ELIGIBILITY AND EFFECTIVE DATES** section

Diagnostic Lab & X-ray, Outpatient – Laboratory, X-ray and other non-surgical services performed to diagnose medical disorders, including scanning and imaging work (e.g., CT scans or MRIs), electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the United States.

Eligible Expense(s) – Expense that is: (1) covered by a specific provision of the Benefit Plan Document and (2) incurred while the person is covered hereunder.

Emergency – see Medical Emergency

Employee – see ELIGIBILITY AND EFFECTIVE DATES section

Employer(s) – The Employer or Employers participating in the Plan as stated in the GENERAL PLAN INFORMATION section.

Essential Health Benefits – Under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental / Investigational Treatment – Expenses for treatments, procedures, devices, or drugs which the Plan determines, in the exercise of its discretion, are experimental, investigational, or done primarily for research. Treatments, procedures, devices, or drugs shall be excluded under this Plan unless:

- approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law; and
- reliable evidence shows that the treatment, procedure, device or drug is not the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses; and
- reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses.

Reliable evidence shall include anything determined to be such by the Plan, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the medical professional community in the United States, including the CMS Medicare Coverage Issues Manual.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental or Investigational.

Fiduciary – Any entity having binding power to make decisions regarding Plan policies, interpretations, practices or procedures.

FMLA – Refers to the Family and Medical Leave Act of 1993, or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

FMLA Leave – A leave of absence, which the Plan Sponsor is required to extend to an Employee under the provisions of the FMLA.

Home Health Care Agency – An agency or organization that:

- is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services;
- has policies established by a professional group associated with the agency or organization that includes at least one registered nurse (RN) to govern the services provided;
- provides for full-time supervision of its services by a Physician or by a registered nurse; maintains a complete medical record on each patient; and
- has a full-time administrator.

In rural areas where there are no agencies that meet the above requirements or areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.

Hospice or Hospice Agency – An entity providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel that includes at least one Physician and one registered nurse, and must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital – An institution that is engaged primarily in providing medical care and treatment of sick and injured persons on an Inpatient basis at the patient's expense and which fully meets these tests:

- it is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations;

- it is approved by Medicare as a Hospital;

- it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians;

- it continuously provides on the premises, 24-hours-a-day nursing services by or under the supervision of registered nurses (RNs); and

- it is operated continuously with organized facilities for operative surgery on the premises.

The definition of Hospital shall be expanded to include:

a facility operating legally as a psychiatric hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates; and

a facility operating primarily for the treatment of substance abuse that meets the following tests:

- maintains permanent and full-time facilities for bed care and full-time confinement of at least fifteen (15) resident patients;
- has a Physician in regular attendance;
- continuously provides 24-hours-a-day nursing service by a registered nurse (RN);
- has a full-time psychiatrist or psychologist on the staff; and

- is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of substance abuse.
-

Incurred – That a covered expense is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, covered expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating the initial step or phase are rendered. More specifically, covered expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Inpatient – A person physically occupying a room and being charged for room and board in a facility (e.g., Hospital or Skilled Nursing Facility) that is covered by the Plan and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises. After twenty-three (23) observation hours, a confinement will be considered an Inpatient confinement.

Intensive Care Unit (ICU), Coronary Care Unit (CCU), Burn Unit, or Intermediate Care Unit – A Hospital area or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician that provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis, and that is separated from the rest of the Hospital's facilities.

Leave of Absence – A leave of absence of an Employee that has been approved by his Participating Employer, as provided for in the Participating Employer's rules, policies, procedures and practices.

Legal Separation – A court decree recognizing that a married couple is living apart and regulating the couple's mutual rights and liabilities. Also called Judicial Separation.

Level I Appeal – An appeal filed in writing by Claimant to the Contract Administrator.

Level II Appeal – If the Level I Appeal is not resolved to the Claimant's satisfaction, Claimant may then file a Level II appeal. The Level II appeal is submitted in writing and reviewed by Hometown Health or a review organization chosen by Hometown Health.

Lifetime – All periods an individual is covered under the Plan, including any prior statements of the Plan. It does not mean a Covered Person's entire lifetime.

Maximum Amount and/or Maximum Allowable Charge – The benefit payable for a specific coverage item or benefit under the Plan, Maximum Allowable Charges(s) may be the lesser of:

- the Usual & Customary amount;
- the allowable charges specified under the terms of the Plan;
- the negotiated rate established in contractual arrangement with a Provider; or the actual billed charges for the covered services.
- The Plan will reimburse the actual charged billed if it is less than the Usual & Customary amount. The Plan has the discretionary authority to decide if a charge is Usual & Customary, Medically Necessary, or a Reasonable service.

The Plan will reimburse the actual charged billed if it is less than the Usual & Customary amount. The Plan has the discretionary authority to decide if a charge is Usual & Customary, Medically Necessary, or a Reasonable service.

The Maximum Allowable Charge may not include any identifiable billing mistakes including, but not limited to, up- coding, duplicate charges, and charges for services not performed.

Medical Emergency – An Accidental Injury or the sudden onset of a medical condition, either of which is of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health or, with respect to a pregnancy, the health of the woman or her unborn child, in serious jeopardy, (2) serious impairment of bodily functions, or (3) serious dysfunction of any bodily organ or part.

Medical Emergency Services – With respect to Medical Emergency:

- a medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency.

- such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Medically Necessary – Means health care services or products that a prudent Physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are:

- provided in accordance with generally accepted standards of medical practice; clinically appropriate with regard to type, frequency, extent, location, and duration;
- not primarily provided for the convenience of the patient, Physician or other Provider of health care; require to improve a specific health condition of a Member or to preserve his existing state of health; the most clinically appropriate level of health care that may be safely provided to the insured; effective as proven by scientific evidence, in materially changing health outcomes;
- not experimental, investigational, or subject to an exclusion under this Policy;
- cost-effective compared to alternative interventions, including not intervention (cost effective is not construed to mean lowest cost); and
- obtained from a Physician and/or licensed, certified or registered Provider.

For purposes of this Benefit Plan Document & Summary Plan Description, the phrase generally accepted standards of medical practice is defined as standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, endorsed through national Physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas with regard to a patient’s condition.

Medical Record Review – The process by which the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing. The Plan Administrator may then determine the Maximum Allowable Charge according to the medical record review and audit results.

Medicare – Health Insurance for the Aged and Disabled as established by Title I of Public Law 89-98 including parts A & B and Title XVIII of the Social Security Act, or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

Mental Health Condition – For Plan purposes, a Mental Health Condition is any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Network – The medical Provider Network the Plan contracts to access discounted fees for service for Participants. The Network Provider will be identified on the Participant's identification card.

Outpatient – Services rendered on other than an Inpatient basis at a hospital or at a covered non-Hospital facility.

Participating Employer – An Employer who is participating in the coverage of the Plan. See **GENERAL PLAN INFORMATION** section for the identity of the Participating Employer(s).

Physician – A Doctor of Medicine, (MD) or Doctor of Osteopathy (DO) who is licensed to practice medicine or osteopathy where the care is provided.

NOTE: The term Physician will not include Covered Person himself, his relatives (see GENERAL EXCLUSIONS section) or interns, residents, fellows or others enrolled in a graduate medical education program.

Plan – The plan of employee welfare benefits provided by the Plan Sponsor. The name of the Plan is shown in the **GENERAL PLAN INFORMATION** section.

Plan Administrator – see Plan Sponsor

Plan Document – A formal written document that describes the Plan, and the rights and responsibilities of the Plan Sponsor with regard to the Plan, including any amendments.

Plan Sponsor – The entity sponsoring this Plan. The Plan Sponsor may also be referred to as the Plan Administrator. See **GENERAL PLAN INFORMATION** section for further information.

Pre-existing Condition – As of 2014 the Affordable Care Act prevents any plan from applying pre-existing condition requirements to any members on the plan.

Pregnancy – pre-natal and post-natal care during pregnancy, childbirth, miscarriage or complications arising there from. See Pregnancy Care in the **ELIGIBLE MEDICAL EXPENSES** section for further information.

Preventive Care – Certain preventive services that are provided in the absence of sickness or injury. When the following covered preventive services are provided by a Network provider, a Covered person will not have to meet a deductible, pay a Co-Pay, or pay a percentage share of the cost. See **MEDICAL**

BENEFIT SUMMARY (for either **PPO** or **HSA OPTION**) sections for benefit levels when Preventive Care services are provided by a non-Network provider.

Covered preventive services include but are not limited to:

Periodic physical examinations, X-rays, laboratory blood tests, and routine immunizations including the following:

- Routine gynecologic examination (one per calendar year), including annual cytology screening test (Pap smear) for women 18 years of age or older, pelvic examination, urinalysis, and breast examination;
- Screening mammograms including an initial baseline mammogram for female Members 35–39 and annually for women 40 years of age or older;
- Well-baby care, including immunizations in accordance with the American Academy of Pediatrics and other federal agencies;

Prostate and colorectal cancer screening in accordance with the guidelines concerning such screening that are published by the American Cancer Society or other guidelines or reports concerning such screening that are published by nationally recognized professional organizations and that include current or prevailing supporting scientific data;
Influenza, pneumovax, haemophilus influenza B, hepatitis A, hepatitis B, hepatitis C, rubella, and tetanus immunizations; and

Hearing and vision screening for children through age 17 to determine the need for hearing and vision correction.

Notwithstanding anything to the contrary in this Benefit Plan Document, Non-Grandfathered Plans will cover the following services without any Member cost-sharing requirements if such services are provided by a Participating Provider:

- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force, provided that, with regard to breast cancer screening, mammography, and prevention, the current recommendations of the United States Preventive Services Task Force (USPSTF) will be the most current other than those issued in or around November 2009;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- With respect to infants, children, and adolescents, evidence-informed Preventive Care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services; and
- With respect to women, such additional Preventive Care and screenings not described under this section as provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the
- U.S. Department of Health and Human Services: well-woman visits, screening for gestational diabetes, human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling and screening for human immune-deficiency virus, contraceptive methods and counseling, breast feeding support, supplies, and counseling, screening and counseling for interpersonal and domestic violence.

Website references:

Regulations: www.healthcare.gov

Overview: https://www.healthcare.gov/coverage/preventive-care-benefits/

U.S. Preventive Services Task Force A & B Recommendations:
https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Vaccines: https://www.cdc.gov/vaccines/index.html

Women's Health & Well-Being www.hrsa.gov/womensguidelines/

Preventive Medications – There will be no co-pay for the following medications recommended by The Preventive Services Task Force (USPSTF) upon the physician's order only at a participating retail or mail order pharmacy.

- Aspirin to prevent cardiovascular diseases (CVD): 45 years and older; quantity limit 1/day; generic only; OTC (requires a prescription).
- Sodium fluoride products (not in combination): 5 years old and younger, whose primary water source is deficient in fluoride; tablet 0.5mg, chewable tablet 0.25mg005mg, solution.
- Folic Acid for all women planning or capable of pregnancy: Age limit 55 years old or younger; (not in combination); 0.4mg and 0.8mg; quantify limit 1/day; OTC (requires a prescription).
- Iron Supplements for asymptomatic children aged 6 to 12 months who are increased risk for iron deficiency anemia: Age limit 0-1 year; prescription or OTC (requires a prescription); iron suspension, ferrous sulfate elixir, syrup and solution.
- Tobacco Cessation – The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products: Annual limit of 2 cycles (12 weeks per cycle); OTC generics only; generic Zyban only; Rx or OTC (requires a prescription); Nicotrol Inhaler and Nasal Spray; Nicotine polacriliex gum or lozenge; Nicotine TD patch 24-hour kits; Bupropion HC1 SR tabs; Varenicline (Chantix) tablets.
- Immunizations: Vaccines: The following vaccines are covered if provided by a Certified Immunizing pharmacist: Influenza, Hepatitis A & B; Human Paillomavirus inactive; Poliovirus; Rubella; Meningococcal, Pneumococcal; Rotavirus, Tetanus Diphtheria, Pertussis and Varcella Zoster. These may be administered or dispensed at the pharmacy, but are part of the preventive services covered in the benefits outlined within document.

Prior to Effective Date or After Termination Date – Dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

Privacy Rules & Security Standards & Intent to Comply – To the extent required by law, the Plan Sponsor certifies that the Plan will: (1) comply with the Standards for Privacy of Individually Identifiable Health Information (see PRIVACY RULES section) of the Health Insurance Portability and Accountability Act (HIPAA) and (2) comply with HIPAA Security Standards with respect to electronic PHI. The Plan, as required by law, will notify Covered Person in the event of breach to unsecured PHI.

Protected Health Information (PHI) – PHI is individually identifiable health information created or received by the Plan that relates to a person's physical or mental health, to the health care of that person, or to the payment for that health care, whether that information is transmitted by electronic media, maintained in any electronic medium, or transmitted or maintained in any other form or medium.

Rehabilitation Center – A facility that is designed to provide therapeutic and restorative services to sick or injured persons and that:

- carries out its stated purpose under all relevant state and local laws; or
- is accredited for its stated purpose by either the JCAHO or the Commission on Accreditation for Rehabilitation Facilities; or
- is approved for its stated purpose by Medicare.

Reasonable and/or Reasonableness – In the Plan Administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating Provider. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator taking into consideration usual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply, industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the services(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and Organizations; and (b) The Food and Drug Administration. To be Reasonable, services(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility acquired conditions deemed reasonably preventable through the use of evidence-based guidelines taking into consideration, but not limited to, CMS guidelines.

The Plan reserves for itself, and parties acting on its behalf, the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

Semi-Private Room Charge – The standard charge by a facility for semi-private room and board accommodations, or the average of such charges where the facility has more than one established level of such charges, or 70% of the facility's average charge for single bed room and board accommodations where the facility does not provide any semi-private accommodations.

Sickness – Bodily illness or disease (other than mental health conditions), congenital abnormalities, birth

defects and premature birth. Also, a condition must be diagnosed by a Physician in order to be considered a Sickness by this Plan.

Skilled Nursing Facility – An institution that:

- is duly licensed as a convalescent hospital, extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with the governing laws and regulations;
- is primarily engaged in providing accommodations and skilled nursing care 24 hours a day for convalescing persons;
- is under the full-time supervision of a Physician or a registered nurse;
- admits patients only upon the recommendation of a Physician, maintains complete medical records, and has available at all times the services of a Physician;
- has established methods and procedures for the dispensing and administering of drugs; has an effective utilization review plan;
- is approved and licensed by Medicare;
- has a written transfer agreement in effect with one or more Hospitals; and
- is not, other than incidentally, a nursing home, a hotel, a school or a similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.
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Substance Abuse – Is physical and/or psychological dependence on drugs, narcotics, alcohol, toxic inhalants, or other addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine.

Urgent Care Facility – A facility that is engaged primarily in providing minor emergency and episodic medical care and that has:

- a board-certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance at all times;
- X-ray and laboratory equipment and a life support system.

An Urgent Care Facility may include a clinic located at, operated in conjunction with, or that is part of a regular Hospital.

Usual & Customary (U & C) – Covered expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same area by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) same geographic locale and/or area shall be defined as a metropolitan area county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services or supplies for which a specific charge is made. To be Usual & Customary, fee(s) must be in compliance with generally accepted billing practices for

unbundling or multiple procedures.

The term Usual refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term Customary refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care of treatment of

the same sex, comparable age and who receive such services or supplies within the same geographic locale. With regard to charges made by a provider of service not participating in the Plan's Network program, Usual & Customary means the Network's negotiated rate, but not to exceed the actual charge or the Usual & Customary charge for non-Network services.

The term Usual & Customary does not necessarily mean the actual charge made or the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual & Customary charge is, for any procedure, services, or supply, and whether a specific procedure, service or supply is Usual & Customary.

Usual & Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions, and/or manufacturer's retail pricing (MRP) for supplies and devices

MEDICAL BENEFIT SUMMARY – PPO OPTION

This schedule applies to those Employees (and their eligible and enrolled Dependents) who are enrolled in the **PPO OPTION**. See Coverage Options in the **ELIGIBILITY AND EFFECTIVE DATES** section for more information.

CHOICE OF PROVIDERS

The Plan Sponsor has contracted with an organization or Network of health care providers. When obtaining health care services, a Covered Person has a choice of using providers who are participating in that Network or any other Covered Providers of his choice (non-network providers).

Network providers have agreed to provide services to Covered Persons at negotiated rates. When a Covered Person uses a Network provider, his out-of-pocket costs may be reduced because he will not be billed for expenses in excess of those rates. The Plan may also include other benefit incentives to encourage Covered Persons to use Network providers whenever possible (see Schedule of Medical Benefits).

If you reside in Nevada, your PPO Network is the Hometown Health Network. If you are traveling outside of Nevada and require emergency care, use a CIGNA Network provider when possible.

If you reside outside of Nevada, your PPO Network is the CIGNA Network.

The Plan Sponsor will automatically provide a Plan participant with information about how he can access a directory of Network Providers for his service area. This information will be provided without charge. The directory will be available in electronic format with the option to download in hardcopy format. An up-to-date directory is available on the Hometown Health website at www.hometownhealth.com. Since certain covered services and supplies may not be available through the Network, a Covered Person should refer to the Network list or directory to determine if any particular specialty is included. See Continuity of Care in the **ADDENDUM FOR NEVADA LAWS** section for more information.

Although there may be circumstances when a Network provider cannot be used, non-network services will be covered at the non-network benefit levels except that, if a Covered Person is unable to use a Network provider because there is no Network specialist of the necessary type within a 100-mile radius of Covered Person's home, then services of a non-network specialist will be covered at the Network benefit levels. Prior authorization for such service must be obtained through the Contract Administrator.

When a PPO cannot be used, non-PPO providers will be paid at the PPO benefit level only when;

While receiving treatment in a PPO facility, a covered member receives ancillary services from a non-PPO in which there is no choice over provider selection (such as a physician, anesthesiologist, or for diagnostic services).

Emergency Medical Care - If a Plan participant requires Emergency care and must use the services of a non-network provider, any such Emergency medical expenses will be paid at the Network benefit level until Medical Management and the attending Physician agree that the Covered Person is medically stable to be transferred to a Network provider of care. If the Covered Person does not transfer to a Network provider of care, benefits for continued use of the non-network provider(s) maybe reduced to the non-network benefit level.

SCHEDULE OF MEDICAL BENEFITS

The percentages shown in the following schedule reflect the amounts the Plan pays of Eligible Expenses after any required Deductible or Co-Pay has been deducted. The percentages apply to Usual &Customary and Reasonable charges. For Network providers, this means that the percentages apply to the negotiated rates. See Usual & Customary and Reasonable in the DEFINITIONS section for more information.

A Co-Pay is an amount Covered Person must pay. Co-Pays are usually paid to the provider at the time of service.

MAXIMUM ANNUAL BENEFIT	unlimited
Total Plan benefits for each Covered Person will not exceed the Maximum Annual Benefit. The Maximum Annual Benefit applies to all periods a person is covered under the Plan. Lesser limits may apply to all or certain periods of Plan coverage, or to certain conditions or types or levels of care. Such limits are also included in this summary.	

CALENDAR YEAR DEDUCTIBLES	**Network**	**Non-Network**
Individual Deductible (waived for Accidental Injury)	$850	$1,700
Family Deductible	$2,550	$5,100

Individual Deductible - The Individual Deductible is an amount a Covered Person must contribute each year toward payment of eligible medical expenses. The deductible usually applies before the Plan begins to provide benefits but is waived for treatment of an Accidental Injury.
Family Deductible - If eligible medical expenses equal to the Family Maximum Deductible are incurred collectively by family members during a Calendar Year and are applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A family includes a covered Employee and his covered Dependents.
The Non-Network Deductible amounts are the maximum Deductibles that will be required. For Network providers, however, only the lesser Deductibles will apply.
Deductible Carry-Over - Eligible Expenses incurred in the last 3 months of a Calendar Year and applied toward that year's Deductible can be carried forward and applied toward the person's Deductible for the next Calendar Year.

Prescription Drug Deductible – There is a separate $75 prescription drug calendar year deductible. See below.

OUT-OF-POCKET MAXIMUMS	**Network**	**Non-Network**
Individual	$5,500	$11,000
Family	$11,000	$22,000

Network Out-of-Pocket Maximums: For Network Eligible Expenses, there are separate Out-of-Pocket Maximums for medical services and prescription drugs.
Individual Out-of-Pocket Maximum - Except as noted, a Covered Person will not be required to pay more than $5,500 in any Calendar Year toward his share of Eligible Expenses for medical services that are not paid by the Plan. Once he has paid this out-of-pocket maximum, his Eligible Expenses for medical services will be paid at 100% for the balance of the Calendar Year. See below for information on the separate Individual Out-of-Pocket Maximum for prescription drugs.
Family Out-of-Pocket Maximum - Except as noted, a covered family (Employee and his Dependents) will not be required to pay more than $11,000 in any Calendar Year toward their Eligible Expense for medical services obligations. Once the family has paid this out-of-pocket maximum, their Eligible Expenses for medical services will be paid at 100% for the balance of the Calendar Year. See below information on the separate Family Out-of-Pocket Maximum for prescription drugs.
Non-Network Out-of-Pocket Maximums: For Non-Network Eligible Expenses, the Out-of-Pocket Maximums are aggregate for medical services and prescription drugs.

Individual Out-of-Pocket Maximum - Except as noted, a Covered Person will not be required to pay more than $11,000 in any Calendar Year toward his share of Eligible Expenses that are not paid by the Plan. Once he has paid this out-of-pocket maximum, his Eligible Expenses will be paid at 100% for the balance of the Calendar Year.
Family Out-of-Pocket Maximum - Except as noted, a covered family (Employee and his Dependents) will not be required to pay more than $22,000 in any Calendar Year toward their Eligible Expense obligations. Once the family has paid this out-of-pocket maximum, their Eligible Expenses will be paid at 100% for the balance of the Calendar Year.

The non-network out-of-pockets are the maximum out-of-pockets that will be required. For Network providers, however, only the lesser maximums will apply.

NOTE: The out-of-pocket maximums do not apply to or include:

- expenses that are not covered or that are in excess of Usual &Customary and Reasonable allowances; or
- expenses that become Covered Person's responsibility for failure to comply with the requirements of the Utilization Management Program.

† Calendar Year Deductible does not apply.

ELIGIBLE MEDICAL EXPENSES	**Network**	**Non-Network**
Allergy Services	75%	55%
Ambulance	75%	75%
Autism Spectrum Disorder Limited to 515 hours per Calendar Year.	75%	55%
Breast Pump (Has to be billed according to the USPSTF to be covered as Preventive)	100%†	55%
Diagnostic Lab & X-ray, Outpatient: Pre-Admission Testing – see NOTE Other Outpatient Diagnostic Services	 100%† 75%	 100%† 55%
NOTE: Pre-admission testing are lab tests and X-rays performed on an Outpatient basis within 7 days before a scheduled Hospital admission, related to the condition requiring admission, and performed in place of tests otherwise performed after admission. The 100% benefit will apply even if tests show that the condition requires medical treatment prior to Hospital admission or that the Hospital admission is not required.		
Durable Medical Equipment	75%	55%
Genetic Testing	75%	55%
Prior Authorization Required		
Home Health Care, per visit	75%	55%
Limited to 100 visits per Calendar Year. Each visit by a nurse or by a therapist and each 4 hours of home health aide services will count as 1 visit.		
Hospice Care	75%	55%
Hospital Services: Emergency Room Inpatient Care, per admission Outpatient Services & Supplies	 75% 75% 75%	 55% 55% 55%
Eligible Expenses for Inpatient room and board are limited to the Semi-Private Room Charge (see **DEFINITIONS** section) or the Usual &Customary and Reasonable charge for necessary confinement to an Intensive Care Unit.		

Mental Health Care:		
Inpatient Care	75%	55%
Outpatient Visits	$20/visit	55%
Partial Hospitalization	75%	55%
Nursing Services, Private-Duty	75%	55%
Outpatient services of a private-duty nurse are limited to 1,000 hours of care per Calendar Year and a maximum Eligible Expense allowance of $22.50 per hour		
Physician Services:		
Inpatient Visits	75%	55%
Primary Care Office Visit	$50/visit	60%
Specialty Care Office Visit	$60/visit	60%
Other Physician Services (surgery, etc.)	$60/visit	55%
Prescription Drugs, Outpatient:		
CALENDAR YEAR DEDUCTIBLES	$75	
OUT-OF-POCKET MAXIMUMS		
Individual	$4,100	
Family	$5,700	

Individual Out-of-Pocket Maximum - Except as noted, a Covered Person will not be required to pay more than $4,100 in any Calendar Year toward his share of Eligible Expenses for prescription drugs that are not paid by the Plan. Once he has paid this out-of-pocket maximum, his Eligible Expenses for prescription drugs will be paid at 100% for the balance of the Calendar Year. See above for information on the separate Individual Out-of-Pocket Maximum for in-Network medical services.

Family Out-of-Pocket Maximum - Except as noted, a covered family (Employee and his Dependents) will not be required to pay more than $5,700 in any Calendar Year toward their Eligible Expenses for prescription drug obligations. Once the family has paid this out-of-pocket maximum, their Eligible Expenses for prescription drugs will be paid at 100% for the balance of the Calendar Year. See above for information on the separate Family Out-of-Pocket Maximum for in-Network medical services.

For non-network medical services and prescription drugs, the Individual and Family out-of-pockets described above are aggregate maximum out-of-pockets and will apply to combined medical services and prescription drug Eligible Expenses.

NOTE: The out-of-pocket maximums do not apply to or include:

- expenses that are not covered or that are in excess of Usual &Customary and Reasonable allowances; or
- expenses that become Covered Person's responsibility for failure to comply with the requirements of the Utilization Management Program.

Retail Feature:	
Preventive Medications	$0 Co-Pay†
Generic Drug	$15 Co-Pay or 20% Co-Pay, whichever is greater†
Preferred Brand-Name Drug	$35 Co-Pay or 20% Co-Pay, whichever is greater
Non-Preferred Brand-Name Drug	$50 Co-Pay or 20% Co-Pay, whichever is greater
Specialty Drug	$55 Co-Pay or 20% Co-Pay, whichever is greater
Mail-Order Option:	
Preventive Medications	$0 Cop-Pay†
Generic Drug	$30 Co-Pay†
Preferred Brand-Name Drug	$70 Co-Pay
Non-Preferred Brand-Name Drug	$100 Co-Pay

Prescription Drug coverage involves a program through an independent vendor. To use the retail feature, a Covered Person takes his drug ID card to a participating pharmacy to fill his prescription order. A prescription can be purchased in up to a 30-day supply or 100-unit dose for the Co-Pays shown.

Preventive Medications - see **DEFINITIONS** section for benefit description.

The program also includes a mail-order option for maintenance (longer-term) drugs only. Mail-order drugs are available in up to a 90-day supply or 300-unit dose for the Co-Pays shown.
If a drug is purchased from a non-participating pharmacy or a participating pharmacy when Covered Person's ID card is not used, the amount payable in excess of the Co-Pay will be the ingredient cost and dispensing fee.
A Covered Person should request a generic drug if one is available and should always ask if the prescribed drug appears on the MaxorPlus Formulary. The formulary may be found by visiting www.maxorplus.com.
A list of covered and excluded drugs is provided elsewhere in this document or is available from the Plan Sponsor.
NOTE: The full terms and conditions of the Prescription Drug program are not described herein but are as determined between the Plan Sponsor and the organization(s) offering the program(s). Further information should be obtained from the Employer's personnel office or the office of the Plan Sponsor.

MaxorPlus Specialty Copay Assistance Program:

1. Maxor Specialty Pharmacy Patient Care Advocates can assist members with enrollment with manufacturer copay assistance programs, call MaxorPlus Specialty Pharmacy at 1-866-629-6779. *Please note that not all specialty medications will have copay assistance available. Those medications that do have assistance available are subject to availability and may be discontinued at any time.

2. Any portion known to have been paid by a secondary payer (i.e., patient assistance, copay cards, or other insurance) will not be considered as true member out-of-pocket and will not apply to deductible and out-of-pocket maximums for prescriptions filled at Maxor Specialty Pharmacy
Manufacturer coupons cannot be used in conjunction of your plan benefits unless prior consent from the Plan Sponsor or as a part of the benefit sanctioned program specific to the Intercept program.

Preventive Care:		
Well Adult and Well Child Care (including physical exams)	100%†	55%, subject to deductible
Preventive Care includes routine well adult and well child care (including physical exams, X-rays, laboratory blood tests and immunizations) and includes, but is not limited to (see DEFINITIONS section for benefit description): Mammogram screening, cytology screening test (Pap smear), colorectal screening, prostate specific antigen (PSA) screen, counseling for sexually transmitted infections (STI) HIV counseling and testing, breastfeeding support, supplies and counseling, screening for interpersonal & domestic violence, contraceptives & counseling for FDA approved in office including injections, implants, and contraceptive devices not covered under pharmacy benefits, screening for gestational diabetes, and high-risk human papillomavirus (HPV) testing in women.		
Second (&3rd) Surgical Opinion (when required for prior authorized by the Utilization Management Program)	100%†	100%†
Skilled Nursing Facility / Rehabilitation Center	75%	55%
Eligible Expenses for room and board are limited to the facility's Semi-Private Room Charge.		
Sleep Studies		

In office	$60/visit	55%
Outpatient	75%	55%
Substance Abuse Care:		
Inpatient Care	75%	55%
Outpatient Visits	$20/visit	55%
Telemedicine (TelaDoc)		
General Medical	$15/visit	55%
Dermatology	$30/visit	55%
Behavioral Health	$20/visit	55%
TMJ / Jaw Joint Treatment	75%	55%
Transplant-Related Expenses	Based on place and type of service	
Benefits for eligible donor-related expenses are limited to $5,000 per Lifetime for all transplants received by a Covered Person.		
Urgent Care Facility, per visit	$50/visit	55%
Wound Care	75%	55%
All Other Eligible Medical Expenses	75%	55%
THIS IS A SUMMARY ONLY. SEE **ELIGIBLE MEDICAL EXPENSES AND MEDICAL LIMITATIONS** AND **EXCLUSIONS** SECTIONS FOR MORE INFORMATION.		
† Calendar Year Deductible does not apply.		

IMPORTANT: CERTAIN SERVICES MAY REQUIRE AUTHORIZATION TO AVOID BENEFIT REDUCTION. SEE **UTILIZATION MANAGEMENT** PROGRAM SECTION**.**

MEDICAL BENEFIT SUMMARY – HSA OPTION

This schedule applies to those Employees (and their eligible and enrolled Dependents) who are enrolled in the **HSA OPTION**. See Coverage Options in the **ELIGIBILITY AND EFFECTIVE DATES** section for more information.

CHOICE OF PROVIDERS

The Plan Sponsor has contracted with an organization or Network of health care providers. When obtaining health care services, a Covered Person has a choice of using providers who are participating in that Network or any other Covered Providers of his choice (non-network providers).

Network providers have agreed to provide services to Covered Persons at negotiated rates. When a Covered Person uses a Network provider his out-of-pocket costs may be reduced because he will not be billed for expenses in excess of those rates. The Plan may also include other benefit incentives to encourage Covered Persons to use Network providers whenever possible - see Schedule of Medical Benefits, below.

The Plan Sponsor will automatically provide a Plan participant with information about how he can access a directory of Network Providers for his service area. This information will be provided without charge. The directory will be available in electronic format with the option to download in hardcopy format. An up-to-date directory is available on the Hometown Health website at www.hometownhealth.com. Since certain covered services and supplies may not be available through the Network, a Covered Person should refer to the Network list or directory to determine if any particular specialty is included. See Continuity of Care in the **ADDENDUM FOR NEVADA LAWS** section for more information.

Although there may be circumstances when a Network provider cannot be used, non-network services will be covered at the non-network benefit levels except that, if a Covered Person is unable to use a Network provider because there is no Network specialist of the necessary type within a 100-mile radius of Covered Person's home, then services of a non-network specialist will be covered at the Network benefit levels. Prior authorization for such service must be obtained through the Contract Administrator.

NOTE: Out-of-area emergency services will be covered at the non-network benefit levels. A Covered Person may need to use the appeal process (see **CLAIMS PROCEDURES** section) for reconsideration of the charges to be paid at the Network benefit levels.

SCHEDULE OF MEDICAL BENEFITS

The percentages shown in the following schedule reflect the amounts the Plan pays of Eligible Expenses after any required Deductible has been deducted. The percentages apply to Usual &Customary and Reasonable charges. For Network providers, this means that the percentages apply to the negotiated rates. See Usual & &Customary and Reasonable in the **DEFINITIONS** section for more information.

MAXIMUM ANNUAL BENEFIT	Unlimited
Total Plan benefits for each Covered Person will not exceed the Maximum Annual benefit. The Maximum Annual benefit applies to all periods a person is covered under the Plan. Lesser limits may apply to all or certain periods of Plan coverage, or to certain conditions or types or levels of care. Such limits are also included in this summary.	

CALENDAR YEAR DEDUCTIBLES		
Individual		$2,275
Family		$4,550
Individual Deductible - The $2,275 Individual Deductible is an amount a Covered Person must contribute each year toward payment of eligible medical expenses. **Family Deductible** - If family coverage is elected, the $4,550 Calendar Year deductible must be met either by a single person or cumulatively by all family members. A family includes a covered Employee and his covered Dependents.		
OUT-OF-POCKET MAXIMUMS		
Individual: Combined Medical & Rx		$6,960
Family: Combined Medical & Rx		$13,920
Individual Out-of-Pocket Maximum - Except as noted, a Covered Person will not be required to pay more than $6,960 in any Calendar Year toward his Deductible obligation and share of Eligible Expenses that are not paid by the Plan. Once he has paid his out-of-pocket maximum, his Eligible Expenses will be paid at 100% for the balance of the Calendar Year. **Family Out-of-Pocket Maximum** - Except as noted, a covered family (Employee and his Dependents) will not be required to pay more than $13,920) in any Calendar Year toward their Deductible requirement and Eligible Expense obligations. Once the family has paid their out-of-pocket maximum, their Eligible Expenses will be paid at 100% for the balance of the Calendar Year. **NOTE: The out-of-pocket maximums do not apply to or include:** - expenses that are not covered or that are in excess of Usual &Customary and Reasonable allowances; - expenses that become Covered Person's responsibility for failure to comply with the requirements of the Utilization Management Program.		
Allergy Services	**80%**	**60%**
Ambulance	80%	80%
Autism Spectrum Disorder Limited to 515 hours per Calendar Year	80%	60%
Breast Pump (Has to be billed according to the USPSTF to be covered as Preventive)	100%†	60%
Diagnostic Lab & X-ray, Outpatient	80%	60%
Durable Medical Equipment	80%	60%
Genetic Testing	80%	60%
Authorization Required		
Home Health Care, per visit	80%	60%
Limited to 100 visits per Calendar Year. Each visit by a nurse or by a therapist and each 4 hours of home health aide services will count as 1 visit.		
Hospice Care	80%	60%
Hospital Services		
Emergency Room	80%	80%
Inpatient Care	80%	60%
Outpatient Services & Supplies	80%	60%
Eligible Expenses for Inpatient room and board are limited to the Semi-Private Room Charge (see **DEFINITIONS** section) or the Usual & &Customary and Reasonable charge for necessary confinement to an Intensive Care Unit.		

Mental Health Care		
Inpatient Care	80%	60%
Partial Hospitalization	80%	60%
Outpatient Visits	80%	60%
Nursing Services, Private-Duty		
Outpatient services of a private-duty nurse are limited to 1,000 hours of care per Calendar Year and a maximum Eligible Expense allowance of $22.50 per hour.		
Physician Services	80%	60%
All Other Services done in office	80%	60%
Prescription Drugs, Outpatient		
Retail & Mail-Order	80%	60%
Preventive Medications – Retail & Mail-Order	100%†	60%
Preventive Medications - see **DEFINITION** section for benefit description. Non-Network Prescription Drug benefits are subject to the calendar year deductible. Prescription Drug coverage involves a program through an independent vendor. To use the retail feature, a Covered Person takes his drug ID card to a participating pharmacy to fill his prescription order. A retail prescription can be purchased in up to a 30-day supply or 100-unit dose. The program also includes a mail-order option for maintenance (longer-term) drugs only. Mail-order drugs are available in up to a 90-day supply or 300-unit dose. If a drug is purchased from a non-participating pharmacy or a participating pharmacy when Covered Person's ID card is not used, the amount payable in excess of the Co-Pay will be the ingredient cost and dispensing fee. A Covered Person should request a generic drug if one is available and should always ask if the prescribed drug appears on the MaxorPlus Formulary. The formulary may be found by visiting www.maxorplus.com. A list of covered and excluded drugs is provided elsewhere in this document or is available from the Plan Sponsor. NOTE: The full terms and conditions of the Prescription Drug program are not described herein but are as determined between the Plan Sponsor and the organization(s) offering the program(s).		
Preventive Care		
Well Adult and Well Child Care (including physical exams)	100%†	60%
Preventive Care includes routine well adult and well child care (including physical exams, X-rays, laboratory blood tests and immunizations) and includes, but is not limited to (see **DEFINITIONS** section for benefit description): Mammogram screening, cytology screening test (Pap smear), colorectal screening, prostate specific antigen (PSA) screen, counseling for sexually transmitted infections (STI) HIV counseling and testing, breastfeeding support, supplies and counseling, screening for interpersonal & domestic violence, contraceptives & counseling for FDA approved in office including injections, implants, and contraceptive devices not covered under pharmacy benefits, screening for gestational diabetes, and high-risk human papillomavirus (HPV) testing in women.		
Second (& 3rd) Surgical Opinion (when required or prior authorized by the Utilization Management Program)	80%	60%
Skilled Nursing Facility / Rehabilitation Center	80%	60%
Eligible Expenses for room and board are limited to the facility's Semi-Private Room Charge.		

Sleep Studies		
In Office	80%	60%
Outpatient	80%	60%
Substance Abuse Care		
Inpatient Care	80%	60%
Outpatient Visit	80%	60%
Telemedicine (TelaDoc)		
General Medical	80%	60%
Dermatology	80%	60%
Behavioral Health	80%	60%
TMJ / Jaw Joint Treatment	80%	60%
Transplant-Related Expenses	Based on Place and Type of Service	
Benefits for eligible donor-related expenses are limited to $5,000 for all transplants of a covered recipient per Lifetime.		
Urgent Care Facility, Per Visit	80%	60%
Wound Care	80%	60%
All Other Eligible Medical Expenses	80%	60%
† Calendar Year Deductible does not apply.		

THIS IS A SUMMARY ONLY. SEE **ELIGIBLE MEDICAL EXPENSES** AND **MEDICAL LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION

ELIGIBLE MEDICAL EXPENSES

This section is a listing of those medical services, supplies and conditions that are covered by the Plan. This section must be read in conjunction with the **MEDICAL BENEFIT SUMMARY** sections (either PPO Option or HSA Option) to understand how Plan benefits are determined (application of Deductible requirements and benefit sharing percentages, etc.). All medical care must be received from or ordered by a Covered Provider.

Except as otherwise noted below or in the **MEDICAL BENEFIT SUMMARY** sections (either PPO Option or HSA Option), eligible medical expenses are the Usual &Customary and Reasonable charges for the items listed below and that are incurred by a Covered Person - subject to the **DEFINITIONS and LIMITATIONS AND EXCLUSIONS** sections and all other provisions of the Plan. In general, services and supplies must be approved by a Physician or other appropriate Covered Provider and must be Medically Necessary for the care and treatment of a covered Sickness, Accidental Injury, Pregnancy or other covered health care condition.

For benefit purposes, medical expenses will be deemed to be incurred on:

- the date a purchase is contracted; or
- the actual date a service is rendered.

Alcoholism – see Substance Abuse Care

Ambulance – Local Medically Necessary professional land or air ambulance service to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided, unless the Plan Sponsor finds a longer trip was Medically Necessary.

Ambulatory Surgical Center – Services and supplies provided by an Ambulatory Surgical Center (see **DEFINITIONS** section) in connection with a covered Outpatient surgery.

Anesthesia – Anesthetics and services of a Physician or certified registered nurse anesthetist (CRNA) for the administration of anesthesia.

Autism Spectrum Disorder – Coverage is provided for Medically Necessary screening for and diagnosis of autism spectrum disorders, and for the Medically Necessary treatment of autism spectrum disorders to individuals under the age of 18 (or under the age of 22), for individuals enrolled in high school).

Autism spectrum disorder means a neurobiological medical condition including, without limitation, autistic disorder, Asperger's Disorder, and Pervasive Developmental Autism Disorder Not Otherwise Specified. Treatment must be identified in a treatment plan prescribed by a licensed Physician, or psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst. Subject to the other requirements of this Plan, treatment may include Medically Necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavior therapy, or therapeutic care that is:

- Prescribed for a person diagnosed with an autism spectrum disorder by a licensed Physician or licensed psychologist; and

- Provided to a person diagnosed with an autism spectrum disorder by a licensed Physician, licensed

psychologist, licensed behavior analyst, licensed assistant behavior analyst, certified autism behavior interventionist or other provider that is supervised by the licensed Physician, psychologist, or behavior analyst.

Coverage is subject to a maximum benefit of $36,000 per calendar or Plan Year for applied behavioral analysis treatment. While PPO's have some services that require prior authorization, not all services do. Services that are delivered subject to this specific benefit for services for Autism Spectrum Disorders do require prior authorization. Coverage is not provided for reimbursements to an early intervention agency or school for services delivered through early intervention or school services.

Blood – Blood and blood derivatives (if not replaced by or for the patient), including blood processing and administration services.

Cardiac Rehabilitation – A monitored exercise program directed at restoring both physiological and psychological well-being to individuals with heart disease.

Services rendered must be:

- under the supervision of a Physician;
- in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery;
- initiated within twelve (12) weeks from when treatment ends for the medical condition;
- and provided in a covered medical care facility as defined by the Plan.

Chemical Dependency – see **Substance Abuse Care**

Chemotherapy – Professional services and supplies related to the administration of chemical agents in the treatment or control of a Sickness.

Chiropractic-type Care – Musculoskeletal manipulation and modalities (hot & cold packs, etc.) provided by a chiropractor (DC) or Physician (MD or DO) to correct vertebral disorders such as incomplete dislocation, off- centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain.

Clinical Trial or Study – see **ADDENDUM FOR NEVADA LAWS** section for coverage information

Contraceptive Services - Physician services and related supplies for the fitting and placement of a intrauterine device. An office visit copayment or coinsurance may apply if services during that visit are for more than the contraceptive visit. There will be no copayment or coinsurance for the contraceptive device(s) if inserted by a participating physician.

Contraceptives such as skin patch, vaginal ring, diaphragm, cervical cap, female condom and spermicidal foam and sponges, with a written prescription from a Physician, can be obtained through the Prescription Drug Program. See **ADDENDUM FOR PRESCRIPTION DRUGS**.

Diabetes Management & Treatment – see **ADDENDUM FOR NEVADA LAWS** section for coverage information.

Diagnostic Lab & X-ray, Outpatient – Laboratory, X-ray and other non-surgical services performed to diagnose medical disorders, including scanning and imaging work (e.g., CT scans or MRIs), electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the United States.

Dialysis Services – Dialysis services and supplies, including the training of a person to assist the patient with home dialysis, when provided by a hospital, freestanding dialysis center or other appropriate Covered Provider.

Durable Medical Equipment – Rental of durable medical equipment (but not to exceed the fair market purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost-effective due to a long-term need for the equipment and is agreed to in advance by the Plan Administrator. Such equipment must be prescribed by a Physician and required for therapeutic use in treatment of an active Sickness or Accidental Injury.

Durable Medical Equipment includes such items as crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen and dialysis equipment, etc., that: (1) can withstand repeated use, (2) are primarily and customarily used to serve a medical purpose, (3) generally are not useful to a person in the absence of Sickness or Accidental Injury, and (4) are appropriate for use in the home.

NOTE: Duplicate equipment or excess charges for deluxe equipment or devices will not be covered.

Formulas & Food Products for Inherited Metabolic Diseases – see **ADDENDUM FOR NEVADA LAWS** for coverage information

Genetic Counseling & Testing - Genetic testing may only be done after consultation with an appropriately certified genetic counselor and/or, as approved by a Physician designated to review the utilization, medical necessity, clinical appropriateness, and quality of such genetic testing based on medical necessity.

Coverage is not available for tests solely for research or for the benefit of individuals not covered under the Policy.
Eligible Medical Expenses include:

A. BRCA 1 and BRCA 2 testing.
B. Genetic disease testing of human DNA, chromosomes, proteins, or other gene products to determine the presence of disease related genotypes, phenotypes, karyotypes, or mutations for clinical purposes. Such purposes include those tests meeting criteria for the medically accepted standard of care for the prediction of disease risk, identification of carriers, monitoring, diagnosis, or prognosis within the confines of the statements in this definition.
C. Explanation by a genetic counselor of medical and scientific information about an inherited condition, birth defect, or other genome-related effects to an individual or family. Genetic counselors are trained to review family histories and medical records, discuss genetic conditions and how they are inherited, explain inheritance patterns, assess risk and review testing options, where available.
D. Genetic counseling in connection with pregnancy management with respect to the following individuals:
    1. Parents of a child born with a genetic disorder;
    2. Birth defect, inborn error of metabolism, or chromosome abnormality;
    3. Parents of a child with mental retardation, autism, Down syndrome, trisomy conditions, or fragile X syndrome;
    4. Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein test, test for sickle cell

anemia, or tests for other genetic abnormalities, have been told their pregnancy may be at increased risk for complications or birth defects;

5. Parents affected with an autosomal dominant disorder who are contemplating pregnancy;
6. Women who are known to be, or who are likely to be, carriers of an X-linked recessive disorder.

Eligible Medical Expenses will include genetic testing of heritable disorders when the following conditions are met:

A. The results will directly impact clinical decision-making and/or clinical outcome for the individual;
B. The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and one of the following conditions is met:
    1. Member demonstrates signs/symptoms of a genetically-linked heritable disease;
    2. Member or fetus has a direct risk factor (e.g., based on family history or pedigree analysis) for the development of a genetically-linked heritable disease

Routine panel screening for preconception genetic diseases, routine chorionic villous sampling, or amniocentesis panel screening testing, and pre-implantation embryonic testing will not be covered unless the testing is endorsed by the American College of Obstetrics and Gynecology or mandated by federal or state law.

Additional genetic testing will be covered per federal or state mandates. Assembly Bill No. 155 update to (NRS 287.010, 287.04335, 422.2717-422.27248, 689A.04033-689A.0465, 689B.0303-689B.0379, 689C.1655-689C.169, 689C.194-689C.195, 689C.425, 695A.184-695A.1875, 695B.1901-695B.1949, 695C.050, 695C.1691-695C.176, 695G.162-695G.177)

Gender Dysphoria and Gender Incongruence(assignment) - Coverage of medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders provided by:

A. Endocrinologists;
B. Pediatric endocrinologists;
C. Social workers;
D. Psychiatrists;
E. Psychologists;
F. Gynecologists;
G. Speech-language pathologists;
H. Primary care physicians;
I. Advanced practice registered nurses;
J. Physician assistants; and
K. Any other providers of medically necessary services for the treatment of gender dysphoria or gender incongruence.

Requirements that must be satisfied before the insurer covers surgical treatment of conditions relating to gender dysphoria or gender incongruence for an insured who is less than 18 years of age. Such requirements may include, without limitation, requirements

A. The treatment must be recommended by a psychologist, psychiatrist or other mental health professional;
B. The treatment must be recommended by a physician;
C. The insured must provide a written expression of the desire of the insured to undergo the treatment;

D. A written plan for treatment that covers at least 1 year must be developed and approved by at least two providers of health care; and
E. Parental consent is provided for the insured unless the insured is expressly authorized by law to consent on his or her own behalf.

Gender reassignment surgery consisting of any combination of the following when the following criteria is met:

Requirement for mastectomy for female-to-male patients:

A. Single letter of referral from a qualified mental health professional; and,
B. Persistent, well-documented gender dysphoria; and,
C. Capacity to make a fully informed decision and to consent for treatment; and,
D. Age of majority in the State of Nevada; and,
E. Significant medical or mental health concerns are reasonably well controlled.

Requirements for gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to-female):

A. Two (2) referral letters from qualified mental health professionals, one in a purely evaluative role; and,
B. Persistent, well-documented gender dysphoria; and
C. Capacity to make a fully informed decision and to consent for treatment; and,
D. Age of majority in the State of Nevada; and,
E. Significant medical or mental health concerns are reasonably well controlled; and,
F. Twelve (12) months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones.)

Requirements for genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female-to-male; penectomy, vaginoplasty, labiaplasty and clitoroplasty in male-to-female):

A. Two (2) referral letters from qualified mental health professionals, one in a purely evaluative role; and,
B. Persistent, well-documented gender dysphoria; and,
C. Capacity to make a fully informed decision and to consent for treatment; and,
D. Age of majority in the State of Nevada; and,
E. If significant medical or mental health concerns are present, they must be reasonably well controlled; and
F. Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones); and,
G. Twelve months of living in a gender role that is congruent with their gender identity (real life experience.)

NOTE: See Gender dysphoria and gender incongruence under MEDICAL LIMITATIONS AND EXCLUSIONS for services and procedures that are not covered.

Additional services may be covered per federal or state mandates. Senate Bill No. 163 updates to (NRS 287.010, 287.04335, 422.2712-422.27241, 689A.04033-689A.0465, 689B.0303-689B.0379,

689C.1655-689C.169, 689C.194, 689C.1945, 689C.195, 695A.184-695A.1875, 695B.1901-695B.1948, 695C.1691-695C.176, 695G.162-695G.177)

Home Health Care – Services and supplies that are furnished to a Covered Person in accordance with a written home health care plan. The home health care plan must include the diagnosis, care and treatment and must be certified and reviewed at least every thirty (30) days by the attending Physician. Also, the attending Physician must certify that the condition would require Inpatient confinement in a hospital or Skilled Nursing Facility in the absence of

home health care.

Eligible home health care services and supplies include only:

- Part-time or intermittent nursing services provided by or under the supervision of a registered nurse (RN); services of physical, occupational and speech therapists;
- part-time or intermittent services of home health aides provided through a Home Health Care Agency (this does not include general housekeeping services);
- medical supplies; and
- laboratory services that are provided by or on behalf of a hospital.

Hospice Care – Care of a Covered Person with a terminal prognosis (i.e., a life expectancy of six months or less) who has been admitted to a formal program of Hospice care. Eligible Expenses include Hospice Agency care of the patient in a Hospice unit or other licensed facility, and home care.

Hospice care also includes bereavement counseling sessions by a licensed social worker or a licensed pastoral counselor for members of the patient's immediate family (covered spouse and/or covered Dependent children). Such services must be furnished within six (6) months following the patient's death.

Hospital Services – Hospital services and supplies provided on an Outpatient basis and Inpatient care, including daily room and board and ancillary services and supplies.

Infusion Therapy – Professional services of an appropriate Covered Provider for the intravenous or aerosol administration of Prescription Drugs or other prepared or compounded substances. Infusion therapy may be administered in a Covered Person's home, Physician's office or at a Covered Provider facility.

Infusion therapy supplies including injectable Prescription Drugs or other substances that are approved by the Food and Drug Administration, and durable medical equipment necessary for infusion therapy.

Medical Supplies, Disposable – Disposable medical supplies such as surgical dressings, catheters, colostomy bags and related supplies.

Medicines – Medicines that are dispensed and administered to a Covered Person during an Inpatient confinement, during a Physician's office visit, or as part of a home health care or hospice care program.

Mental Health Care – Inpatient and Outpatient treatment of mental health conditions.

For Plan purposes, a mental health condition is any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Midwife – Services of a certified or registered nurse midwife when provided in conjunction with a covered Pregnancy; see Pregnancy Care.

Newborn Care – see Pregnancy Care for newborn coverage during the child's/mother's confinement for delivery.

A covered newborn that is sick or injured is eligible for benefits to the same extent as any other Covered Person. Eligible Expenses will include necessary transportation costs from the child's place of birth to the nearest specialized treatment center.

Non-Grandfathered Plan – means coverage provided by the Plan Sponsor and described in this Benefit Plan Document in which no individual was enrolled on March 23, 2010, or, with respect to coverage in which an individual was enrolled on March 23, 2010 coverage that has been modified or changed in such a way as to cease to maintain grandfathered status under applicable law.

Nursing Services, Private-Duty – Private-duty services of a registered nurse (RN), licensed vocational nurse (LVN) or licensed practical nurse (LPN) when provided on an Inpatient or Outpatient basis. Any such services must be Medically Necessary, not custodial in nature, and prescribed in writing by the attending Physician or surgeon specifically as to duration and type. When provided on an Inpatient basis, the Hospital's Intensive Care Unit must be filled or the Hospital must have no Intensive Care Unit. Outpatient private-duty nursing on a 24-hour shift basis is not covered. See Home Health Care for other Outpatient nursing coverage information.

Occupational Therapy – Professional services of a licensed occupational therapist to improve a body function when ordered by a Physician and necessitated by an Accidental Injury or Sickness.

NOTE: Recreational programs, maintenance therapy or supplies used in occupational therapy are not covered.

Orthotics, Orthotic Shoes & Braces – Orthopedic Braces, Orthopedic Shoes, and other foot orthotics.

Oxygen – see Durable Medical Equipment

Physical Therapy – Professional services of a licensed physical therapist when provided in accordance with a Physician's exact orders as to type, frequency and duration and to improve a body function.

Physician Services – Medical and surgical treatment by a Physician (MD or DO), including office, home or Hospital visits, clinic care and consultations. See Second (& 3rd) Surgical Opinion for requirements applicable to surgery opinion consultations.

Pregnancy Care – Pregnancy-related expenses of a covered Employee, dependent spouse or dependent child. Pregnancy- related expenses include the following, but may include other services that are deemed to be Medically Necessary by the patient's attending Physician:

- pre-natal visits and routine pre-natal and post-partum care;
- expenses associated with a normal or cesarean delivery as well as expenses associated with any complications of pregnancy;
- genetic testing or counseling when deemed Medically Necessary by a Physician;
- newborn Hospital (nursery) care and Physician services provided to a newborn child during the mother's confinement for delivery. This includes well-newborn care and care for a child who is sick or injured.

In accordance with the Newborns' and Mothers' Health Protection Act, the Plan will not restrict benefits for a Pregnancy Hospital stay for a mother and her newborn to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section. Also, the Utilization Management Program requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the decision is made between the attending Physician and the mother.

Complications of pregnancy will be covered as any other Sickness and will be covered with regard to an Employee, spouse or a Dependent child. For Plan purposes complications of pregnancy include:

- the following conditions before the pregnancy ends – acute nephritis, ectopic pregnancy, miscarriage, nephrosis, cardiac decompensation, missed abortion, hyperemesis gravidarum, and eclampsia of pregnancy;
- other pregnancy-related conditions that are as medically severe as those listed but not including false labor, occasional spotting, rest during pregnancy even if prescribed by a Physician, morning sickness, or like conditions that are not medically termed as complications of pregnancy.

NOTE: Pregnancy coverage will not include: (1) Lamaze and other charges for education related to pre-natal care and birthing procedures, (2) adoption expenses, or (3) expenses of a surrogate mother who is not a Covered Person.

Prescription Drugs - Drugs and medicines that are dispensed and administered to a Covered Person during an Inpatient confinement or during a Physician's office visit.

Coverage for other Outpatient drugs (i.e., pharmacy purchases) is provided through a separate program. See **MEDICAL BENEFIT SUMMARY** section for additional information.

See Cancer Drugs in the **ADDENDUM FOR NEVADA LAWS** section for additional coverage information

Preventive Care – Certain preventive services that are provided in the absence of sickness or injury. When the following covered preventive services are provided by a Network provider, a Covered person will not have to meet a deductible, pay a Co-Pay or pay a percentage share of the cost. **See MEDICAL BENEFIT SUMMARY** (either PPO or HSA OPTION) sections for benefit levels when Preventive Care services are provided by a non-Network provider.

Covered preventive services include but are not limited to:

Periodic physical examinations, X-rays, laboratory blood tests, and routine immunizations including the following:

- Routine gynecologic examination (one per calendar year), including annual cytology screening test (Pap smear) for women 18 years of age or older, pelvic examination, urinalysis, and breast examination;
- Screening mammograms including an initial baseline mammogram for female Members 35–39 and annually for women 40 years of age or older;
- Well-baby care, including immunizations in accordance with the American Academy of Pediatrics and other federal agencies;

Prostate and colorectal cancer screening in accordance with the guidelines concerning such screening that are published by the American Cancer Society or other guidelines or reports concerning such screening that are published by nationally recognized professional organizations and that include current or prevailing supporting scientific data;

Influenza, pneumovax, haemophilus influenza B, hepatitis A, hepatitis B, hepatitis C, rubella, and tetanus immunizations; and

Hearing and vision screening for children through age 17 to determine the need for hearing and vision correction.

Notwithstanding anything to the contrary in this Benefit Plan Document, Non-Grandfathered Plans will cover the following services without any Member cost-sharing requirements if such services are provided by a Participating Provider:

- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force, provided that, with regard to breast cancer screening, mammography, and prevention, the current recommendations of the United States Preventive Services Task Force (USPSTF) will be the most current other than those issued in or around November 2009;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
- With respect to infants, children, and adolescents, evidence-informed Preventive Care and screenings provided for in comprehensive guidelines supported by the Health Resources and

Services Administration of the U.S. Department of Health and Human Services; and

- With respect to women, such additional Preventive Care and screenings not described under this section as provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services: well-woman visits, screening for gestational diabetes, human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling and screening for human immune-deficiency virus, contraceptive methods and counseling, breast feeding support, supplies, and counseling, screening and counseling for interpersonal and domestic violence.

Website references:

Regulations: www.healthcare.gov

Overview: https://www.healthcare.gov/coverage/preventive-care-benefits/

U.S. Preventive Services Task Force A & B Recommendations:

https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Vaccines: https://www.cdc.gov/vaccines/vpd/vaccines-age.html

Women's Health & Well-Being

www.hrsa.gov/womensguidelines/

Preventive Medications – There will be no co-pay for the following medications recommended by The Preventive Services Task Force (USPSTF) upon the physician's order only at a participating retail or mail order pharmacy.

- Aspirin to prevent cardiovascular diseases (CVD): 45 years and older; quantity limit 1/day; generic only; OTC (requires a prescription).
- Sodium fluoride products (not in combination): 5 years old and younger, whose primary water source is deficient in fluoride; tablet 0.5mg, chewable tablet 0.25mg005mg, solution.
- Folic Acid for all women planning or capable of pregnancy: Age limit 55 years old or younger; (not in combination); 0.4mg and 0.8mg; quantify limit 1/day; OTC (requires a prescription).
- Iron Supplements for asymptomatic children aged 6 to 12 months who are increased risk for iron deficiency anemia: Age limit 0-1 year; prescription or OTC (requires a prescription); iron suspension, ferrous sulfate elixir, syrup and solution.
- Tobacco Cessation – The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products: Annual limit of 2 cycles (12 weeks per cycle); OTC generics only; generic Zyban only; Rx or OTC (requires a prescription); Nicotrol Inhaler and Nasal Spray; Nicotine polacriliex gum or lozenge; Nicotine TD patch 24-hour kits; Bupropion HC1 SR tabs; Varenicline (Chantix) tablets.
- Immunizations: Vaccines: The following vaccines are covered if provided by a Certified Immunizing pharmacist: Influenza, Hepatitis A & B; Human Paillomavirus inactive; Poliovirus; Rubella; Meningococcal, Pneumococcal; Rotavirus, Tetanus Diphtheria, Pertussis and Varcella Zoster. These may be administered or dispensed at the pharmacy, but are part of the preventive services covered in the benefits outlined within document.

Prosthetics – The initial purchase, fitting, repair and replacement of fitted prosthetic devices which replace body parts. To comply with the Women's Health and Cancer Rights Act, coverage includes post-mastectomy breast prostheses (implants, special bras, etc.).

Radiation Therapy – Radium and radioactive isotope therapy.

Rehabilitation Center – see **Skilled Nursing Facility or Rehabilitation Center**

Respiratory Therapy – Professional services of a licensed respiratory or inhalation therapist, when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of respiratory function.

Second (& 3rd) Surgical Opinion – A second surgical opinion consultation following a surgeon's recommendation for surgery when required or prior authorized by the Utilization Management Program. The Physician rendering the second opinion regarding the Medical Necessity of a proposed surgery must be qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

A third opinion consultation will also be covered if the second opinion does not concur with the first Physician's recommendation. This third Physician must be qualified to render such a service and must not be affiliated in any way with the Physician who will be performing the actual surgery.

Skilled Nursing Facility or Rehabilitation Center – Inpatient care in Skilled Nursing Facility or Rehabilitation Center, but only when the admission to the facility or center is Medically Necessary and:

- the attending Physician certifies that the confinement is needed for further care of the condition that caused a hospital confinement; and
- the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge.

Speech Therapy – Services by a qualified speech therapist when ordered by a Physician and following either: (1) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex, other than a frenectomy, (2) an Accidental Injury, or (3) a Sickness that is other than a learning or mental disorder.

Spinal Manipulation – see Chiropractic-type Care

Sterilization Procedures – A surgical procedure for the purpose of sterilization (i.e., a vasectomy for a male or a tubal ligation for a female).

NOTE: Reconstruction (reversal) of a prior elective sterilization procedure is not covered.

Substance Abuse Care – Inpatient and Outpatient treatment of addiction resulting from substance abuse.

For Plan purposes, substance abuse is physical and/or psychological dependence on drugs, narcotics, alcohol, toxic inhalants, or other addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine.

Telemedicine Services – Services from a Provider who is in a different location through the use of information and audio-visual communication technology. Telemedicine does not include communication through facsimile, or email. This service is available to members through TelaDoc where they can register and connect face-to-face with a board-certified doctor or licensed psychologist on a smartphone, tablet, or computer through live video. Alternatively, telemedicine may be available from in-network providers. It is your responsibility to ensure the providers you use are in-network providers.

TMJ / Jaw Joint Treatment – Medically Necessary treatment of jaw joint problems, including temporomandibular joint syndrome, cranio-mandibular disorders or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to that joint. Eligible treatment includes, but is not limited to: orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Transplant-Related Expenses – Eligible Expenses incurred by a Covered Person who is the recipient of an organ or tissue transplant that is not experimental or investigational in nature.

In addition to Eligible Expenses as listed in this section, eligible transplant-related expenses will include certain expenses related to obtaining donor organs or tissue. When the donor has medical coverage, his plan will pay first and the benefits of this Plan will be reduced by those payable by the donor's plan. Eligible donor-related expenses include only:

- evaluation of the organ or tissue;
- removal of the organ or tissue from the donor; and
- transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to be performed.

Urgent Care Facility – Eligible Medical Expenses, as defined herein, that are incurred by a Covered Person at an Urgent Care Facility.

MEDICAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated otherwise, no benefits will be payable for:

Abortion – Elective abortion, unless the mother's life would be endangered if the Pregnancy were allowed to continue to term.

NOTE: Complications arising out of an abortion are covered as any other Sickness.

Acupuncture / Acupressure – Needle puncture or application of pressure at specific points, whether used to cure disease, to relieve pain or as a form of anesthesia for surgery.

Air Purification Units, Etc. – Air conditioners, air-purification units, humidifiers and electric heating units.

Biofeedback – Biofeedback, recreational, or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing.

Complications of Non-Covered Treatment – Care, services or treatments that are required to treat complications resulting from a treatment or surgery that is not or would not be covered under the terms of the Plan, unless expressly stated otherwise.

Cosmetic & Reconstructive Surgery, Etc. – Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic that is within the broad range of normal but that may be considered unpleasing or unsightly, except for:

- services necessitated by an Accidental Injury;
- coverage required by the Women's Health and Cancer Rights Act (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including lymphedemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient;
- treatment necessary to correct a congenital abnormality (birth defect).

Custodial & Maintenance Care – Care or confinement primarily for the purpose of meeting personal needs (bathing, walking, etc.) which could be rendered at home or by persons without professional skills or training.

Services or supplies that cannot reasonably be expected to lessen the patient’s disability or to enable him to live outside of an institution.

Any type of maintenance care which is not reasonably expected to improve the patient's condition within

a reasonable period of time, except as may be included as part of a formal Hospice care program.

Dental Care – Care or treatment on or to the teeth, alveolar processes, gingival tissue, or for malocclusion, except for:

- excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- repair of sound natural teeth that are damaged in an Accidental Injury when such repair is made within twelve
- (12) months from the date of the accident;
- surgery needed to correct an Accidental Injury to the jaw, cheeks, lips, tongue, floor and roof of the mouth; excision of benign bony growths of the jaw and hard palate;
- external incision and drainage of cellulitis;
- incision of sensory sinuses, salivary glands or ducts;
- removal of bone or tissue impacted teeth. However, benefits for these services will be paid first under the Plan's dental benefits (see **DENTAL BENEFIT SUMMARY** section). If or when the dental benefits are exhausted, remaining Eligible Expenses will be covered under these medical benefits;
- reductions of dislocations and excision of temporomandibular joints (TMJs).

Diagnostic Hospital Admissions – Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting.

Drugs in Testing Phases – Medicines or drugs that are in the Food and Drug Administration Phases I, II, or III testing, drugs that are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

Ecological or Environmental Medicine – Chelation or chelation therapy, orthomolecular substances, or use of substances of animal, vegetable, chemical or mineral origin that are not specifically approved by the FDA as effective for treatment.

Educational or Vocational Testing or Training – Testing and/or training for educational purposes or to assist an individual in pursuing a trade or occupation.

Training of a Covered Person for the development of skills needed to cope with an Accidental Injury or Sickness, except as may be expressly included.

Exercise Equipment / Health Clubs – Exercising equipment, vibratory equipment, swimming or therapy pools. Enrollment in health, athletic or similar clubs.

Experimental / Investigational Treatment – Charges for Experimental/Investigational Treatment except when such expenses are considered under the Addendum for Nevada State Laws.

Foot Care, Routine – Routine and non-surgical foot care services and supplies including, but not limited to:

- trimming or treatment of toenails;
- foot massage;

- treatment of corns, calluses, metatarsalgia or bunions;
- treatment of weak, strained, flat, unstable or unbalanced feet.

NOTE: This exclusion does not apply to orthopedic braces, orthopedic shoes, custom made foot orthotics, or Medically Necessary treatment of the feet (e.g., the removal of nail roots, other podiatry surgeries, or foot care services necessary due to a metabolic or peripheral-vascular disease).

Hair Restoration – Replacement of nonproductive hair follicles with productive follicles from another area of the scalp or body for treatment of alopecia (baldness), or any other surgeries, treatments, drugs, services or supplies relating to baldness or hair loss.

NOTE: The Plan will cover the purchase of a wig for hair loss resulting from medical treatment (e.g., chemotherapy).

Hearing Exams & Hearing Aids – Hearing exams, hearing aids or the fitting of hearing aids.

Holistic, Homeopathic or Naturopathic Medicine – Services, supplies, drugs or accommodations provided in connection with holistic, homeopathic or naturopathic treatment.

Hypnotherapy – Treatment by hypnotism.

Impregnation – Artificial insemination, in-vitro fertilization, G.I.F.T. (Gamete Intrafallopian Transfer) or any type of artificial impregnation procedure, whether or not any such procedure is successful.

Infertility Testing or Treatment – Diagnostic tests or studies, or procedures, drugs or supplies to correct infertility or to restore or enhance fertility.

Maintenance Care – see Custodial & Maintenance Care

Marriage & Family Counseling – Counseling for marital or family problems when there is no diagnosed mental health condition.

Non-Prescription Drugs – Drugs for use outside of a hospital or other Inpatient facility that can be purchased over- the-counter and without a Physician's written prescription - except as may be included in the prescription coverage of the Plan.

Drugs for which there is a non-prescription equivalent available.

Not Medically Necessary / Not Physician Prescribed – Any services or supplies that are: (1) not Medically Necessary and (2) not incurred on the advice of a Physician unless expressly included herein.

Inpatient room and board when hospitalization is for services that could have been performed safely on an Outpatient basis including, but not limited to: preliminary diagnostic tests, physical therapy, medical

observation, treatment of chronic pain or convalescent or rest cure.

Orthognathic Surgery – Surgery to correct a receding or protruding jaw.

Personal Comfort or Convenience Items – Services or supplies that are primarily and customarily used for nonmedical purposes or are used for environmental control or enhancement (whether or not prescribed by a Physician) including but not limited to: (1) air conditioners, air purifiers, or vacuum cleaners, (2) motorized transportation equipment, escalators, elevators, ramps, (3) waterbeds or non-hospital adjustable beds, (4) hypoallergenic mattresses, pillows, blankets or mattress covers, (5) cervical pillows, (6) swimming pools, spas, whirlpools, exercise equipment, or gravity lumbar reduction chairs, (7) home blood pressure kits, (8) personal computers and related equipment, televisions, telephones, or other similar items or equipment, (9) food liquidizers, or (10) structural changes to homes or autos.

Preventive or Routine Care – Routine exams, physicals or anything not ordered by a Physician or not Medically Necessary for treatment of Sickness, Accidental Injury or Pregnancy, except as may be specifically included in the **MEDICAL BENEFIT SUMMARY** (either **PPO** or **HSA OPTION** sections).

Self-Procured Services – Services rendered to a Covered Person who is not under the regular care of a Physician and for services, supplies or treatment, including any periods of hospital confinement, that are not recommended, approved and certified as necessary and reasonable by a Physician, except as may be specifically included in the list of **Eligible Medical Expenses**.

Gender dysphoria and gender incongruence Surgery - Services and supplies when the criteria required under Gender Reassignment in the Eligible Medical Expenses section, are not met.

Procedures that may be performed as a component of a gender reassignment as cosmetic (not an all-inclusive list) will not be covered: abdominoplasty, blepharoplasty brow lift, calf implants, cheek/malar implants, chin/nose implants, collagen injections, construction of a clitoral hood, drugs for hair loss or growth, forehead lift, hair removal/hair transplantation, lip reduction, liposuction, mastopexy, neck tightening, pectoral implants, removal of redundant skin, rhinoplasty, voice therapy/voice lessons.

Sleep Disorders – Care or treatment for sleep disorders unless deemed Medically Necessary.

Vaccinations – Immunizations or vaccinations other than: (1) those included within the Preventive Care coverage (see MEDICAL BENEFIT SUMMARY – either PPO or HSA OPTION sections), and (2) tetanus or rabies vaccinations administered in connection with an Accidental Injury.

Vision Care – Eye examinations for the purpose of prescribing corrective lenses.

Vision supplies (eyeglasses or contact lenses, etc.) or their fitting, replacement, repair or adjustment.

Orthoptics, vision therapy, vision perception training, or other special vision procedures, including procedures whose purpose is the correction of refractive error, such as radial keratotomy or laser surgery.

NOTE: This exclusion will not apply to: (1) services necessitated by a Sickness or Accidental Injury, (2) the initial purchase of glasses or contact lenses following cataract surgery, or (3) aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

Vitamins or Dietary Supplements – Prescription or non-prescription organic substances used for nutritional purposes.

Vocational Testing or Training – Vocational testing, evaluation, counseling or training.

Weekend Admissions – Hospital expenses incurred on a weekend that coincides with admission to a hospital between 12:00 (noon) on Friday and 12:00 (noon) on Sunday unless: (1) the admission occurs one day prior to a scheduled surgery, (2) Covered Person is admitted on an emergency basis, or (3) the admission is for Pregnancy delivery.

Weight Control – Services or supplies for obesity, weight reduction or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness, except when Medically Necessary for treatment of morbid obesity. Morbid obesity means Covered Person's body weight exceeds the medically-recommended weight by either 100 pounds or is twice the medically-recommended weight for a person of the same height, age and mobility as Covered Person.

Wigs or Wig Maintenance – see Hair Restoration

- (See also **GENERAL EXCLUSIONS** section) –

GENERAL EXCLUSIONS

The following exclusions apply to all health benefits and no benefits will be payable for:

Criminal Activities – Any injury resulting from or occurring during a Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation.

This exclusion will not apply to injuries suffered by a Covered Person who is:

- a victim of domestic violence; or
- an individual with mental or physical medical conditions.

Excess Charges – Charges in excess of the Usual & Customary amount or charges for services not deemed to be Reasonable or Medically Necessary will be excluded based upon the Plan Administrator's determination.

Forms Completion – Charges made for the completion of claim forms or for providing supplemental information

Government-Operated Facilities – Services furnished to Covered Person in any veteran's hospital, military hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments.

NOTE: This exclusion does not apply to treatment of non-service-related disabilities or for Inpatient care provided in a military or other Federal government hospital to dependents of active-duty armed service personnel or armed service retirees and their dependents. This exclusion does not apply where otherwise prohibited by law.

Late-Filed Claims – Claims that are not filed with the Contract Administrator for handling within the required time periods as included in the CLAIMS PROCEDURES section.

Military Service – Conditions that are determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

Missed Appointments – Expenses incurred for failure to keep a scheduled appointment.

No Charge / No Legal Requirement to Pay – Services for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. Where Medicare coverage is involved and this Plan is a secondary coverage, this exclusion will apply to those amounts a Covered Person is not legally required to pay due to Medicare's limiting charge amounts. NOTE: This exclusion does not apply to any benefit or coverage that is available through the Medical Assistance Act (Medicaid).

Not Listed Services or Supplies – Any services, care or supplies that are not specifically listed in the Benefit Plan Document as Eligible Expenses.

Other Coverage – Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Payor or Medicaid Priority rules.

Services or supplies received from a health care department maintained by or on behalf of an employer, mutual benefit association, labor union, trustees or similar person(s) or group.

Outside United States – Charges incurred outside of the United States if Covered Person traveled to such a location for the primary purpose of obtaining such services or supplies.

Postage, Shipping, Handling Charges, Etc. – Any postage, shipping or handling charges that may occur in the transmittal of information to the Contract Administrator. Interest or financing charges.

Prior Coverages – Services or supplies for which Covered Person is eligible for benefits under the terms of the document that this Benefit Plan Document replaces.

Prior to Effective Date / After Termination Date – Charges incurred prior to an individual's effective date of coverage under the Plan or after coverage is terminated, except as may be expressly stated.

Relative or Resident Care – Any service rendered to a Covered Person by a relative (whether the relationship is by blood or exists in law) or anyone who customarily lives in Covered Person's household.

Sales Tax, Etc. – Sales or other taxes or charges imposed by any government or entity. However, this exclusion will not apply to surcharges required by the New York Health Care Reform Act of 1996 or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time, or similar surcharges imposed by other states.

Self-Inflicted Injury – Any expenses resulting from voluntary self-inflicted injury or voluntary attempted self- destruction, except that, this exclusion will not apply where such self-inflicted injury results from a medical condition (physical or mental), or a medical condition resulting from domestic violence.

Telecommunications – Advice or consultation given by or through any form of telecommunication.

Travel – Travel or accommodation charges, whether or not recommended by a Physician, except for ambulance charges or as otherwise expressly included (see ELIGIBLE MEDICAL EXPENSES section).

War or Active Duty – Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications there from, or service (past or present) in the armed forces of any country, to the extent not prohibited by law.

Work-Related Conditions – Any condition that arises from or is sustained in the course of any occupation or employment for compensation, profit or gain, including self-employment. This exclusion applies whether or not Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose. If the Plan elects to provide benefits for any such condition, the Plan will be entitled to establish a lien upon such other benefits up to the amount paid.

DENTAL BENEFIT SUMMARY

CHOICE OF PROVIDERS

The Plan Sponsor has contracted with an organization or Network of dental providers. When obtaining dental care, a Covered Person has a choice of using a dentist who is participating in that Network or using any other dentist of his choice (a non-network provider). A list or directory of Network providers will be given to Plan participants without charge.

Because Network providers have agreed to provide services to Covered Persons at negotiated rates, when a Covered Person uses a Network provider his out-of-pocket costs may be reduced because he will not be billed for expenses in excess of the negotiated rates.

For provider directories or to nominate a dentist to become a Network provider, an individual can access the Diversified Dental PPO website at www.ddsppo.com or call:

Southern Nevada: (702) 869-6200 or
(800) 249-3538 (toll-free)

Northern Nevada: (775) 337-1180 or
(866) 270-8326 (toll free)

SCHEDULE OF DENTAL BENEFITS

CALENDAR YEAR MAXIMUM BENEFIT		$2,000
Plan benefits for each Covered Person (except for Covered Persons up to age 19 will not exceed the maximums shown above. A Covered Person is permitted to roll-over a maximum of $2,000 of unused benefits (from one Calendar Year to the next Calendar Year only).		
CALENDAR YEAR DEDUCTIBLE		$25 (Applies to Major Services ONLY)
The Calendar Year Deductible is an amount that a Covered Person must contribute toward payment of Major Services before the Plan begins to provide benefits.		
ELIGIBLE DENTAL EXPENSES	**Covered Person Pays**	**Plan Pays**
Preventive Services (Deductible Does not Apply)	-0-	100%
Limits applicable to certain Preventive Services: - routine oral examinations and cleanings are limited to 2 exams/cleanings per Calendar Year; fluoride treatment is limited to children under age 19 and to 1 application per Calendar Year; - sealants are limited to children under age 16 who have not been treated with sealants for at least 4 years; space maintainers are limited to children under age 19; - a routine full-mouth X-ray series or a panoramic X-ray is limited to once every 3 Calendar Years; - routine bitewing X-rays are limited to 2 series every Calendar Year.		
Basic Services (Deductible Does not Apply)	20%	80%
Major Services	20%	80%

THIS IS A SUMMARY ONLY. PLEASE REFER TO THE **ELIGIBLE DENTAL EXPENSES** AND THE **DENTAL LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION.

DENTAL PRE-TREATMENT ESTIMATE

If extensive dental work is needed (i.e., where the proposed course of treatment will cost more than $300), the Plan Sponsor recommends that a pre-treatment estimate be obtained prior to the work being performed. A treatment plan should be submitted in advance so that Covered Person and the dentist will know what is covered and the estimated Plan benefits. Emergency treatments, oral examinations including Prophylaxis, and dental X-rays will be considered part of the extensive dental work but may be performed before the pre-treatment estimate is obtained.

A pre-treatment estimate is obtained by having the attending dentist complete a statement listing the proposed dental work and charges. The form is then submitted to the Contract Administrator for review and estimate of benefits. The Contract Administrator may require an oral exam (at Plan expense) or request X-rays or additional information during the course of its review.

A pre-treatment estimate serves two purposes. First, it gives the patient and the dentist a good idea of benefit levels, maximums, limitations, etc., that might apply to the treatment program so that the patient's portion of the cost will be known and, secondly, it offers the patient and dentist an opportunity to consider other avenues of restorative care that might be equally satisfactory and less costly.

Most dentists are familiar with pre-treatment estimate procedures and the dental claim form is designed to facilitate pre-treatment estimates.

If a pre-treatment estimate is not obtained prior to the work being performed, the Plan Sponsor reserves the right to determine Plan benefits as if a pre-treatment estimate had been obtained.

NOTE: A pre-treatment estimate is not a guarantee of payment. Payment of Plan benefits is subject to Plan provisions and eligibility at the time the expenses are actually incurred.

ELIGIBLE DENTAL EXPENSES

Eligible dental expenses are the Usual &Customary and Reasonable charges for the dental services and supplies that are listed below and: (1) incurred while a person is covered under the Plan, and (2) received from a licensed dentist, a qualified technician working under a dentist's supervision or any Physician furnishing dental services for which he is licensed.

For benefit purposes, a dental charge is incurred on the date the service or supply is performed or furnished. However, when an overall charge is made for all or part of a course of treatment, the charge will be apportioned to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

NOTE: Many dental conditions can be effectively treated in more than one way. The Plan is designed to help pay for dental expenses, but not for treatment that is more expensive than necessary for good dental care. If a Covered Person chooses a more expensive course of treatment, the Plan will pay benefits equivalent to the least expensive treatment that would adequately correct the dental condition.

PREVENTIVE SERVICES

Exams & Cleanings, Routine – Routine oral examinations and routine cleaning and polishing of the teeth.

Fluoride – Topical application of stannous or sodium fluoride.

Palliatives – Emergency treatment for the relief of dental pain.

Prophylaxis – Measures designed to preserve health and prevent the spread of disease (see SCHEDULE OF DENTAL BENEFITS).

Sealants – Application of sealants to the pits and fissures of the teeth, with the intent to seal the teeth and reduce the incidence of decay. Coverage is limited to application on the occlusal (biting) surface of permanent molars that are free of decay or prior restoration.

Space Maintainers – Fixed and removable appliances to retain the space left by a prematurely lost primary or baby tooth and to prevent abnormal movement of the surrounding teeth.

X-rays, Full Mouth & Bitewings – Routine full mouth X-rays or a panoramic X-ray, and routine bitewing X-rays.

BASIC SERVICES

Anesthesia – General anesthesia or intravenous sedation when Medically Necessary.

NOTE: Separate charges for pre-medication, local anesthesia, or analgesia are not covered. Such services should be included in the cost of the procedure itself.

Endodontia – Endodontic services including but not limited to: root canal therapy (except for final restoration), pulpotomy, apicoectomy and retrograde filling.

Extraction – see Oral Surgery

Fillings, Non-Precious – Amalgam, silicate, composite and plastic restorations, including pins to retain a filling restoration when necessary.

Injections – Injection of antibiotic drugs.

Oral Surgery – Oral surgery but limited to:

- extraction of teeth, including simple extractions and surgical extraction of bone or tissue-impacted teeth; preparation of the mouth or dentures; and
- removal of tooth-generated cysts of less than ¼ inch.

Periodontia – Treatment of the gums and tissues of the mouth, including periodontal scaling and root planning.

Re-cementing – Re-cementing of bridges, crowns or inlays.

X-rays, Other – Dental X-rays not included under Preventive Care above.

MAJOR SERVICES

Crowns – Placement of a gold, porcelain or composite crown restoration when a tooth cannot be satisfactorily restored with a filling restoration. Coverage for a crown includes a post and core when necessary.

NOTE: Crowns placed for periodontal splinting are not covered.

Gold Inlays, Onlays, Foil Fillings – A gold inlay, onlays or foil filling when a tooth cannot be satisfactorily restored with a less costly filling (amalgam, etc.) restoration.

Implants – Implants (materials implanted into or on bone or soft tissue) and all related services or supplies.

Prosthetics – Initial placement of a full or partial denture or fixed bridge to replace one or more natural teeth that are extracted while the person is covered hereunder, including the installation of precision attachments for removable dentures. Any allowance made for a prosthetic includes necessary adjustments within six (6) months of placement.

The addition of clasps or rests to existing partial removable dentures.

Replacement of or addition of teeth to an existing full or partial denture or bridge, but only if:

- the replacement or addition of teeth is required because of the extraction of one or more natural teeth while the person is covered hereunder;
- the existing denture or bridgework cannot be made serviceable and is at least five (5) years old; or
- the existing denture is an immediate temporary denture to replace one (1) or more natural teeth and replacement by a permanent denture is required and takes place within twelve (12) months from the date of the initial installation of the immediate temporary denture.

Repairs & Relines – Repair of crowns, bridgework and removable dentures. Rebasing or relining of removable dentures.

DENTAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated, no benefits will be payable under this Plan for:

Appliances – Items intended for sport or home use, such as athletic mouth guards or habit-breaking appliances.

Cosmetic Dentistry – Treatment rendered for cosmetic purposes.

Discoloration Treatment – Teeth whitening or any other treatment to remove or lessen discoloration, except in connection with endodontia.

Excess Care – Services that exceed those necessary to achieve an acceptable level of dental care. If it is determined that alternative procedures, services, or courses of treatment could be (could have been) performed to correct a dental condition, Plan benefits will be limited to the least costly procedure(s) that would produce a professionally satisfactory result.

Duplicate prosthetic devices or appliances.

Experimental Procedures – Services that are considered experimental or that are not approved by the American Dental Association.

Hospital Expenses – Any dental-related services to the extent to which coverage is provided under the terms of the medical benefits of this Plan.

Lost or Stolen Prosthetics or Appliances – Replacement of a prosthetic or any other type of appliance that has been lost, misplaced, or stolen.

Medical Expenses – Any dental-related services to the extent to which coverage is provided under the terms of the medical benefits of this Plan.

Myofunctional Therapy – Muscle training therapy or training to correct or control harmful habits.

Non-Professional Care – Services rendered by someone other than: a dentist (DDS or DMD);

a dental hygienist, X-ray technician or other qualified technician who is under the supervision of a dentist; or a Physician furnishing dental services for which he is licensed.

Occlusal Restoration – Procedures, appliances or restorations that are performed to alter, restore or maintain occlusion (i.e., the way the teeth mesh), including:

- increasing the vertical dimension;
- replacing or stabilizing tooth structure lost by attrition; realignment of teeth;
- gnathological recording or bite registration or bite analysis;

- occlusal equilibration.

Oral Hygiene Instruction & Supplies, Etc. – Dietary or nutritional counseling or related supplies, personal oral hygiene instruction or plaque control. Oral hygiene supplies including but not limited to: toothpaste, toothbrushes, water picks, and mouthwashes.

Orthodontia, Etc. – Orthodontia procedures, appliances or restorations used to increase vertical dimension or to restore occlusion.

Orthognathic Surgery – Surgery to correct a receding or protruding jaw.

Personalization or Characterization of Dentures

Prescription Drugs – see Prescription Drugs, Outpatient in the MEDICAL BENEFIT SUMMARY (either PPO or HSA OPTION sections)

Prior to Effective Date / After Termination Date – Courses of treatment that began prior to Covered Person's effective date, including crowns, bridges or dentures that were ordered prior to the effective date.

Expenses incurred after termination of coverage.

Splinting – Appliances or restorations for splinting teeth.

Temporary Restorations & Appliances – Excess charges for temporary restorations and appliances. Expenses for the permanent restoration or appliance will be the maximum Eligible Expense.

- (See also **GENERAL EXCLUSIONS** section) -

VISION BENEFIT SUMMARY

Vision Service Plan (VSP) providers offer an examination and the prescribing and fitting of corrective lenses. When you select a doctor from the VSP provider network list ("VSP Provider"), the Plan covers examination, professional services, lenses and frames as outlined below. To get the maximum vision benefit, Covered Persons should use VSP Providers.

You may also use the VSP toll-free number (800-877-7195) or internet website (**www.vsp.com**) to locate a VSP Provider in your area. Select a VSP Provider of your choice from the list and make an appointment for an examination. Selecting a doctor from the network list assures direct payment to the doctor and a guarantee of quality and cost control. However, benefits are also available from non-network doctors, as explained below.

You may obtain services from a non-network licensed optometrist, ophthalmologist or dispensing optician. Prior Authorization is not required. You are responsible for paying the doctor his or her full fee. You will be reimbursed according to the reimbursement schedule below. There is no assurance that the schedule will be sufficient to pay for the examination or the glasses. Reimbursement will be paid to you, not directly to the non-network doctor.

Vision Benefit Summary	**VSP Participating Provider**	**Non-Participating Provider**
Examination	Covered in full every 12 months	Plan pays up to $45
Frames	Covered every 24 months with some restrictions as to cost	Plan pays up to $70
Lenses	Covered every 12 months with some restrictions. Patient is responsible for payment on tinted, blended or oversize lenses	Single vision -Plan pays up to $30 Bifocal -Plan pays up to $50 Trifocal -Plan pays up to $65 Lenticular -Plan pays up to $100
Contact Lenses - Benefits are provided in lieu of all other plan benefits	Covered every 12 months not to exceed an annual maximum of $120. The co-pay for the examination is $60. Necessary- Conditional, covered in full with prior approval	Covered every 12 months not to exceed an annual maximum of $105. The co-pay for the examination is $60. Necessary - Plan pays up to $210 (exam benefit is also available)

THIS IS A SUMMARY ONLY. PLEASE REFER TO THE **VISION LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION.

VISION LIMITATIONS AND EXCLUSIONS

Except as expressly stated below, no vision coverage will be provided for:

Medical or Surgical Treatment of the Eye – Any vision-related services to the extent to which coverage is provided under the terms of the medical benefits of this Plan.

Non-Professional Care – A vision examination performed other than by a licensed ophthalmologist or optometrist.

Orthoptics – Services or supplies in connection with orthoptics, vision training or other special procedures.

Non-Prescription Lenses – Lenses that do not correct refractive error (plano lenses) or that are not obtained upon prescription by an ophthalmologist, optometrist or optician.

Replacement – Replacement of lost or broken lenses or frames (except in accordance with the allowable frequencies as shown in the **VISION BENEFIT SUMMARY** section).

Safety Glasses and/or Goggles

Subnormal Vision Aids

Sunglasses – Sunglasses or photosensitive lenses, including prescription sunglasses.

- (See also **GENERAL EXCLUSIONS** section) -

ELIGIBILITY AND EFFECTIVE DATES

Coverage Options

The medical coverage described herein includes optional schedules from which an Employee chooses at the point of initial enrollment in the Plan. An Employee must enroll himself and his Dependents (if any are to be enrolled) in the same option. During an annual Open Enrollment, the Plan Sponsor will allow Employees to transfer from one option to another. See Open Enrollment for more information

Eligibility Requirements - Employees

To participate as an Employee in the Plan coverages that are described herein, an individual must be in one of the following classes:

Class 1 - a contracted teacher who is covered by the teachers' bargaining unit contract and who is in active employment for the Employer in a permanent position of half-time or more;

Class 2 - a licensed administrator or classified supervisor in active employment for the Employer in a permanent position of half-time or more;

Class 3 – any other person in a permanent position of full-time active employment for the Employer who normally works at least 25 hours per week and at least 140 days per year, is on the regular payroll of the Employer and who has consented to taking contracted payments over the entire year (except for bus drivers who are paid from time sheets);

Class 4 – an eligible retiree. See Extension of Coverage for Retirees in the **EXTENSIONS OF COVERAGE** section for more information;

Class 5 – an active member of the Employer's Board of Trustees.

Class 6 – an employee in a permanent position of full-time active employment for the Carson Valley Swim Center who works a minimum of 30 hours per week and at least 140 days per year, or an eligible retiree of the Carson Valley Swim Center. Eligible retirees see Extension of Coverage for Retirees in the **EXTENSIONS OF COVERAGE** section for more information;

An Employee will be deemed in active employment on each day he is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day. An Employee will also be deemed in active employment on any day on which he is absent from work during an approved FMLA leave or solely due to his own health status (see Non-Discrimination Due to Health Status in the **GENERAL PLAN INFORMATION** section). An exception applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on his first scheduled workday, he will not be considered as having commenced active employment. In no case will coverage under this Plan begin prior to the Employee's first actual day worked.

See EXTENSIONS OF COVERAGE section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

NOTE: In no case will coverage begin prior to an Employee's first actual day worked.

If for any reason the Plan's eligibility requirements are in conflict or differ from provisions contained in a negotiated agreement, the negotiated agreement will prevail.

Effective Date - Employees

An employee's coverage is effective, subject to timely enrollment, as follows:

Class 1 – on the first day of the month that contracted payments begin if Employee is contracted for the entire year, or on the first of the month following commencement of actual work if contracted for less than a full year. If the contract begins prior to the first day worked, the effective date of coverage will be the first day of the month following the commencement of actual work;

Class 2 – on the first day of the month that contracted payments begin if Employee is contracted for the entire year, or on the first of the month following commencement of actual work if contracted for less than a full year. If the contract begins prior to the first day worked, the effective date of coverage will be the first day of the month following the commencement of actual work;

Class 3 – on the first day of the month following a waiting period of 60 days of active employment;

Class 4 – see Extension of Coverage for Retirees in the EXTENSIONS OF COVERAGE section for information;

Class 5 – on the first day of the month following the official date the person becomes a Board Member.

Class 6 – on the first day of the month that contracted payments begin if Employee is contracted for the entire year, or on the first of the month following commencement of actual work if contracted for less than a full year. If the contract begins prior to the first day worked, the effective date of coverage will be the first day of the month following the commencement of actual work;

If an Employee fails to enroll within thirty-one (31) days after completion of the waiting period, his coverage can become effective only in accordance with the Open Enrollment or Special Enrollment Rights provisions below.

Eligibility Requirements - Dependents

An eligible Dependent of an Employee is:

- a legally married spouse. The Plan Administrator may require documentation proving a legal marital relationship;
- a child who is under age 26 (i.e., through the last day of the month in which a child reaches age 26). The child need not: (1) reside with the Employee or any other person, (2) be a student, (3) be a tax-code dependent of the Employee or financially dependent on the Employee or any other person, (4) be unmarried, or (5) be unemployed, (6) be eligible for coverage under some other employer-sponsored group health plan.

A child will include:

- a natural child;
- a stepchild;
- a child placed under the court-appointed legal guardianship of the Employee;
- a foster child who lives in the Employee's household, for whom the Employee has assumed a legal obligation, who is being raised as the Employee's child, and for whom the Employee may legally claim a federal income tax deduction. An eligible foster child does not include a child temporarily living in the Employee's home, one placed in the Employee's home by a social service agency which retains control of the child, or a child whose natural parent(s) may exercise or share parental responsibility and control;
- a child who is adopted by the Employee or placed with him for adoption prior to age 19. Placed for adoption means the assumption and retention by the Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have begun. Placement ends when the legal support obligation ends;
- Notwithstanding any residency or main support and care requirements, a child for whom Plan coverage is required due to a Medical Child Support Order (MCSO) which the Plan Administrator determines to be a Qualified Medical Child Support Order in accordance with its written procedures (that are incorporated herein by reference and that can be obtained without charge). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and having the force and effect of law under state law and that satisfies the QMCSO requirements of ERISA (section 609(a));

NOTE: An eligible Dependent does not include:

- a spouse following legal separation or a final decree of dissolution or divorce;
- a spouse who has or qualifies for insurance through an employer;
    - Effective January 1, 2023, if a spouse or domestic partner is eligible for group health insurance through his or her employer, then he or she will not be eligible to obtain coverage under Douglas County School District's group health plan. Employees must complete an affidavit to indicate their spouse or domestic partner's eligibility for participation in Douglas County School District's health plan. If any changes occur during the year regarding an employee's spouse or domestic partner's availability of coverage

through his/her employer, it is the employee's responsibility to notify Douglas County School District's Human Resources Office. Misstatements on the spousal carve out affidavit may be used as a basis for termination of medical benefits from the original effective date and the employee will be required to reimburse all claims paid. In addition, past monthly premiums for spousal coverage will not be reimbursed to the employee.

- any person who is on active duty in a military service, to the extent permitted by law; any person who is eligible and has enrolled as an Employee under the Plan;
- any person who is covered under the Plan as a Dependent of another Employee.
-

See **EXTENSION OF COVERAGE** section(s) for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.

Effective Date - Dependents

A Dependent who is eligible and enrolled when the Employee enrolls, will have coverage effective on the same date as the Employee. Dependents acquired later may be enrolled within thirty-one (31) days of their eligibility date (see **Special Enrollment Rights** provision for details as well as instances when the loss of other coverage and other circumstances can allow a Dependent to be enrolled). Otherwise, a Dependent can be enrolled only in accordance with the Open Enrollment provision.

NOTE: In no instance will a Dependent's coverage become effective prior to the Employee's coverage effective date.

Special Enrollment Rights

Entitlement Due to Loss of Other Coverage - An individual who did not enroll in the Plan when previously eligible will be allowed to apply for coverage hereunder at a later date if:

- he was covered under another group health plan or other health insurance coverage (including Medicaid) at the time coverage was initially offered or previously available to him. Health insurance coverage means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;
- the Employee stated in writing at the time a prior enrollment was offered or available that other coverage was the reason for declining enrollment in the Plan. However, this only applies if the Plan Sponsor required such a written statement and provided the person with notice of the requirement and the consequences of failure to comply with the requirement;
- the individual lost the other coverage as a result of a certain event and the Employee requested Plan enrollment within thirty-one (31) days of termination of the other coverage. A loss of coverage event includes but is not limited to:
  - loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment;

- loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual);
- loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
- loss of eligibility when a plan no longer offers any benefits to a class of similarly situated individuals. For example, if a plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility, even if the plan continues to provide coverage to other employees;
- loss of eligibility when employer contributions toward the employee's or dependent's coverage terminates. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer;
- loss of eligibility when COBRA Continuation Coverage is exhausted.

If the above conditions are met, Plan coverage will be effective on the first day of the first calendar month that begins after the date of termination of other coverage.

NOTE: For a Dependent to enroll under the terms of this provision, the Employee must be enrolled or must enroll concurrently. Loss of other coverage for failure to pay premiums on a timely basis or for cause (e.g., making a fraudulent claim or making an intentional misrepresentation of a material fact with respect to the other coverage) will not be a valid loss of coverage for these purposes.

Entitlement Due to Medicaid - Each individual who did not enroll in the Plan when previously eligible may later enroll for coverage under the terms of the Plan if either:

- the individual is covered under a Medicaid plan under Title XIX of the Social Security Act or under a State's Children's Health Insurance Program ("CHIP") under Title XXI of the Social Security Act and (a) coverage of the individual under such a plan is terminated as a result of loss of eligibility for such coverage and (b) the Employee requests coverage for the individual under the Plan no later than 60 days after the date such coverage terminates; or
- the individual becomes eligible for assistance, with respect to group health coverage under the Plan, under a Medicaid plan or CHIP (including under any waiver or demonstration project conducted under or in relation to such a plan) and the Employee requests coverage under the group health coverage under the Plan no later than 60 days after the date individual is determined to be eligible for such assistance.

Entitlement Due to Acquiring New Dependent(s) - If an Employee acquires one (1) or more new eligible Dependents through marriage, birth, adoption, or placement for adoption (as defined by Federal law), application for their coverage may be made within thirty-one (31) days of the date the new Dependent or Dependents are acquired (the triggering event) and Plan coverage will be effective as follows:

- where Employee's marriage is the triggering event - the spouse's coverage (and the coverage of any eligible Dependent children the Employee acquires in the marriage) will be effective on the

first day of the first calendar month that begins after the date on which the triggering event occurs;

- where acquisition of a child is the triggering event - the child's coverage will be effective on the date of the event (i.e., concurrent with the child's date of birth, date of placement or date of adoption). The triggering event date for a newborn adoptive child is the child's date of birth if the child is placed with the Employee within 31 days of birth.

NOTE: For a newly-acquired Dependent to be enrolled under the terms of this provision, the Employee must be enrolled or must be eligible to enroll (i.e., must have satisfied any waiting period requirement) and must enroll concurrently. If the newly-acquired Dependent is a child, the spouse is also eligible to enroll. However, other Dependent children who were not enrolled when first eligible are not considered to be newly acquired and can only be enrolled in accordance with the late enrollment provisions of the Plan.

Court or Agency Ordered Coverage - If an Employee or an Employee's spouse is required to provide coverage for a child under a Medical Child Support Order, coverage for the child shall be effective as of the date specified in such order provided that such order is qualified according to the Plan Sponsor's written procedures and provided that a request for coverage is made on a form acceptable to the Plan Sponsor within 31 days from the date such order is determined to be qualified (QMCSO). A request to enroll the child may be made by the Employee, the Employee's spouse, the child's other parent, or by a State Agency on the child's behalf.

If the Employee is not enrolled when the Plan is presented with an MCSO that is determined to be qualified, and the Employee's enrollment is required in order to enroll the child, both must be enrolled. The Employer is entitled to withhold any applicable payroll contributions for coverage from the Employee's pay.

Newborn Children - Limited Automatic 31-Day Benefit Period for Ill or Injured Children

An Employee's ill or injured newborn child will be eligible for benefits for Eligible Expenses that are incurred within the first thirty-one (31) days after the child's birth. Benefits for such child will be available for the 31-day period only. After the 31-day period, coverage for the child will be available only if, within the thirty-one (31) days after the child's birth, the Employee has notified the Plan Sponsor or the Contract Administrator of the birth, has enrolled the child, and has agreed to make any required contributions for coverage from the moment of birth.

A newborn child, will be eligible for coverage effective on the child's date of birth. Coverage for the child will cease after 31 days unless the Subscriber enrolls the child within the appropriate enrollment period. We require a copy of the birth certificate, adoption certificate or certification of placement by the placing agency. During the first 31 day-period after birth adoption, coverage for the child shall consist of Medically Necessary care for Injury and sickness, including well child care and treatment of medically diagnosed congenital defects and birth abnormalities. All services provided during the first 31 days of coverage are subject to the Cost Sharing requirements such as Deductibles, Copayments and Coinsurance that are applicable to other sicknesses, diseases and conditions otherwise covered.

Open Enrollment

If an individual does not enroll when he is first eligible to do so or if he allows coverage to lapse, he may later enroll during an Open Enrollment period that will be held annually. Plan coverage will be effective on the first of the month following the end of the Open Enrollment period

NOTE: see Special Enrollment Rights for exceptions to this provision.

Reinstatement / Rehire

If an employee returns to an eligible status after termination of Plan coverage due to an unpaid leave and completes any necessary enrollment form, such Employee (and any of his Dependents who were covered at point of termination) will have coverage become effective on the first of the month following Employee's return to active and eligible status. A new waiting period requirement will not be applied.

If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA), and during the leave Employee discontinued paying his share of the cost of coverage causing coverage to terminate, such Employee may have coverage reinstated as if there had been no lapse (for himself and any Dependents who were covered at the point contributions ceased). The Plan Sponsor will have the right to require that unpaid coverage contribution costs be repaid.

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain Employees who return to active employment following active-duty service as a member of the United States armed forces, will be reinstated to coverage under the Plan immediately upon returning from military service. Additional information concerning the USERRA can be obtained from the Plan Sponsor.

If an Employee returns to an eligible status after having experienced a Qualifying Event and having continued Plan coverage, without interruption, as a Qualified Beneficiary under the terms of the COBRA Continuation Coverage, such Employee will be reinstated to active status and will have uninterrupted coverage under the Plan. That is, a new waiting period requirement will not be applied.

NOTE: Except in the above instances, any terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements. Benefits for any Employee or Dependent who is covered under the Plan, whose employment or coverage is terminated, and who is subsequently rehired or reinstated at any time, shall be limited to the maximum benefits that would have been payable had there been no interruption of employment or coverage.

Transfer of Coverage

If a husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of his eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such new coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

If a Covered Person changes status from Employee to Dependent or vice versa, and the person remains eligible and covered without interruption, then Plan benefits will not be affected by the person's change in status.

TERMINATION OF COVERAGE

Employee Coverage Termination

An Employee's coverage under the Plan will terminate upon the earliest of the following: termination of the Plan;

- termination of participation in the Plan by the Employee;
- the date the Employee begins active-duty service in the armed services of any country or organization, except for reserve duty of less than thirty (30) days. See Extension of Coverage During U.S. Military Service in the EXTENSIONS OF COVERAGE section for more information;
- the end of the period for which Employee last made the required contribution, if the coverage is provided on a contributory basis (i.e. Employee shares in the cost);
- at midnight on the last day of the month in which the covered Employee leaves or is dismissed from the employment of the Employer, ceases to be eligible, or ceases to be engaged in active employment for the required number of hours as specified in the ELIGIBILITY AND EFFECTIVE DATES section - except when coverage is extended (see terms in the EXTENSIONS OF COVERAGE section). For an Employee receiving contracted payments, eligibility ceases at the end of the month in which the contracted payments end;
- the date the Employee dies.

NOTE: An Employee otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his health status or need for health services. The Plan has the right to cancel or rescind coverage for participants who provide fraudulent or incomplete information.

Dependent Coverage Termination

A Dependent's coverage under the Plan will terminate upon the earliest of the following: termination of the Plan or discontinuance of Dependent coverage under the Plan;

- termination of the coverage of the Employee or, in the case of termination due to the Employee's death, at the end of the month following Employee's death;
- at midnight of the last day the Dependent meets the eligibility requirements of the Plan, except when coverage is extended under the terms of any Extension of Coverage provision. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee;
- the end of the period for which the Employee last made the required contribution for such coverage, if Dependent's coverage is provided on a contributory basis (i.e., Employee shares in the cost). However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has replacement coverage that will take effect immediately upon termination.

NOTE: A Dependent otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his health status or need for health services. The Plan has the right to cancel or rescind coverage for participants who provide fraudulent or incomplete information.

- (See COBRA **CONTINUATION COVERAGE** section) -

EXTENSIONS OF COVERAGE

Coverage may be continued beyond the Termination of Coverage date in the circumstances identified below. Unless expressly stated otherwise, however, coverage for a Dependent will not extend beyond the date the Employee's coverage ceases.

Extension of Coverage for Developmentally Disabled or Handicapped Dependent Children

If an already covered Dependent child attains the age that would otherwise terminate his status as a Dependent, and:

- if on the day immediately prior to the attainment of such age the child was a covered Dependent under the Plan;
- at the time of attainment of such age the child is incapable of self-sustaining employment by reason of mental retardation, cerebral palsy, epilepsy, other neurological disorder, physical handicap, or disability due to injury, accident, congenital defect or sickness;
- the child's condition has been diagnosed by a Physician as a permanent or long-term dysfunction or condition; and
- such child is primarily dependent upon the Employee for support and maintenance;

then such child's status as a Dependent will not terminate solely by reason of his having attained the limiting age and he will continue to be considered a covered Dependent under the Plan so long as he remains in such condition, and otherwise conforms to the definition of Dependent.

The Employee must submit proof of the child's incapacity to the Contract Administrator within thirty-one (31) days of the child's attainment of the limiting age, and thereafter as may be required, but not more frequently than once a year after the two-year period following the child's attainment of such age

Extensions of Coverage During Absence from Work

If an Employee fails to continue in eligible active status but is not terminated from employment (e.g., he is absent due to an approved leave or a temporary layoff), he may be permitted to continue health care coverages for himself and his Dependents though he could be required to pay the full cost of coverage during such absence. Any such extended coverage allowances will be provided on a non-discriminatory basis.

Except as noted, any coverage that is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

- on the date coverage terminates as specified in the Employer's personnel policies or other Employer communications, if any. Such documents are incorporated into the Plan by reference;
- in the case of an unpaid leave, at the end of the month of Employee's cessation of active employment, if the unpaid leave is longer than twenty (20) consecutive contracted workdays;
- the date the person becomes covered under any other group plan for benefits of a type similar to those provided by this Plan;
- the end of the period for which the last contribution was paid, if such contribution is required;
- the date of termination of this Plan.

To the extent that the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), it intends to comply with the Act. The Employer is subject to FMLA if it is engaged in commerce or in any industry

or activity affecting commerce and employs fifty (50) or more employees for each working day during each of twenty (20) or more calendar workweeks in the current or preceding Calendar Year.

In accordance with the FMLA, an Employee is entitled to continued coverage if he: (1) has worked for the Employer for at least twelve months, (2) has worked at least 1,250 hours in the year preceding the start of the leave, and (3) is employed at a worksite where the Employer employs at least fifty employees within a 75-mile radius.

Except as noted, continued coverage under the FMLA is allowed for up to 12 workweeks of unpaid leave in any 12- month period. Such leave must be for one or more of the following reasons:

the birth of an employee's child and in order to care for the child;

- the placement of a child with the Employee for adoption or foster care;
- to care for a spouse, child or parent of the Employee where such relative has a serious health condition; Employee's own serious health condition that makes him unable to perform the functions of his job;
- the Employee has a qualifying exigency (as defined by DOL regulations) arising because the Employee's spouse, son, daughter or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation (a specified military operation).

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. The above is a summary of FMLA requirements. An Employee can obtain a more complete description of his FMLA rights from the Plan Sponsor's Human Resources or Personnel department. Any Plan provisions which are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

NOTE: An eligible Employee will be entitled to take up to a combined total of 26 workweeks of FMLA leave during a single 12-month period where the Employee is a spouse, son, daughter, parent or next of kin (i.e., nearest blood relative) of a covered service member. A covered service member is a member of the Armed Forces (including the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is an Outpatient, or is on the temporary disability retired list, for a serious injury or illness (an injury or illness incurred in line of duty on active duty in the Armed Forces that may render the service member medically unfit to perform his duties).

Extension of Coverage During U.S. Military Service

Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

An Employee who is ordered to active military service is (and the Employee's eligible Dependent(s) are) considered to have experienced a COBRA Qualifying Event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the stipulations set forth herein.

Notice Requirements - To be protected by USERRA and to continue health coverage, an Employee must generally provide the Employer with advance notice of his military service. Notice may be written or oral, or may be given by an appropriate officer of the military branch in which the Employee will be serving. Notice will not be required to the extent that military necessity prevents the giving of notice or if the giving of notice is otherwise impossible or unreasonable under the relevant circumstances. If the Employee's ability to give advance notice was impossible, unreasonable or precluded by military necessity, then the Employee may elect to continue coverage at the first available moment and the Employee will be retroactively reinstated in the Plan to the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premiums from date of termination of Plan coverage. No administrative or reinstatement charges will be imposed.

If the Employee provides the Employer with advance notice of his military service but fails to elect continuation of coverage under USERRA, the Plan Administrator will continue coverage for the first thirty (30) days after Employee's departure from employment due to active military service. The Plan Administrator will terminate coverage if Employee's notice to elect coverage is not received by the end of the 30-day period. If the Employee subsequently elects to continue coverage while on active military service and within the time set forth in the subsection entitled Maximum Period of Coverage below, then the Employee will be retroactively reinstated in the Plan as of the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premium charges from the date Plan coverage terminated.

Cost of USERRA Continuation Coverage - The Employee must pay the cost of coverage (herein "premium"). The premium may not exceed 102% of the actual cost of coverage, and may not exceed the active Employee cost share if the military leave is less than 31 days. If the Employee fails to make timely payment within the same time period applicable to those enrollees of the Plan continuing coverage under COBRA, the Plan Administrator will terminate the Employee's coverage at the end of the month for which the last premium payment was made. If the Employee applies for reinstatement to the Plan while still on active military service and otherwise meets the requirements of the Plan and of USERRA, the Plan Administrator will reinstate the Employee to Plan coverage retroactive to the last day premium was paid. The Employee will be responsible for payment of all back premium charges owed.

Maximum Period of Coverage – The maximum period of USERRA continuation coverage following Employee's cessation of active employment is the lesser of:

- 24 months; or
- the duration of Employee's active military service.

Reinstatement of Coverage Following Active Duty - Regardless of whether an Employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the Employee returns to active employment if the Employee was released under honorable conditions.

The Employee must return to employment:

- on the first full business day following completion of military service for military leave of 30 days or less; or within 14 days of completion of military service for military leave of 31-180 days; or
- within 90 days of completion of military service for military leave of more than 180 days.

When coverage hereunder is reinstated, all Plan provisions and limitations will apply to the extent that they would have applied if the Employee had not taken military leave and coverage had been continuous. No waiting period can be imposed on a returning Employee or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

Extension of Coverage for Retirees

If an Employee retires from active service with the Employer and:

- begins drawing retirement benefits from the Nevada Public Employees Retirement Systems immediately upon his separation from the Employer; or
- begins drawing disability retirement benefits from the State of Nevada Public Employee's Retirement System immediately upon his separation from the Employer;

then, within thirty-one (31) days of the date of his retirement, he may elect to continue Plan coverage, without interruption, for himself and his eligible Dependents.

An enrolled retiree and his eligible and enrolled Dependents will be treated in the same manner as active enrollees to the extent required by applicable law – including the special enrollment rights as outlined in the **ELIGIBILITY AND EFFECTIVE DATES** section.

The retiree will be required to contribute to the Plan at rates determined by the Plan Sponsor. Contributions must be kept current in order for coverage to remain in effect. The requirements for timely payment are as determined by the Plan Sponsor.

NOTE: This Plan will be secondary to Medicare for any such individual who is eligible for Medicare – see **COORDINATION OF BENEFITS (COB**) section for more information.

Extension of Coverage for Former Board Members & Surviving Dependents

A former member of the Board of Trustees who has served at least one (1) full term of office, has the option of canceling or continuing Plan coverage to the extent that coverage is not provided to him or a Dependent by the Health Insurance for the Aged Act, 42 U.S.C. 1395 et seq.

A former board member who continues Plan coverage will be responsible for the full cost of continued coverage. A Dependent of such a board member has the option, which may be exercised to the same extent and in the same manner as the board member, to continue coverage in effect on the date the former board member dies.

Notice of selection of the option to continue coverage must be given, in writing, to the Board of Trustees of the school district within thirty (30) days after the expiration of the board member's term of office or the date of his death, as the case may be. If no notice is given by that date, the board member and his Dependents shall be deemed to have selected the option to cancel the coverage.

- (See **COBRA CONTINUATION COVERAGE** section) –

COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, that is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent will prevail over this summary.

Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if part of the Employer's Plan) are not eligible for continuation under COBRA.

If a retired Employee is covered under the Plan and one of his Dependents has a Qualifying Event (e.g., divorce or loss of Dependent child eligibility), such Dependent may be eligible for COBRA Continuation Coverage. Also, certain other COBRA rights apply to such retirees and their covered Dependents with regard to an Employer's bankruptcy. Anywhere retirees are referenced herein it means only those retired Employees who were covered under the Plan.

Definitions – When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary – An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee, or the covered Dependent spouse (as defined by the federal Defense of Marriage Act) or child of a covered Employee.

Any child who is born to or placed for adoption with a covered Employee during a period of COBRA Continuation Coverage. Such child has the right to immediately elect, under the COBRA Continuation Coverages the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a Qualified Beneficiary if those individual experiences a Qualifying Event.

Exception: An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which he was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

Qualifying Event – Any of the following events that would result in the loss of health coverage under the Plan in the absence of COBRA Continuation Coverage:

- voluntary or involuntary termination of Employee's employment for any reason other than Employee's gross misconduct;
- reduction in an employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his portion of the cost of Plan coverage during the FMLA leave;
- for an employee's spouse or child, Employee's entitlement to Medicare. For COBRA purposes, entitlement means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that his Medicare coverage is in effect;
- for an employee's spouse or child, the divorce or legal separation of the Employee and spouse; for an employee's spouse or child, the death of the covered Employee;
- for an employee's child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit).

Non-Qualified Beneficiary – An individual who is covered under the Plan on an active basis (i.e., an individual to whom a Qualifying Event has not occurred).

Notification Responsibilities

If the Employer is the Plan Administrator and if the Qualifying Event is Employee's termination/reduction in hours, death, or Medicare entitlement, then the Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA Continuation Coverage rights, or the unavailability of COBRA rights, within 44 days of the event. If the Employer is not the Plan Administrator, then the Employer's notification to the Plan Administrator must occur within 30 days of the Qualifying Event and the Plan Administrator must provide Qualified Beneficiaries with their COBRA rights notice within 14 days thereafter. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

If COBRA Continuation Coverage terminates early (e.g., the Employer ceases to provide any group health coverage, a Qualified Beneficiary fails to pay a required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election), the Plan Administrator must provide the Qualified Beneficiary/ies with notification of such early termination. Notice must include the reason for early termination, the date of termination and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA Continuation Coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred that permits him to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA Continuation Coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is a

Dependent child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the Employee from his spouse. A Qualified Beneficiary is also responsible for other notifications. See **COBRA NOTIFICATION PROCEDURES** section for further details and time limits imposed on such notifications. Upon receipt of a notice, the Plan Administrator must notify the Qualified Beneficiary/ies of their continuation rights within 14 days.

Election and Election Period

COBRA Continuation Coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA Continuation Coverage rights is provided to the Qualified Beneficiary. Failure to make a COBRA election within the 60-day period will result in the inability to elect COBRA Continuation Coverage.

If the COBRA election of a covered Employee or spouse does not specify self-only coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA Continuation Coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA Continuation Coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA Continuation Coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Plan Administrator.

Open enrollment rights that allow Non-COBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the special enrollment rights of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

<u>The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.</u>

NOTE: See Effect of the Trade Act provision for information regarding a second 60-day election period allowance.

Effective Date of Coverage

COBRA Continuation Coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See Election and Election Period for an exception to the above when a Qualified Beneficiary initially waives COBRA Continuation Coverage and then revokes his waiver. In that instance, COBRA Continuation Coverage is effective on the date the waiver is revoked.

Level of Benefits

COBRA Continuation Coverage will be equivalent to coverage provided to similarly situated Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated Non-COBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to his deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA Continuation Coverage are carried forward to the COBRA Continuation Coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

Cost of Continuation Coverage

The cost of COBRA Continuation Coverage is fixed in advance for a 12-month determination period and will not exceed 102% of the Plan's full cost of coverage during the period for similarly situated Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. The full cost includes any part of the cost that is paid by the Employer for Non-COBRA Beneficiaries. Qualified Beneficiaries will be charged 150% of the full cost for the 11-month disability extension period if the disabled person is among those extending coverage.

The initial premium (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. If payment is not made within such time period, the COBRA election is null and void. The initial premium payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Payment is considered to be made on the date it is sent to the Plan or Plan Sponsor.

The Plan must allow the payment for COBRA Continuation Coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA Continuation Coverage can only increase during the Plan's 12-month determination period if:

- the cost previously charged was less than the maximum permitted by law;
- the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law which is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or
- the Qualified Beneficiary changes his coverage option(s) which results in a different coverage cost.

Timely payments that are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least 30 days) to make full payment. A payment will be considered an insignificant shortfall if it is not greater than $50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTE: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically-indigent or due to a certain disability. The Employer's personnel offices should be contacted for additional information.

See Effect of the Trade Act provision for additional cost of coverage information.

Maximum Coverage Periods

The maximum coverage periods for COBRA Continuation Coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

- if the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the loss of coverage due to the Qualifying Event. With a disability extension (see Disability Extension provision), the 18 months is extended to 29 months;
- if the Qualifying Event occurs to a Dependent due to Employee's enrollment in the Medicare program before the Employee himself experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare;
- for any other Qualifying Event, the maximum coverage period ends 36 months after the loss of coverage due to the Qualifying Event.

If a Qualifying Event occurs that provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment will not expand the maximum COBRA continuation period. In no

circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first Qualifying Event.

COBRA entitlement runs concurrently with continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) - USERRA does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

Disability Extension

An 11-month disability extension (an extension from a maximum 18 months of COBRA Continuation Coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to be disabled in the first 60 days of COBRA Continuation Coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date that falls within the allowable period. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA Continuation Coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA Continuation Coverage, those family members are also entitled to the 29-month COBRA Continuation Coverage period. This applies even if the disabled person does not elect the extension himself.

Termination of Continuation Coverage

Except for an initial interruption of Plan coverage in connection with a waiver (see Election and Election Period provision), COBRA Continuation Coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the loss of coverage due to the Qualifying Event and ending on the earliest of the following dates:

- the last day of the applicable maximum coverage period - see Maximum Coverage Periods provision;
- the date on which the Employer ceases to provide any group health plan to any Employee;
- the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan;
- the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, entitled means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his Medicare coverage is in effect;

In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

- 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
- the end of the maximum coverage period that applies to the Qualified Beneficiary without regard

to the disability extension; or

- the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium).

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated Non-COBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA Continuation Coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA Continuation Coverage available will cease when the Plan is no longer obligated to make COBRA Continuation Coverage available to the Qualified Beneficiary.

Effect of the Trade Act

In response to Public Law 107-210, referred to as the Trade Act of 2002 (“TAA”), the Plan is deemed to be Qualified Health Insurance pursuant to TAA, the Plan provides COBRA continuation of coverage in the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

Eligible Individuals – The Plan Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation (“PBGC”), pursuant to TAA as of or after November 4, 2002. The Plan Administrator shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement or federal income tax filings. The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

Temporary Extension of COBRA Election Period

Definitions:

> Nonelecting TAA-Eligible Individual – A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA Continuation Coverage during the TAA-Related Election Period.

TAA-Eligible Individual – An eligible TAA recipient and an eligible alternative TAA recipient.

TAA-Related Election Period – with respect to a TAA-related loss of coverage, the 60-day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual.

TAA-Related Loss of Coverage – means, with respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

In the case of an otherwise COBRA Qualified Beneficiary who is a Nonelecting, TAA-Eligible Individual, such individual may elect COBRA continuation of coverage during the TAA-Related Election Period, but only if such election is made not later than 6 months after the date of the TAA-Related Loss of Coverage.

Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA- Related Election Period, and shall not include any period prior to the such individual's TAA-Related Election Period.

Applicable Cost of Coverage Payments

Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA- Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in IRS regulations 54.4980B-8, A-5(d), the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise, the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.

Alternatives to COBRA

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

COBRA NOTIFICATION PROCEDURES

It is a Plan participant's responsibility to provide the following Notices as they relate to COBRA Continuation Coverage:

Notice of Divorce or Legal Separation – Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee from his spouse.

Notice of Child's Loss of Dependent Status – Notice of a Qualifying Event that is a child's loss of Dependent status under the Plan (e.g., a Dependent child reaching the maximum age limit).

Notice of a Second Qualifying Event – Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.

Notice Regarding Disability – Notice that: (a) a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months is determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage, or (b) a Qualified Beneficiary as described in (a) has subsequently been determined by the Social Security Administration to no longer be disabled.

Notice Regarding Address Changes – It is important that the Plan Administrator be kept informed of the current addresses of all Plan participants or beneficiaries who are or may become Qualified Beneficiaries.

Notification must be made in accordance with the following procedures. Any individual who is the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee or Qualified Beneficiary may provide the Notice. Notice by one individual shall satisfy any responsibility to provide Notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Form & Delivery

Notification of the Qualifying Event must be made on a form that is available from the Human Resources Department of the Douglas County School District. See **GENERAL PLAN INFORMATION** section for contact information.

Notification must be received by the Benefits Coordinator in the Human Resources Department of the Douglas County School District. See **GENERAL PLAN INFORMATION** section for contact information.

Content

Notification must include the following proof of the Qualifying Event:

- for a divorce, a copy of the divorce decree;
- for a child's loss of dependent status, a copy of the child's birth certificate;
- for extending the maximum duration due to disability, a copy of the Social Security Administration's disability determination letter.

Time Requirements for Notification

In the case of a divorce, legal separation or a child losing dependent status, Notice must be delivered within 60 days from the later of: (1) the date of the Qualifying Event, (2) the date health plan coverage is lost due to the event, or (3) the date the Qualified Beneficiary is notified of the obligation to provide Notice through the Summary Plan Description or the Plan Sponsor's General COBRA Notice. If Notice is not received within the 60-day period, COBRA Continuation Coverage will not be available, except in the case of a loss of coverage due to foreign competition where a second COBRA election period may be available – see Effect of the Trade Act in the **COBRA CONTINUATION COVERAGE** section of the Plan's Summary Plan Description or Benefit Plan Document.

If an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, Notice must be delivered within 60 days from the later of: (1) the date of the determination, (2) the date of the Qualifying event, (3) the date coverage is lost as a result of the Qualifying Event, or (4) the date the covered Employee or Qualified Beneficiary is advised of the Notice obligation through the Benefit Plan Document or the Plan Sponsor's General COBRA Notice. Notice must be provided within the 18-month COBRA coverage period. Any such Qualified Beneficiary must also provide Notice within 30 days of the date he is subsequently determined by the Social Security Administration to no longer be disabled.

The Plan will not reject an incomplete Notice as long as the Notice identifies the Plan, the covered Employee and Qualified Beneficiary/ies, the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete Notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following the request.

COORDINATION OF BENEFITS (COB)

All health care benefits provided under the Plan are subject to Coordination of Benefits as described below, unless specifically stated otherwise.

Definitions – As used in this COB section, the following terms will be capitalized and will have the meanings indicated:

Other Plan – Any of the following that provides health care benefits or services: group or group-type plans, including franchise or blanket benefit plans; Blue Cross and Blue Shield group plans;

- group practice and other group prepayment plans;
- federal government plans or programs, including Medicare;
- other plans required or provided by law – but not including Medicaid or any benefit plan like it that, by its terms, does not allow coordination;
- no-fault auto insurance, by whatever name it is called, when not prohibited by law.

NOTES: An Other Plan includes benefits that are actually paid or payable or benefits that would have been paid or payable if a claim had been properly made for them. If an Other Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

This Plan – As used in this COB section, the coverages of this Plan.

Allowable Expense – The Usual & Customary charge for any Medically Necessary, Reasonable, eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations. This Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of This Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

Application to Benefit Determinations

The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan Deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal Injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

1. The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and
2. The rules in the section entitled “Order of Benefit Determination” would require this Plan to determine its benefits before the Other Plan.

Claim Determination Period – A period that commences each January 1 and ends at 12 o'clock midnight on the next succeeding December 31, or that portion of such period during which the Claimant is covered under This Plan. The Claim Determination Period is the period during which This Plan's normal liability is determined (see Effect on Benefits Under This Plan).

Custodial Parent – A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

EFFECT ON BENEFITS UNDER THIS PLAN

When Other Plan Does Not Contain a COB Provision

If an Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be primary and This Plan will pay its benefits AFTER such Other Plan(s). This Plan's liability will be the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

When Other Plan Contains a COB Provision

When an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the Order of Benefit Determination Rules below. If, in accordance with those rules, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits AFTER an Other Plan(s), it will pay the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

NOTE: The determination of This Plan's normal liability will be made for an entire Claim Determination Period (e.g., Calendar Year). If This Plan is secondary, the difference between the benefit payments that This Plan would have paid had it been the primary plan and the benefit payments that it actually pays as a secondary plan is recorded as a benefit reserve for Covered Person and will be used to pay Allowable Expenses not otherwise paid during the balance of the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero.

ORDER OF BENEFIT DETERMINATION RULES

Whether This Plan is the primary plan or a secondary plan is determined in accordance with the following rules.

Automobile Coverage

When medical benefits are available under vehicle insurance, This Plan will always be considered an

excess (or secondary) coverage – see When This Plan Will Provide Excess Benefits Only.

Medicare as an Other Plan

Medicare will be the primary, secondary or last payer in accordance with federal law. When Medicare is the primary payer, This Plan will determine its benefits based on Medicare Part A and Part B benefits that would have been paid or payable, regardless of whether or not the person was enrolled for such benefits.

Non-Dependent vs. Dependent

The benefits of a plan that covers the Claimant other than as a dependent (i.e., as an employee, member, subscriber or retiree) will be determined before the benefits of a plan that covers such Claimant as a dependent. However, if the Claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan

When the Claimant is a dependent child, the primary plan is the plan of the parent whose birthday is earlier in the year if: (1) the child's parents are married, (2) the parents are not separated, whether or not they have ever been married, or (3) a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

When the Claimant is a dependent child and the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Claim Determination Periods or Plan Years commencing after the plan is given notice of the court decree.

When the Claimant is a dependent child whose father and mother is not married, is separated (whether or not they have ever been married), or is divorced, the order of benefits is:

- the plan of the Custodial Parent;
- the plan of the spouse of the Custodial Parent;
- the plan of the noncustodial parent; and then
- the plan of the spouse of the noncustodial parent.

Active vs. Inactive Employee

The plan that covers the Claimant as an employee, who is neither laid off nor retired, is primary. The plan that covers a person as a dependent of an employee who is neither laid off nor retired, is primary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage (COBRA) Enrollee

If a Claimant is a COBRA enrollee under This Plan, an Other Plan covering the person as an employee,

member, subscriber, or retiree (or as that person's dependent) is primary and This Plan is secondary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer vs. Shorter Length of Coverage

If none of the above rules establish which plan is primary, the benefits of the plan that has covered the Claimant for the longer period of time will be determined before those of the plan that has covered that person for the shorter period of time.

Dual Coverage Dependents - For a Dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the Longer or Shorter Length of Coverage rules applies. In the event the Dependent child's coverage under the spouse's plan began on the same date as the Dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule described in the Child Covered Under More Than One Plan rule to the Dependent child's parent(s) and the Dependent child's spouse.

NOTE: If the preceding rules do not determine the primary plan, the Allowable Expenses shall be shared equally between This Plan and the Other Plan(s). However, This Plan will not pay more than it would have paid had it been primary.

OTHER INFORMATION ABOUT COORDINATION OF BENEFITS

Right to Receive and Release Necessary Information

For the purpose of enforcing or determining the applicability of the terms of this COB section or any similar provision of any Other Plan, the Contract Administrator may, without the consent of any person, release to or obtain from any insurance company, organization, or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish to the Contract Administrator such information as may be necessary to enforce this provision.

Facility of Payment – A payment made under an Other Plan may include an amount that should have been paid under This Plan. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. This Plan will not have to pay that amount again.

Right of Recovery – If the amount of the payments made by This Plan is more than it should have paid under this COB section, This Plan may recover the excess from one or more of the persons it has paid or for whom it has paid - or any other person or organization that may be responsible for the benefits or services provided for the Claimant. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

WHEN THIS PLAN WILL PROVIDE EXCESS BENEFITS ONLY

Excess Benefits

If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (see Coverage as defined in the SUBROGATION AND REIMBURSEMENT PROVISIONS section and including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under This Plan shall apply only as an excess over such other sources of Coverage. This Plan's benefits shall be excess to:

- any responsible third party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party; worker's compensation or other liability insurance company; or
- any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

Vehicle Limitation

When medical payments are available under any vehicle insurance, This Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

SUBROGATION AND REIMBURSEMENT PROVISIONS

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, Plan beneficiaries, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where another party may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

Covered Person(s), his attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits, Covered Person(s) agrees the Plan shall have an equitable lien on any funds received by Covered Person(s) and/or his attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of Covered Person(s). If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

Subrogation

As a condition to participating in and receiving benefits under this Plan, Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which Covered Person(s) is entitled, regardless of how classified or characterized.

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may in its own name or in the name of Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If Covered Person(s) fails to file a claim or pursue damages against:

- the responsible party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party; worker's compensation or other liability insurance company; or
- any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in Covered Person(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether Covered Person(s) is fully compensated by his recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interfere with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by Covered Person(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's **COORDINATION OF BENEFITS (COB)** section.

The Plan's benefits shall be excess to:

- the responsible party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party; worker's compensation or other liability insurance company; or
- any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of Covered Person(s), such that the death of Covered Person(s), or filing of bankruptcy by Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that Covered Person(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

Obligations

It is Covered Person(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

- to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
- to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
- to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan beneficiary may have against any responsible party or Coverage.

If Covered Person(s) and/or his attorney fails to reimburse the Plan for all benefits paid or to be paid, as

a result of said injury or condition, out of any proceeds, judgment or settlement received, Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon Covered Person(s)' cooperation or adherence to these terms.

Offset

Failure by Covered Person(s) and/or his attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of Covered Person(s) may be withheld until Covered Person(s) satisfies his obligation.

Minor Status

In the event Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court- appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

CLAIMS PROCEDURES

SUBMITTING A CLAIM

A claim is a request for a benefit determination that is made, in accordance with the Plan's procedures, by a Claimant or his authorized representative. A claim must be received by the person or organizational unit customarily responsible for handling benefit matters on behalf of the Plan so that the claim review and benefit determination process can begin. A claim must name the Plan, a specific Claimant, a specific health condition or symptom or diagnostic code, and a specific treatment, service or supply (or procedure/revenue codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services are received, and provider name, address, phone number and tax identification number.

The Plan Administrator has contracted with other entities to handle claims communications and benefit determinations for the Plan. Contact information for such entities ("claims offices") is provided below.

There are two types of health claims: (1) Pre-Service Claims, and (2) Post-Service Claims:

1. **A Pre-Service Claim** is where the terms of the Plan condition benefit, in whole or in part, on prior approval of the proposed care. See **UTILIZATION MANAGEMENT PROGRAM** section, Choice of Providers in the Medical Benefit Summary, and Durable Medical Equipment in the list of Eligible Medical Expenses for that information.

   A Pre-Service Claim should be directed to:

   Hometown Health
   10315 Professional Circle
   Reno, NV 89521
   Phone: (800) 336-0123

Important: A Pre-Service Claim is only for the purposes of assessing the Medical Necessity and appropriateness of care and delivery setting. A determination on a Pre-Service Claim is not a guarantee of benefits from the Plan. Plan benefit payments are subject to review upon submission of a claim to the Plan after medical services have been received, and are subject to all related Plan provisions, including exclusions and limitations.

2. **A Post-Service Claim** is a written request for benefit determination after a service has been rendered and expense has been incurred. A Post-Service Claim must be submitted to the claims office within twenty (20) days of the date charges are incurred. Claims filed later than that date may be declined or reduced unless: (1) it is not reasonably possible to submit the claim in that time, and (2) the claim is submitted within one year from the date incurred. This one-year limit will not apply when a person is not legally capable of submitting the claim.

   A Post-Service Claim should be submitted to:

Hometown Health
10315 Professional Circle
Reno, NV 89521

NOTE: In accordance with federal law, the Centers for Medicare and Medicaid Services (CMS) have three (3) years to submit claims when CMS has paid as the primary plan and the Plan should have been primary.

ASSIGNMENTS TO PROVIDERS

All Eligible Expenses reimbursable under the Plan will be paid to the covered Employee except that: (1) assignments of benefits to Hospitals, Physicians or other providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless Covered Person requests otherwise, in writing, within the time limits for filing proof of loss, and (3) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

Benefits due to any Network provider will be considered assigned to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

No covered Employee or Dependent may, at any time, either while covered under the Plan or following termination of coverage, assign his right to sue to recover benefits under the Plan, or enforce rights due under the Plan or any other causes of action he may have against the Plan or its fiduciaries.

NOTE: Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of Covered Person, as created by an assignment of rights made by Covered Person or his beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable under the Plan

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than it should have paid under this COB section, the Plan may recover the excess from one or more of the persons it has paid or for whom it has paid - or any other person or organization that may be responsible for the benefits or services provided for Claimant. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

CLAIMS TIME LIMITS AND ALLOWANCES

The chart below sets forth the time limits and allowances that apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (i.e., how quickly the Plan will respond to claims notices, filings and claims appeals and how much time will be allowed for Claimants to respond, etc.).

Important: These claims procedures address the periods within which claims determinations must be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval.

PRE-SERVICE CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Urgent Claim - defined below	
Claimant Makes Initial Incomplete Claim Request	Within not more than 24 hours (and as soon as possible considering the urgency of the medical situation), Plan notifies Claimant of information needed to complete the claim request. Notification may be oral unless Claimant requests a written notice.
Plan Receives Completing Information	Plan notifies Claimant, in writing or electronically, of its benefit determination as soon as possible and not later than 48 hours after the earlier of: (1) receipt of the completing information, or (2) the period of time Claimant was allowed to provide the completing information.
Claimant Makes Initial Complete Claim Request	Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), Plan responds with written or electronic benefit determination.
Claimant Appeals	See Appeal Procedures subsection. An appeal for an urgent claim may be made orally or in writing.
Plan Responds to Appeal	Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), after receipt of Claimant's appeal.
An Urgent Claim is an oral or written request for benefit determination where the decision would result in either of the following if decided within the time frames for non-urgent claims: (1) serious jeopardy to Claimant's life or health, or the ability to regain maximum function, or (2) in the judgment of a Physician knowledgeable about Claimant's condition, severe pain that could not be adequately managed without the care or treatment being claimed. Where the Time Limit or Allowance stated above reflects "or sooner, if possible," this phrase means that an earlier response may be required, considering the urgency of the medical situation.	
Concurrent Care Claim - defined below	
Plan Wants to Reduce or terminate Already Approved Care	Plan notifies Claimant of intent to reduce or deny benefits before any reduction or termination of benefits is made and provides enough time to allow Claimant to appeal and obtain

	a response to the appeal before the benefit is reduced or terminated. Any decision with the potential of causing disruption to ongoing care that is Medically Necessary is subject to the urgent claim rules.
Claimant Requests Extension for Urgent Care	Plan notifies Claimant of its benefit determination within 24 hours after receipt of the request (and as soon as possible considering the urgency of the medical situation), provided Claimant requests to extend the course of treatment at least 24 hours prior to the expiration of the previously-approved period of time or treatment. Otherwise, the Plan's notification must be made in accordance with the time allowances for appeal of an urgent, pre-service or post-service claim, as appropriate.
A Concurrent Care Claim is a Claimant's request to extend a previously-approved and ongoing course of treatment beyond the approved period of time or number of treatments. A decision to reduce or terminate benefits already approved does not include a benefit reduction or denial due to Plan amendment or termination.	
Non-Urgent Claim	
Claimant Makes Initial Incomplete Claim Request	Within 5 days of receipt of the incomplete claim request, Plan notifies Claimant, orally or in writing, of information needed to complete the claim request. Claimant may request a written notification.
Plan Receives Completing Information	Plan responds with written or electronic benefit determination within 15 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of Full Notice below.
Claimant Makes Initial Complete Claim Request	Within 15 days, Plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to Claimant - see definition of Full Notice below.
Claimant Appeals	See **Appeal Procedures** subsection.
Plan Responds to Appeal	See **Appeal Procedures** subsection.
Full Notice means that notice is provided to Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the time period outlined in the **Appeals Procedures** subsection.	
POST-SERVICE CLAIM ACTIVITY	**TIME LIMIT OR ALLOWANCE**
Claimant Makes Initial Incomplete Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request.
Plan Receives Completing Information	Plan approves or denies claim within 30 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of FULL NOTICE below.
Claimant Makes Initial	Within 30 days of receiving the claim, Plan approves or

Complete Claim Request	denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of FULL NOTICE below.
Claimant Appeals	See **Appeal Procedures** subsection.
Plan Responds to Appeal	See **Appeal Procedures** subsection.
Full Notice means that notice is provided to Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the time period outlined in the Appeals Procedures subsection.	

Authorized Representative May Act for Claimant

Any of the above actions that can be done by Claimant can also be done by an authorized representative acting on Claimant's behalf. Claimant may be required to provide reasonable proof of such authorization. For an urgent claim, a health care professional, with knowledge of a Claimant's medical condition, will be permitted to act as the authorized representative of Claimant. Health care professional means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Written or Electronic Notices

The Plan shall provide Claimant with written or electronic notification of any benefit reduction or denial. Written or electronic notice of an approved benefit must be provided only for Pre-Service benefit determinations.

CLAIMS DENIALS

If a claim is wholly or partially denied, Claimant will be given written or electronic notification of such denial. The notice will include the following and will be provided in a manner intended to be understood by Claimant (including, if necessary, in a culturally and linguistically appropriate manner according to applicable requirements):

the specific reason(s) for the decision to reduce or deny benefits (or uphold the Adverse Benefit Determination), including any denial code, corresponding meaning of such code, and a description of the Plan's standard, if any, that was used in denying the Claim, and, for a final Adverse Benefit Determination, a discussion of the Plan's decision;

- the date of service;
- the name of the Provider; the Claim amount;
- notification that a Claimant may request, and the Plan will provide upon request, the diagnosis code and treatment code along with the corresponding meaning of such codes:
- specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols that were relied upon in making the decision;
- a statement that Claimant is entitled to receive, upon request and free of charge, reasonable access to, and

- copies of, all documents, records or other information relevant to Claimant's claim for benefits;
- if the Adverse Benefit Determination is based on Medical Necessity or Experimental treatment or similar Exclusion or limit, either an explanation of the scientific or clinical judgment or a statement that such explanation will be provided free of charge;
- a description of any additional information needed to change the decision and an explanation of why it is needed;
- a description of the Plan's procedures and time limits for appealed claims, including information regarding how to initiate an Appeal;
- if the denial relates to a Claim involving Urgent Care, a description of the expedited review process applicable to such Claim; and
- Contact information for member assistance provided by the Contract Administrator

APPEAL PROCEDURES

If a claim has been denied in whole or in part by the Contract Administrator, Claimant may appeal the determination of that claim under the lowest review level indicated below. If the denial is upheld, Claimant may appeal to the next highest level of review. This may be repeated until the entire appeals process has been exhausted.

Level I: REVIEW OF THE CLAIM BY THE CONTRACT ADMINISTRATOR

Claimant may submit an appeal letter referencing the claim to the Contract Administrator. Claimant shall have this opportunity to present additional information and/or documentation supporting this appeal. The Contract Administrator will review the claim for appropriateness based on the Benefit Plan Document and, if needed for medical interpretation or clarification, request a Physician review. Appeal letter and additional information and/or documentation must be submitted within one hundred eighty (180) days of the claim denial to:

Hometown Health
ATTN: Claims Manager
10315 Professional Circle
Reno, NV 89521

The Contract Administrator will render a decision within sixty (60) days of receipt of the appeal letter and will notify, in writing, the Plan Sponsor and Claimant of the findings.

Level II: EXTERNAL REVIEW OF THE CLAIM

If, upon Level I denial, Claimant disagrees with Contract Administrator decision, Claimant or Claimant's authorized representative may submit the claim to the external review process described below. This step is not mandatory. If Contract Administrator based a denial, reduction, termination, or refusal to provide payment on a determination that an individual is not eligible under the Plan, no external review is available.

In most circumstances, before Claimant may submit a claim to the external review process, Claimant must first follow the claims procedures outlined above by filing an initial claim and a request for review of an

adverse benefit determination to the Contract Administrator. However, in certain circumstances (described below), Claimant may receive an expedited external review. In this case, Claimant may not have to exhaust the internal claims process before filing a request for external review.

Within four (4) months of the date Claimant receives an adverse benefit determination or final internal adverse benefit determination, Claimant or Claimant's authorized representative may file a request for external review. The request should be sent to:

Hometown Health
ATTN: Claims Manager
10315 Professional Circle
Reno, NV 89521
By Phone: 1-800-336-0123

Claimant or Claimant's authorized representative may make a written or oral request for an expedited external review to the external review examiner if Claimant had filed a request for expedited appeal of an Urgent Care claim and Claimant had received an adverse benefit determination and:

- Claimant had a medical condition where the time for completing the internal review process would seriously jeopardize Claimant's life, health or ability to regain maximum function; or
- the adverse benefit determination concerns the admission, availability of care, continued stay, or health care item or service for which Claimant received services, but Claimant had not been discharged from a facility.

Claimant or Claimant's authorized representative may also make a written or oral request for an expedited external review to the external review examiner if Claimant had received a final adverse benefit determination and:

- Claimant had a medical condition where the time for completing the internal review process would seriously jeopardize Claimant's life, health or ability to regain maximum function; or
- the adverse benefit determination concerns the admission, availability of care, continued stay, or health care item or service for which Claimant received services, but Claimant had not been discharged from a facility.

Claimant can initiate an expedited external review by calling Center for Consumer Information and Insurance Oversight (CCIIO), Centers for Medicare and Medicaid Services (CMS) at 877-549-8152. If the examiner determines that Claimant is not entitled to an expedited internal review, the examiner will notify both Claimant and Contract Administrator as expeditiously as possible.

An independent third party with clinical and legal expertise and with no financial or personal conflicts with Contract Administrator will conduct all external reviews. The reviewer will not defer to the decisions made during the internal review process and will look at Claimant's claim anew. The reviewer will consider all the information and documents that it receives in a timely manner when making its decision.

Contract Administrator and/or the independent review organization will provide written notice of the final

external review decision within 45 days after it receives the request for external review.

If the independent review organization reverses Contract Administrator's denial of Claimant's claim, the decision will be considered final and binding.

Precertification/Prior Authorization Appeals

If the precertification of a service or procedure has not been approved by the Utilization Management Organization and the service or procedure has not yet been rendered, a Claimant may appeal the determination under the lowest review level indicated below. If the determination is upheld, Claimant may appeal to the next highest level of review. This may be repeated until the entire appeals process has been exhausted. If the service or procedure has been rendered, Claimant will need to follow the Claims Appeals procedures outlined above.

Level I: REVIEW OF THE PRE-CERTIFICATION DENIAL BY THE UTILIZATION REVIEW FIRM

Claimant may submit an appeal letter referencing the determination to the Utilization Management Organization. Claimant shall have this opportunity to present additional information and/or documentation supporting this appeal. The Medical Director will review the information to determine medical necessity. If your Claim involves a medical judgment, a health care professional trained in the relevant field will be consulted - one who did not take part in the Claim denial and who is not the subordinate of such a person. You may also request the names of medical professionals who gave advice on your Adverse Benefit Determination. Appeal letter and additional information and/or documentation must be submitted within thirty (30) days of the original determination to:

Hometown Health
ATTN: Manager, Health Services
10315 Professional Circle
Reno, NV 89521

The Medical Director will render a decision within thirty (30) days of the date the appeal letter was received and will notify, in writing, the Plan Sponsor and Claimant of his findings. No deference will be given to the initial adverse benefit determination. Your Appeal will be decided by an individual(s) who did not take part in the initial adverse benefit determination and who is not subordinate of such a person. If we receive insufficient information to decide your Appeal, we will notify you as soon as possible, but not later than 72 hours after receipt of the Appeal, of the specific information necessary to complete the Appeal. You will have a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information.

If your Appeal is denied, you will receive written (or electronic as permitted by law) notice, including the specific reasons, reference to the specific Plan provisions, and you may have access to all records that were used in reaching the decision. If any internal rule, guideline, protocol or other similar criterion was used in the Appeal denial, you will be told about it and may have a copy of it. If the denial is based on an

analysis of Medical Necessity or Experimental treatment or the like, you may have a copy of whatever scientific or clinical explanation was used in the determination. You will also receive, free of charge, any new or additional rationale and/or evidence considered, relied on or generated by the Plan (or at the direction of the Plan) in connection with your Claim. You will receive this rationale and/or evidence sufficiently in advance of the date on which the notice of the Adverse Benefit Determination is required in order to give you a reasonable opportunity to respond prior to that date.

Level II: EXTERNAL REVIEW OF THE PRE-CERTIFICATION DENIAL

If, upon Level I denial, we rescind your coverage or deny your claim for benefits based all or in part on a medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), and Claimant disagrees with Contract Administrator decision, Claimant or Claimant's authorized representative may submit Claimant's preauthorization request to the external review process described below. This step is not mandatory. If Contracted Administrator bases a denial, reduction, termination, or refusal to provide payment on a determination that an individual is not eligible under the Plan, no external review is available.

In most circumstances, before Claimant may submit preauthorization request to the external review process, Claimant must first follow the claims procedures outlined above by filing an initial claim and a request for review of an adverse benefit determination to Contract Administrator. However, in certain circumstances (described below), Claimant may receive an expedited external review. In this case, Claimant may not have to exhaust the internal preauthorization process before filing a request for external review. Also, if the Plan fails to strictly adhere to all of the requirements of the internal Claims and Appeals process with respect to the Claimant's Claim. In such case, the Claimant is deemed to have exhausted the internal Claims and Appeals process and the Claimant may seek an External Review or pursue legal remedies. However, this will not apply if the error was de minimis, if the error does not cause harm to the Claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, the Claimant may resubmit his or her Claim for internal review and the Claimant may ask the Plan to explain why the error is minor and why it meets this exception.

Within four (4) months of the date Claimant receives an adverse benefit determination or final internal adverse benefit determination, Claimant or Claimant's authorized representative may file a request for external review. The request should be sent to:

Hometown Health
ATTN: Manager, Health Services
10315 Professional Circle
Reno, NV 89521
By Phone: 1-800-336-0123

Your written request should include:

- a specific request for an external review;
- your name (or name of you and your Authorized Representative), address, and telephone number

the service that was denied; and
- any new, relevant information that was not provided during the internal Appeal.

The entire External Review process and any associated medical records are confidential.

Claimant or Claimant's authorized representative may make a written or oral request for an expedited external review to the external review examiner if Claimant has filed a request for expedited appeal of an Urgent Care claim and Claimant has received an adverse benefit determination and:

- Claimant has a medical condition where the time for completing the internal review process would seriously jeopardize Claimant's life, health or ability to regain maximum function; or
- the adverse benefit determination concerns the admission, availability of care, continued stay, or health care item
- or service for which Claimant received services, but Claimant has not been discharged from a facility.
-

Claimant or Claimant's authorized representative may also make a written or oral request for an expedited external review to the external review examiner if Claimant has received a final adverse benefit determination and:

- Claimant has a medical condition where the time for completing the internal review process would seriously jeopardize Claimant's life, health or ability to regain maximum function; or
- the adverse benefit determination concerns the admission, availability of care, continued stay, or health care item or service for which Claimant received services, but Claimant has not been discharged from a facility.

Claimant can initiate an expedited external review by calling Center for Consumer Information and Insurance Oversight (CCIIO), Centers for Medicare and Medicaid Services (CMS) at 877-549-8152. If the examiner determines that Claimant is not entitled to an expedited internal review, the examiner will notify both Claimant and Contract Administrator as expeditiously as possible.

An independent third party with clinical and legal expertise and with no financial or personal conflicts with Contract Administrator will conduct all external reviews. The reviewer will not defer to the decisions made during the internal review process and will look at Claimant's claim anew. The reviewer will consider all the information and documents that it receives in a timely manner when making its decision.

Contract Administrator and/or the independent review organization will provide written notice of the final external review decision within 45 days after it receives the request for external review.

If the independent review organization reverses Contract Administrator's denial of Claimant's claim, the decision will be considered final and binding.

PRIVACY RULES

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") and the Security Standards for the Protection of Electronic Protected Health Information (i.e. the "Security Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "Protected Health Information" ("PHI") of Covered Persons. The Privacy Rule and the Security Rule will be implemented and enforced in the offices of the Plan Sponsor and any other entity that may assist in the operation of the Plan.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in HIPAA. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Covered Person's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the Privacy Rule;
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Person's information; and
3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Covered Person has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. *Required by Law*: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;
2. *Public Health and Safety:* The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
    a. A public health authority or other appropriate government authority authorized by law to receive reports of Child abuse or neglect;
    b. Report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA- regulated products or activities;
    c. Locate and notify persons of recalls of products they may be using; and

    d. A person who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition, if authorized by law;
3. *Government Authority:* The Plan may disclose PHI to a government authority, except for reports of Child abuse or neglect, when required or authorized by law, or with the Covered Person's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Covered Person that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI;
4. *Health Oversight Activities:* The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; Claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws;
5. *Lawsuits and Disputes:* The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Covered Person's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Covered Person of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards;
6. *Law Enforcement:* The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Covered Person's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises;
7. *Decedents:* The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years;
8. *Research:* The Plan may use or disclose PHI for research, subject to certain limited conditions;
9. *To Avert a Serious Threat to Health or Safety*: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public;
10. *Workers' Compensation:* The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law; and
11. *Military and National Security*: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized federal officials.

Required Disclosures of PHI

1. *Disclosures to Covered Persons:* The Plan is required to disclose to a Covered Person most of

the PHI in a Designated Record Set when the Covered Person requests access to this information. The Plan will disclose a Covered Person's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant state law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Covered Person's personal representative if it has a reasonable belief that the Covered Person has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Covered Person's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Covered Person; and

2. *Disclosures to the Secretary of the U.S. Department of Health and Human Services*: The Plan is required to disclose the Covered Person's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the Privacy Rule.

Instances When Required Authorization Is Needed from Covered Persons Before Disclosing PHI

1. Most uses and disclosures of psychotherapy notes;
2. Uses and disclosures for marketing;
3. Sale of PHI; and
4. Other uses and disclosures not described in the Plan can only be made with authorization from the Covered Person. The Covered Person may revoke this authorization at any time.

Individual Rights

A Covered Person has the following rights regarding PHI about him/her:

1. *Request Restrictions:* The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions;
2. *Right to Receive Confidential Communication:* The Covered Person has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests;
3. *Right to Receive Notice of Privacy Practices:* The Covered Person is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Plan's Benefits' Coordinator;
4. *Accounting of Disclosures:* The Covered Person has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Person is entitled to such an accounting for the six (6) years prior to his/her request.

Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Covered Person of the basis of the disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Plan's Benefits' Coordinator;

5. *Access:* The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI, or to have a copy of your PHI transmitted directly to another designated person, contact the Plan's Benefits' Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Covered Person and the recipient must be clearly identified. The Plan must respond to the Covered Person's request within thirty (30) days (in some cases, the Plan can request a thirty (30) day extension). In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial;
6. *Amendment:* The Covered Person has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Plan's Benefits' Coordinator. The Plan may deny the Covered Person's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request; and
7. *Fundraising contacts:* The Covered Person has the right to opt out of fundraising contacts.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI and Electronic PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law;
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI and agree to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware;
3. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
4. Not use or disclose genetic information for underwriting purposes;
5. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
6. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
7. Make available PHI in accordance with section 164.524 of the Privacy Rule (45 CFR 164.524);
8. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Rule (45 CFR 164.526);
9. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Rule (45 CFR 164.528);

10. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of HHS, or its delegate, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
11. Report to the Plan any security incident of which it becomes aware.
12. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI 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 PHI infeasible; and
13. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Rule (45 CFR 164.504(f)(2)(iii)), is established as follows and that such separation is supported by reasonable and appropriate security measures;
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Plan Benefits' Coordinator
        ii. The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.
    b. In the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Sponsor shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further noncompliance occurs. The Plan Sponsor will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or noncompliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Third-Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit Claims under the Plan. Such disclosures shall be made in accordance with the Privacy Rule.

Questions or Complaints

For more information about the Plan's privacy practices, questions or concerns, or to report a possible violation of privacy rights, please contact the Plan using the following information. A Covered Person may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the address to file a complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against anyone for filing a complaint with the Plan or the U.S. Department of Health and Human Services

Contact Information

Benefits' Coordinator Contact Information and Additional Contact Information for HIPAA Questions:

Leeann Caires

Douglas County School District

1638 Mono Avenue, Minden, Nevada 89423

Phone: (775) 782-7177

Private Fax: (775) 782-8351 Email: lcaires@dcsd.k12.nv.us

Privacy Officer Contact Information:

Jeannie Dwyer

Executive Director of HR

Douglas County School District

1638 Mono Avenue, Minden, Nevada 89423

Phone: (775) 782-7177

ADDENDUM FOR PRESCRIPTION DRUGS

Prescription Drug coverage is provided through separate agreement(s) between the Plan Sponsor and Prescription Drug vendor(s). If there are any conflicts between the prescription information in this document and the terms of such agreement(s), the agreement(s) will prevail.

COVERED DRUGS

Covered drugs include most Prescription Drugs (e.g., federal legend drugs and compounded drugs that are prescribed by a Physician and that require a prescription either by federal or state law); and

- insulin when prescribed by a Physician;
- Contraceptives – Prescription may be filled for a period not to exceed 12 months. (i.e. oral, shots, skin patch, vaginal ring, diaphragm, cervical cap, female condom, spermicide foam and sponges with a written prescription from a Physician).

EXPENSES NOT COVERED

Prescription drug coverage will not include any of the following:

Administration – Any charge for the administration of a covered drug. Blood, Blood Plasma & Biological Sera

Devices – Devices of any type, even though such devices may require a prescription. These include but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.

Excess Refills – Refills beyond the number specified by a Physician or refills more than one (1) year from the date of the initial prescription order.

Experimental & Non-FDA Approved Drugs – Experimental drugs and medicines, even though a charge is made to the Covered Person. Drugs not approved by the Food and Drug Administration.

Fertility Drugs

Immunizations Agents – Serums, toxoids, vaccines.

Investigational Drugs – A drug or medicine labeled: “Caution – limited by federal law to investigational use.”

Medical Exclusions – Any charge excluded in the medical benefits – see **MEDICAL LIMITATIONS AND EXCLUSIONS** section.

No Charge – A prescribed drug that may be properly received without charge under a local, state or federal program or for which the cost is recoverable under any workers' compensation or occupational disease law.

Non-Home Use – Drugs intended for use in a health care facility (Hospital, Skilled Nursing Facility, etc.) or in Physician's office or setting other than home use.

Non-Prescription Drugs – A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin. This also does not apply to the over-the-counter drugs covered as Preventive Care items.

DISCLAIMER: THIS IS ONLY A SUMMARY OF THE PRESCRIPTION DRUG COVERAGES OFFERED BY THE PLAN. THE ACTUAL CONTROLLING PROVISIONS AND LISTS OF COVERED AND EXCLUDED DRUGS, ETC., MUST BE OBTAINED DIRECTLY FROM THE PLAN SPONSOR OR THE PRESCRIPTION PROGRAM PROVIDER

ADDENDUM FOR NEVADA LAWS

In general, self-funded plans are not subject to state insurance requirements. However, as a public entity in the State of Nevada, this Plan will comply with the following Nevada Revised Statutes (NRS). Titles preceding the NRS identification numbers are for ease of reference only.

CANCER DRUGS (NRS 689B.0365)

Coverage for a drug approved by the Food and Drug Administration for use in the treatment of an illness, disease or other medical condition may not be delivered or issued for delivery in the State of Nevada unless the Plan includes coverage for any other use of the drug for the treatment of cancer, if that use is:

- specified in the most recent edition of, or supplement to:
    - the United States Pharmacopoeia Drug Information; or
    - the American Hospital Formulary Service Drug Information; or
- supported by at least two articles reporting the results of scientific studies that are published in scientific or medical journals, as defined in 21 C.F.R. § 99.3.

Coverage includes any medical services necessary to administer the drug to Covered Person. Coverage does not include:

- any experimental drug used for the treatment of cancer if that drug has not been approved by the Food and Drug Administration; or
- use of a drug that is contraindicated by the Food and Drug Administration.

CLINICAL TRIAL OR STUDY (NRS 689B.0306)

The Plan provides coverage for medical treatment which a Covered Person receives as part of a clinical trial or study if:

- the medical treatment is provided in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome;
- the clinical trial or study is approved by:
    - an agency of the National Institutes of Health as set forth in 42 U.S.C. § 281(b);
    - a cooperative group;
    - the Food and Drug Administration as an application for a new investigational drug;
    - the United States Department of Veterans Affairs; or
    - the United States Department of Defense.
- the medical treatment is provided by a provider of health care and the facility and personnel have the experience and training to provide the treatment in a capable manner;

- there is no medical treatment available which is considered a more appropriate alternative than the medical treatment provided in the clinical trial or study;
- there is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment;
- the clinical trial or study is conducted in the State of Nevada; and
- Covered Person has signed, before his participation in the clinical trial or study, a statement of

consent indicating that he has been informed of:

- the procedure to be undertaken; and
- alternative methods of treatment; and
- the risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks.

Coverage for medical treatment is limited to:

- any drug or device that is approved for sale by the Food and Drug Administration without regard to whether the approved drug or device has been approved for use in the medical treatment of Covered Person;
- the cost of any reasonably necessary health care services that are required as a result of the medical treatment provided in the clinical trial or study or as a result of any complication arising out of the medical treatment provided in the clinical trial or study, to the extent that such health care services would otherwise be covered under the Plan;
- the initial consultation to determine whether Covered Person is eligible to participate in the clinical trial or study;
- health care services required for the clinically appropriate monitoring of Covered Person during the clinical trial or study;

Except as otherwise provided in NRS 689B.0303, the services provided pursuant to the above underlined items must be covered only if a Network provider is used. If the Plan has not contracted for such services, the Plan shall pay the provider the rate of reimbursement that is paid to other providers with whom the Plan has contracted for similar services and the provider shall accept that rate of reimbursement as payment in full.

Medical treatment provided to a Covered Person is not required to be covered if that particular medical treatment is provided by the sponsor of the clinical trial or study free of charge to Covered Person.

Coverage does not include:

- any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry;
- coverage for a drug or device which is paid for by the manufacturer, distributor or provider of such drug or device;
- health care services that are specifically excluded from coverage under the Plan, regardless of whether such services are provided under the clinical trial or study;
- health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to the participants in the trial or study;
- extraneous expenses related to participation in the clinical trial or study including, without limitation, travel, housing and other expenses that a participant may incur;
- any expenses incurred by a person who accompanies Covered Person during the clinical trial or study;
- any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of Covered Person;

- any costs for the management of research relating to the clinical trial or study.

The Plan may require copies of the approval or certification, the statement of consent signed by Covered Person, protocols for the clinical trial or study and any other materials related to the scope of the clinical trial or study relevant to the coverage of medical treatment.

The Plan shall provide benefits subject to the same deductibles, copayments, coinsurances and other such conditions for coverage that apply to other Plan benefits.

The Plan is immune from liability for any injury to a Covered Person caused by:

- any medical treatment provided to a Covered Person in connection with his participation in a clinical trial or study; or
- an act or omission by a provider of health care who provides medical treatment or supervises the provision of medical treatment to Covered Person in connection with his participation in a clinical trial or study;
- any adverse or unanticipated outcome arising out of a Covered Person's participation in a clinical trial or study.

As used in this provision:

- cooperative group means a network of facilities that collaborate on research projects and has established a peer
- review program approved by the National Institutes of Health. The term includes:
    - the Clinical Trials Cooperative Group Program; and
    - the Community Clinical Oncology Program;
- provider of health care means:
    - a hospital; or
    - a person licensed pursuant to chapter 630, 631 or 633 of NRS.

COLORECTAL CANCER SCREENING (NRS 689B.0367)

The Plan will provide coverage for colorectal cancer screening in accordance with:

- the guidelines concerning colorectal cancer screening which are published by the American Cancer Society; or
- other guidelines or reports concerning colorectal cancer screening which are published by nationally recognized professional organizations and which include current or prevailing supporting scientific data.

CONTINUITY OF CARE (NRS 689B.0303)

The following provision applies if a Covered Person receives health care through a defined set of providers of health care who have contracted with the Plan to provide services (e.g., Network providers).

Except as otherwise provided, if a Covered Person is receiving medical treatment from a Network provider whose contract is terminated during the course of the medical treatment, the Plan provides that:

Covered Person may continue to obtain medical treatment if:

- he is actively undergoing a Medically Necessary course of treatment; and
- the Network provider and Covered Person agree that the continuity of care is desirable.

the Network provider is entitled to receive reimbursement from the Plan for the medical treatment if he agrees:

- to provide medical treatment to Covered Person under the terms of the contract with the Plan, including without limitation, the rates of payment for providing medical service, as those terms existed before the termination of the contract; and
- not to seek payment from Covered Person for any medical service that the provider of health care could not have received were the provider of health care still under contract with the Plan.

The above allowances will be provided until the later of:

- the 120th day after the date the provider's contract is terminated; or
- if the medical condition is Pregnancy, the 45th day after:
  - the date of delivery; or
  - if the Pregnancy does not end in delivery, the date of the end of the Pregnancy.

The above requirements do not apply if:

- the Plan terminated the Network provider's contract because of the medical incompetence or professional misconduct; and
- the Plan did not enter into another contract with the Network provider after the contract was terminated.

CYTOLOGIC SCREENING TESTS & MAMMOGRAMS FOR WOMEN (NRS 689B.0374)

The Plan will provide coverage for:

- an annual cytology screening test for women 18 years of age or older;
- a baseline mammogram for women between the ages of 35 and 40; and
- an annual mammogram for women 40 years of age or older.

The Plan does not require a Covered Person to obtain prior authorization.

DIABETES MANAGEMENT & TREATMENT (NRS 69B.0357)

The Plan will provide coverage for the management and treatment of diabetes, including, without limitation, coverage for the self-management of diabetes.

The Plan shall provide coverage subject to the same deductibles, copayments, coinsurances and other such conditions as apply to other Eligible Expenses under the Plan.

As used in this provision:

- coverage for the management and treatment of diabetes includes coverage for medication, equipment, supplies and appliances that are Medically Necessary for the treatment of diabetes;
- coverage for the self-management of diabetes includes:
  - the training and education provided to a Covered Person after he is initially diagnosed with diabetes which is Medically Necessary for the care and management of diabetes, including, without limitation, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes;
  - training and education which is Medically Necessary as the result of a subsequent diagnosis that indicates a significant change in the symptoms or condition of Covered Person and which requires modification of his program of self-management of diabetes; and
  - training and education which is Medically Necessary because of the development of new techniques and treatment for diabetes;
- diabetes includes type I, type II and gestational diabetes.

FORMULAS & FOOD PRODUCTS FOR INHERITED METABOLIC DISEASES (NRS 689B.0353)

The Plan will provide coverage for:

- enteral formulas for use at home that are prescribed or ordered by a Physician as Medically Necessary for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat; and
- up to $2,500 per year for special food products which are prescribed or ordered by a Physician as Medically Necessary for the treatment of a Covered Person.

As used in this provision:

- inherited metabolic disease means a disease caused by an inherited abnormality of the body chemistry of a person;
- special food product means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a Physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.