

WASHOE COUNTY SCHOOL DISTRICT

**QUALIFIED HIGH DEDUCTIBLE
HEALTH PLAN
(QHDHP Plan)**

**PLAN DOCUMENT
and
SUMMARY PLAN DESCRIPTION**

Effective January 1, 2026

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 (TPA) The service provider that handles the processing of your medical claims in accordance with the District's QHDHP Plan. You may contact the TPA to obtain additional information about your Plan coverage and claims procedures.	Anthem Blue Cross Blue Shield P.O. Box 5747 Denver, CO 80217-5747 (833) 914-0825 www.anthem.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.	Anthem Blue Cross Blue Shield (833) 914-0825
Preferred Provider Organization for Medical (PPO) The service provider that provides the network of medical Preferred Providers that have agreed to negotiated discounted rates.	Anthem Blue Cross Blue Shield (833) 914-0825 www.anthem.com
Preferred Provider Organization for Dental (PPO) The service provider that provides the network of dental Preferred Providers that have agreed to negotiated discounted rates.	Anthem Blue Cross Blue Shield Essential Choice-Prime www.anthem.com (833) 914-0825
Prescription Drug Vendor The service provider that provides a network of participating retail pharmacies to obtain prescription drugs by using your Plan identification card.	Carelon (833) 914-0825

TYPE OF SERVICE	SERVICE PROVIDER
Benefits Department	Washoe County School District (775) 348-0321
Health Savings Account	American Fidelity 1890 Donald St., Suite B Reno, Nevada 89502 (800) 616-3576, ext. 11

INTRODUCTION

This document is both the Summary Plan Description and the Plan Document for the Washoe County School District's (District) Qualified High Deductible Health Plan (QHDHP). We recommend that you take the time to review the contents of this document. We call the following to your attention:

- Most health claims of the Plan are handled by a Contract Administrator (the TPA). The TPA's contact information is on the Directory of Service Providers and on your Plan identification card.
- The name of the PPO network is on the health plan identification card that you received from Anthem Blue Cross Blue Shield, your TPA. In order to receive the maximum benefits it is IMPORTANT that you utilize the providers listed in the PPO Network that is listed on your identification card.

Understanding Your HSA-Qualified High-Deductible Health Plan

This plan is a qualified high-deductible health plan that may be used in conjunction with a Health Savings Account (HSA). An HSA is a special tax-exempt custodial account or trust owned by an individual where contributions to the account may be used to pay for current and future qualified medical expenses.

Members are required to pay the Copayment, Coinsurance and Annual Deductible amounts described in the Medical Benefit Summary. Generally, with the exception of Preventive Care, Covered Persons must meet the Deductible before the Plan will pay for any benefits. Copayments and/or Coinsurance amounts are due to the Provider at the time eligible medical services are received.

With the QHDHP Plan you have the option of opening a personal tax-advantaged Health Savings Account (HSA) to save money and pay for your or your Dependents' qualified medical expenses now and in the future. While covered under a high deductible health plan, your HSA contributions:

- accumulate over time with interest or investment earnings;
- are portable after employment; and
- can be used to pay for qualified health expenses tax-free or for non-health expenses on a taxable basis.

A Covered Person must satisfy federal HSA eligibility criteria in order to open and contribute to an HSA. The HSA is an account set up and owned directly by the participating employee and is theirs to maintain both during their employment with the Washoe County School District and if they should leave employment with the District. Accordingly, the HSA is not a plan that is subject to or governed by ERISA. Your rights and obligations under the HSA will be described in the contract you have with your HSA provider. That is important information that you need to review carefully and keep with your important papers.

YOU ARE SOLELY RESPONSIBLE FOR ADHERING TO ALL FEDERAL REGULATIONS AND GUIDELINES CONCERNING HSA ELIGIBLE EXPENSES, CONTRIBUTIONS AND QUALIFIED WITHDRAWALS. IN ADDITION, YOU ARE RESPONSIBLE FOR NOTIFYING YOUR HSA CUSTODIAN OR TRUSTEE IF ENROLLMENT UNDER THIS PLAN HAS BEEN CANCELED OR TERMINATED.

PLEASE CONSULT A PROFESSIONAL TAX ADVISOR FOR MORE INFORMATION ABOUT THE TAX IMPLICATIONS OF AN HSA.

SEE PAGE 8 FOR MORE INFORMATION ABOUT HOW THE QHDHP WORKS WITH AN HSA.

How to use this Summary Plan Description (SPD)

- Please read this SPD carefully to be sure you understand the benefits, exclusions and general provisions of the Plan. It is your responsibility to keep informed about any changes in your health coverage.
- 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).
- Some of the terms used in the document begin with a capital letter. These terms have a special meaning and are included in the **DEFINITIONS** section. When reading the provisions of this Plan, it may be helpful to refer to this section. Becoming familiar with the terms defined there will give you a better understanding of the benefits and provisions.
- The **Table of Contents** lists the section titles and descriptions of what may be in that Section. It is a great place to go if you are looking for specific information.
- It is important that you review the **UTILIZATION MANAGEMENT PROGRAM** so you are aware of the **Pre-certification Requirements**.
- The deductibles, coinsurance and benefit percentages can be found in the **MEDICAL BENEFIT SUMMARY** section for the plan you selected and is only the highlights of the Plan and should not be relied on to determine the extent to which a service or benefit is covered or excluded.
- Services that are eligible can be found in the **ELIGIBLE MEDICAL EXPENSES** section and services that are not eligible can be found in the **MEDICAL LIMITATIONS AND EXCLUSIONS** and **GENERAL EXCLUSIONS** sections of the SPD.
- Many of the sections of the SPD are related to other sections of the SPD. You may not have all the information you need by reading just one section.

If you do not understand the **UTILIZATION MANAGEMENT PROGRAM**, a benefit or exclusion, contact your Contract Administrator (TPA).

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IMPORTANT NOTICES

CONSOLIDATED APPROPRIATIONS ACT OF 2021

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Act as well as the Provider transparency requirements that are described below.

Surprise Billing Claims

Surprise Billing Claims are claims that are subject to the No Surprises Act requirements:

- Emergency Services provided by Out-of-Network Providers;
- Covered Services provided by an Out-of-Network Provider at an In-Network Facility; and
- Out-of-Network Air Ambulance Services.

No Surprises Act Requirements

Emergency Services

As required by the CAA, Emergency Services are covered under your Plan:

- Without the need for Precertification;
- Whether the Provider is In-Network or Out-of-Network;

If the Emergency Services you receive are provided by an Out-of-Network Provider, Covered Services will be processed at the In-Network benefit level.

Note that if you receive Emergency Services from an Out-of-Network Provider, your Out-of-Pocket costs will be limited to amounts that would apply if the Covered Services had been furnished by an In-Network Provider. However, Out-of-Network cost-shares (i.e., Copayments, Deductibles and/or Coinsurance) will apply to your claim if the treating Out-of-Network Provider determines you are stable, meaning you have been provided necessary Emergency Care such that your condition will not materially worsen and the Out-of-Network Provider determines: (i) that you are able to travel to an In-Network Facility by non-emergency transport; (ii) the Out-of-Network Provider complies with the notice and consent requirement; and (iii) you are in condition to receive the information and provide informed consent. If you continue to receive services from the Out-of-Network Provider after you are stabilized, you will be responsible for the Out-of-Network cost-shares, and the Out-of-Network Provider will also be able to charge you any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charges. This notice and consent exception does not apply if the Covered Services furnished by an Out-of-Network Provider result from unforeseen and urgent medical needs arising at the time of service.

Out-of-Network Services Provided at an In-Network Facility

When you receive Covered Services from an Out-of-Network Provider at an In-Network Facility, your claims will be paid at the Out-of-Network benefit level if the Out-of-Network Provider gives you proper notice of its charges, and you give written consent to such charges. This means you will be responsible for Out-of-Network cost-shares for those services and the Out-of-Network Provider can also charge you any difference between the Maximum Allowed Amount and the Out-of-Network Provider's billed charges.

This requirement does not apply to Ancillary Services. Ancillary Services are one of the following services: (A) Emergency Services; (B) anesthesiology; (C) laboratory and pathology services; (D) radiology; (E) neonatology; (F) diagnostic services; (G) assistant surgeons; (H) Hospitalists; (I) Intensivists; and (J) any services set out by the U.S. Department of Health & Human Services. In addition, Anthem will not apply this notice and consent process to you if Anthem does not have an In-Network Provider in your area who can perform the services you require.

Out-of-Network Providers satisfy the notice and consent requirement as follows:

1. By obtaining your written consent not later than 72 hours prior to the delivery of services; or
2. If the notice and consent is given on the date of the service, if you make an appointment within 72 hours of the services being delivered.

How Cost-Shares Are Calculated

Your cost shares for Emergency Services or for Covered Services received by an Out-of-Network Provider at an In-Network Facility, will be calculated using the median Plan In-Network contract rate that we pay In-Network Providers for the geographic area where the Covered Service is provided. Any Out-of-Pocket cost shares you pay to an Out-of-Network Provider for either Emergency Services or for Covered Services provided by an Out-of-Network Provider at an In-Network Facility will be applied to your In-Network Out-of-Pocket Limit.

Appeals

If you receive Emergency Services from an Out-of-Network Provider or Covered Services from an Out-of-Network Provider at an In-Network Facility or Out-of-Network Air Ambulance Services and believe those services are covered by the No Surprises Act, you have the right to appeal that claim. If your appeal of a Surprise Billing Claim is denied, then you have a right to appeal the adverse decision to an Independent Review Organization as set out in the “Appeals” section of this Benefit Book.

Provider Directories

Anthem is required to confirm the list of In-Network Providers in its Provider Directory every 90 days. If you can show that you received inaccurate information from Anthem that a Provider was In-Network on a particular claim, then you will only be liable for In-Network cost shares (i.e., Copayments, Deductibles, and/or Coinsurance) for that claim. Your In-Network cost-shares will be calculated based upon the Maximum Allowed Amount.

Transparency Requirements

Anthem provides the following information on its website (i.e., www.anthem.com):

- Protections with respect to Surprise Billing Claims by Providers, including information on how to contact state and federal agencies if you believe a Provider has violated the No Surprises Act.

You may also obtain the following information on Anthem’s website or by calling Member Services at the phone number on the back of your ID card:

- Cost sharing information for 500 defined services, as required by the Centers for Medicare & Medicaid Services (CMS); and
- A listing / directory of all In-Network Providers.

In addition, Anthem will provide access through its website to the following information:

- In-Network negotiated rates; and
- Historical Out-of-Network rates.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

The Mental Health Parity and Addiction Equity Act provides for parity in the application of aggregate treatment limitations (day or visit limits) on mental health and substance abuse benefits with day or visit limits on medical and surgical benefits. In general, group health plans offering mental health and substance abuse benefits cannot set day/visit limits on mental health or substance abuse benefits that are lower than any such day or visit limits for medical and surgical benefits. A plan that does not impose day or visit limits on medical and surgical benefits may not impose such day or visit limits on mental health and substance abuse benefits offered under the Plan. Also, the Plan may not impose Deductibles, Copayment, Coinsurance, and out of pocket expenses on mental health and substance abuse benefits that are more restrictive than Deductibles, Copayment, Coinsurance and out of pocket expenses applicable to other medical and surgical benefits. Medical Necessity criteria are available upon request.

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

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this plan provides coverage for: 1) All stages of reconstruction of the breast on which the mastectomy has been performed; 2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage.

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 this section. Becoming familiar with the terms defined therein will provide a better understanding of the benefits and provisions.

PROHIBITION ON RESCISSIONS

The health care component plans in this Plan shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this Section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan or coverage. Such Plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under Section 2701(c) or Section 2742(b) of the Patient Protection and Affordable Care Act (PPACA).

PREGNANCY DISCRIMINATION ACT OF 1978

Most Employers must provide coverage for Pregnancy expenses in the same manner as coverage is provided for any other illness. This requirement applies to Pregnancy expenses of an Employee or a covered Dependent spouse of an Employee.

NON-GRANDFATHERED PLAN

Non-Grandfathered Plan – This Plan Sponsor complies with the requirements of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, together referred to as the Affordable Care Act (ACA) and all other applicable state and federal insurance laws, regulations

and guidance effective on the date of publication of this Summary Plan Document. These laws, regulations and supporting guidance may change. Coverage under this Plan will remain in accordance with these laws, regulations and guidance as they are issued. The Plan participant may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 (“GINA”)

GINA prohibits the group health Plan from:

1. Adjusting premiums or contribution amounts for the group as a whole on the basis of Genetic Information.
2. Requesting or requiring an individual or a family member to undergo a genetic test. However, subject to certain conditions, the Plan may request that an individual voluntarily undergo a genetic test as part of a research study as long as the results are not used for underwriting purposes.
3. Requesting, requiring or purchasing Genetic Information for underwriting purposes (which includes eligibility rules or determinations, computation of premium or contribution amounts, and other activities related to the creation, renewal or replacement of coverage). The Plan is also prohibited from requesting, requiring or purchasing Genetic Information with respect to any individual prior to such individual's enrollment under the Plan or coverage. However, if the Plan obtains Genetic Information incidental to the collection of other information prior to enrollment, it will not be in violation of GINA as long as it is not used for underwriting purposes.

GINA allows the group health Plan to obtain and use the results of genetic tests for purposes of making payment determinations.

What is “Genetic Information” under GINA?

Under GINA, the term “Genetic Information” includes:

1. Information about an individual or his/her family member's genetic tests (defined as analyses of the individual's DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations or chromosomal changes);
2. The manifestation of a Disease or disorder in the family members of the individual. Family members are broadly defined under GINA to include individuals who are Dependents, as well as any other first, second, third or fourth degree relative. Further, Genetic Information includes that information of any fetus or embryo carried by a pregnant woman; and
3. Information obtained through genetic services (that is genetic tests, genetic counseling or genetic education) or participation in clinical research that includes genetic services.

Genetic Information does not include the sex or age of an individual.

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

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs,

but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

FAMILY AND MEDICAL LEAVE ACT OF 1993 (P.L. 103-3)

If a covered Employee ceases Active Employment due to an Employer-approved Family Medical Leave of Absence in accordance with the requirements of Public Law 103, coverage availability will continue under the same terms and conditions which would have applied had the Employee continued in Active Employment. Contributions will remain at the same Employer/Employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other Employees in the same classification).

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (H.R. 3103, 1996)

The Health Insurance Portability and Accountability Act (HIPAA) amended ERISA and was enacted, among other things, to improve portability and continuity of health care coverage.

HIPAA also requires that Covered Persons and beneficiaries receive a summary of any change that is a “Material Reduction in covered services or benefits under a group health plan” within 60 days after the adoption of the modification or change, unless the Plan Sponsor provides summaries of modifications or changes at regular intervals of 90 days or less.

UTILIZATION MANAGEMENT PROGRAM

PRE-SERVICE REVIEW REQUIREMENTS

The purpose of the Utilization Management Program is to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. The health care professionals in the Medical Management Department of the Contract Administrators (listed below) will focus their review on the necessity and appropriateness of hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical or surgical services.

The fact that your physician recommends surgery, hospitalization, confinement in a skilled nursing/sub acute facility, or that your physician or other health care provider proposes any other medical services or supplies does not mean the recommended services or supplies will be considered medically necessary for determining coverage under the Plan

The Utilization Management Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of plan benefits. Medical Management's certification that a service is medically necessary does not mean a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered, or if the services were not covered by the Plan, either in whole or in part.

Contact Information:

Anthem Blue Cross Blue Shield
P.O. Box 5747
Denver, CO 80217-5747
(833)914-0825

Pre-Service Review Compliance Procedures - The procedures outlined below should be followed to avoid a possible penalty:

Inpatient Admission - Except as noted, at least three (3) working days prior to any elected Hospital, substance abuse and residential treatment or Skilled Nursing Facility admission which is not a Medical Emergency, the Covered Person's attending Physician must contact the Utilization Management company above for pre-service review. For an emergency admission, Utilization Management must be contacted within seventy-two (72) hours after admission or on the first business day following a weekend or holiday admission. **See Penalty for Non-Compliance of Pre-service Review Requirements.**

During an Inpatient confinement, Medical Management will provide concurrent review services to ensure the most appropriate level of care for the individual's condition.

NOTE: Pre-service review requirements 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, pre-service review for such extended confinement is required.

Nevada Clinical Trials - Nevada law allows some clinical trials for cancer and chronic fatigue syndrome, taking place in Nevada, to be covered if certain criteria are met. Medical Management must be contacted and pre-certification provided prior to obtaining such services. See "Experimental/Investigational Treatment" in the **General Exclusions** section. **See Penalty for Non-Compliance of Pre-Service Review Requirements.**

Dialysis – Medical Management must be contacted and pre-certification provided for any dialysis services.

Infusion Therapy – Medical Management must be contacted and pre-certification provided for any infusion therapy services.

Outpatient Procedures & Supplies Where the Cost Is Expected To Exceed \$10,000 - Medical Management must be contacted and pre-certification provided for any outpatient procedure(s), the purchase or rental of any supply or durable medical equipment where the cost is expected to exceed \$10,000. Examples of such services and supplies include, but are not limited to: durable medical equipment, prosthetics, radiology, PET scans, special testing and surgery. **See Penalty for Non-Compliance of Pre-Service Review Requirements.**

Physical and Occupational Therapy, Outpatient – If treatment exceeds 50 visits, per therapy per calendar year, your Provider may contact Medical Management to have additional visits pre-certified if medically necessity criteria is met. Your Provider will need to submit medical records, treatment plan and the medical necessity for additional visits.

Transplants (Organ and Tissue) - Medical Management must be contacted and pre-certification provided prior to all pre-transplantation related expenses, including the admission for transplantation services. See “Transplant-Related Expenses” in the **Eligible Medical Expenses** section. **See Penalty for Non-Compliance of Pre-Service Review Requirements.**

Unavailable Services in PPO Network – Medical Management must be contacted and pre-certification provided prior to receiving services from a Non-PPO provider because the necessary specialty is not represented in the PPO Network. If pre-certification is not obtained prior to services being rendered, then the Non-PPO benefit level (deductible and coinsurance) and Usual and Customary (U&C) will be applied.

Weight Reduction Surgery - Medical Management must be contacted and pre-certification provided prior to any weight reduction surgery. **See Penalty for Non-Compliance of Pre-Service Review Requirements.**

Penalty for Non-Compliance of Pre-Service Review Requirements - If the Pre-Service Review Requirements are not followed but it is determined that an Inpatient Admission, Nevada Clinical Trial(s), Outpatient Procedures & Supplies is Expected to Exceed \$10,000, Transplant(s), Infusion Therapy, Dialysis or Weight Reduction Surgery were Medically Necessary, Eligible Expenses will be payable at 50% in lieu of the Plan's normal benefit percentage. **No benefits will be payable if the services are deemed Not Medically Necessary.**

Any additional share of expenses that becomes the 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 pre-service review impossible or where application of the pre-service review 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 Pre-Service Review Requirements of the **Utilization Management Program** are completed. To minimize the risk of reduced

benefits, the Covered Person should contact the Utilization Management organization to make certain that the facility or attending Physician has initiated the necessary processes.

Pre-Service Review and certification is **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, Medical Management may, with the patient's and Plan Administrator's consent, provide case management services. Such services may include contacts with the patient, his/her family, the primary treating Physician, other caregivers and care consultants, and the hospital staff as necessary.

Medical Management 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 Administrator, review the progress of alternative treatment after implementation, and make appropriate recommendations to the Plan Administrator.

The Plan Administrator 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.

MEDICAL BENEFIT SUMMARY

IMPORTANT INFORMATION REGARDING CHOICE OF PPO OR NON-PPO PROVIDERS

The Plan Sponsor has contracted with a Preferred Provider Organization (PPO) of health care providers. When obtaining health care services, a Covered Person has a choice of using providers who are participating in the PPO network or any other Covered Providers of his/her choice (Non-PPO providers).

PPO providers have agreed to provide services to Covered Persons at negotiated rates. When a Covered Person uses a PPO provider his/her out-of-pocket costs may be reduced because he/she will not be billed for expenses in excess of those negotiated rates. The Plan may also include other benefit incentives to encourage Covered Persons to use PPO providers whenever possible. Non-PPO provider fees are subject to Usual and Customary (U&C) and the Non-PPO benefit level (deductible and coinsurance). Your out-of-pocket costs will be greater when using a Non-PPO provider because they can balance bill you for the amount in excess of their billed charges.

Your PPO Network name and contact information is listed on your identification card and is assigned to you based on where you permanently live. If you permanently move outside your assigned PPO Network listed on your identification card, you must contact Benefits Department at (775) 348-0321 as soon as possible, but no more than 30 days of your move, so that you can be assigned a new PPO Network and be issued a new identification card.

To locate a provider in your PPO Network go to
<https://enrollment.anthem.com/WashoeCountySchoolDistrict>.

In the following circumstances Non-PPO provider services will be covered at the PPO benefit levels (deductible and coinsurance) and the Non-PPO provider fees will be subject to Usual and Customary (U&C).

Emergency Care - If a Covered Person must use the services of a Non-PPO provider as a result of an **Emergency Medical Condition**, as defined below, any such expenses will be paid at the PPO benefit levels (deductible and coinsurance). If the **Emergency Medical Condition** results in hospitalization, any such expenses will be paid at the PPO benefit levels (deductible and coinsurance) until the Covered Person's medical condition has stabilized and Medical Management has determined that the Covered Person can be transferred to a PPO facility. If the Covered Person chooses not to transfer to a PPO facility, the Non-PPO benefit levels (deductible and coinsurance) will apply.

NOTE: Emergency Medical Condition means a sudden onset of a medical condition with symptoms severe enough to cause a prudent layperson to believe that lack of immediate medical attention could result in serious jeopardy to his/her health, jeopardy to the health of an unborn child and impairment of a bodily organ or part.

Ancillary Services - Services of a Non-PPO ancillary provider (i.e. emergency room Physician, urgent care Physician, radiologist, pathologist, on-call Physician) will be covered at the PPO benefit levels (deductible and coinsurance) if such services are received while a Covered person is being treated in the emergency room of a PPO hospital, PPO Urgent Care Facility, PPO Ambulatory Surgery Center or confined in a PPO hospital facility.

HOW THE QHDHP WORKS WITH AN HSA

An HSA is an account owned and funded by you, or any other person on your behalf. The HSA can help you to cover, on a tax free basis, medical plan expenses that require you to pay out-of-pocket, such as Deductibles, Copayments or Coinsurance. You gain choice and control over your health care decisions and expenditures when you establish an HSA to complement the District's Qualified High Deductible Health Plan.

Note: The HSA described in this section is not an arrangement that is established and maintained by the District. Rather, an HSA is established and maintained by the HSA trustee. For administrative convenience, the District has arranged to forward pre-tax contributions to HSA accounts established with American Fidelity.

What is an HSA?

An HSA is a tax-advantaged account covered that Employees can use to pay for qualified health expenses they or their eligible dependents incur, while covered under a high deductible medical plan in accordance with Section 223 of Internal Revenue Code. HSA contributions accumulate over time with interest or investment earnings; are portable after employment; and can be used to pay for qualified health expenses tax-free or for non-health expenses on a taxable basis. It is the District's intention to comply with Department of Labor guidance set forth in Field Assistance Bulletin No. 2004-1, which specifies that an HSA is not an ERISA plan if certain requirements are satisfied.

Who Is Eligible And How To Enroll

You are eligible to establish an HSA if you are enrolled in the District's Qualified High Deductible Health Plan, provided you meet the following conditions:

- you must not be covered by any non-high deductible medical plan. (This does not include coverage under an ancillary plan such as vision or dental, or any other permitted insurance as defined by the IRS.)
- you must not participate in a traditional health care Flexible Spending Account (FSA).
- you cannot coordinate benefits with Medicare (be enrolled in Medicare) or other insurance, such as a Spouse's employer plan; and
- you must not be claimed as a dependent on another person's tax return.

You may elect to enroll or make changes to your HSA election anytime during the year. You do not need to have a Qualified Life Event, such as a marriage or divorce, to enroll or make changes.

Contributions

Washoe County School District contributes funds into the member's HSA account twice per year; once at the beginning of the year and once mid-year. All funds placed into your HSA are owned and controlled by you, subject to any reasonable administrative restriction imposed by the trustee. Provided you are eligible, you may contribute to the HSA annually, up to the IRS maximum, until you become enrolled in Medicare. The annual contribution maximum is the single and family limits set by federal regulations and is based on the number of months you are an eligible individual (see "Who is Eligible and How to Enroll above") See IRS Guidelines for applicable limits.

The annual limit tiers are based on the coverage tier you are enrolled in under the QHDHP.

Note: Individuals between the ages of 55 and Medicare entitlement age may contribute additional funds to your HSA each year. This amount is subject to change by the IRS and may be found on the IRS website at www.irs.gov.

Contributions can be made to your HSA beginning on the first day of the month you are enrolled in the Health Savings Account until the earlier of (i) the date on which you file taxes for that year; or (ii) the date on which the contributions reach the contribution maximum. However, if your coverage under the QHDHP terminates, no further contributions may be made to the HSA. See the Rollover Feature section below.

IMPORTANT: Certain services may require Pre-Service Review. To avoid benefit reductions see the **UTILIZATION MANAGEMENT PROGRAM** section.

MEDICAL BENEFIT SUMMARY, continued

Note: If you enroll in your HSA within the year (not on January 1) you may still be allowed to contribute the maximum amount set by federal regulations, provided you are enrolled in the QHDHP on December 1st. However, you must remain enrolled in a high deductible health plan and HSA until the end of the 12th month following that December or you will be subject to tax implications and an additional tax of 10%. A change in health plan coverage is only allowed during Open Enrollment for a January 1st effective date, AFTER you have been on the QHDHP for 12 months, unless you have a special enrollment. (See "Special Enrollment Rights".)

Reimbursable Expenses

The funds in your HSA will be available to help you pay your or your eligible Dependents out-of-pocket costs under the QHDHP, including Annual Deductibles, Copayments and Coinsurance. You may also use your HSA funds to pay for medical care that is not covered under the medical plan design but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time. Such expenses are "qualified health expenses". HSA funds used for such purposes are not subject to income or excise taxes.

Note: There may be some states that require you to pay state income tax on the HSA. The list is subject to change, refer to your State tax information or tax advisor.

"Qualified health expenses" only include the medical expenses of you and your eligible Dependents, meaning your Spouse and any other family members are dependents for purposes of Section 105(b) of the Internal Revenue Code.

Using the HSA for Non-Qualified Expenses

You have the option of using funds in your HSA to pay for non-qualified health expenses. A non-qualified health expense is generally one which is not a deductible medical expense under Section 213(d) of the Internal Revenue Code of 1986. Any funds used from your HSA to pay for non-qualified expenses will be subject to income tax and a 20% additional tax unless an exception applies (i.e., your death, your disability, or your attainment of age 65).

In general, you may not use your HSA to pay for other health insurance without incurring a tax. You may use your HSA to pay for COBRA premiums and Medicare premiums. (However, you may not contribute to your HSA while enrolled in Medicare.)

Rollover Feature

An HSA is a personal bank account that you own. Therefore, if you do not use all of the funds in your HSA during the calendar year, the balance remaining in your HSA will roll-over. If your employment terminates for any reason, the funds in your HSA will continue to be owned and controlled by you, whether or not you elect COBRA coverage for the QHDHP.

If you choose to transfer the HSA funds from one account to another eligible account, you must do so within 60 days from the date that HSA funds are distributed to you to avoid paying taxes on the funds. If you elect COBRA, the HSA funds will be available to assist you in paying your out-of-pocket costs under the medical plan and COBRA premiums while COBRA coverage is in effect.

Important

Be sure to keep your receipts and medical records. If you cannot demonstrate that you used your HSA to pay qualified health expenses, you may need to report a distribution from your HSA as taxable income on your tax return. Consult your tax advisor to determine how your HSA affects your unique tax situation. The IRS may request receipts during a tax audit. The Qualified High Deductible Health Plan and the District are not responsible or liable for the misuse by covered Employees of HSA funds by, or for the use by covered Employees of HSA funds for non-qualified health expenses.

Account Balances

It is important for you to know the amount in your HSA account prior to withdrawing funds. You should not withdraw funds that will exceed the available balance. The money that is left over at the end of the year

IMPORTANT: Certain services may require Pre-Service Review. To avoid benefit reductions see the **UTILIZATION MANAGEMENT PROGRAM** section.

rolls over to the next year to help pay for any future health care needs. The HSA rollover is not limited: all remaining HSA dollars roll over to the next plan year even if you decide to enroll in another medical option (such as the PPO Plan) in the upcoming year or waive coverage. The account is yours to continue, according to the IRS guidelines. Note: If you are married and pass away with an account balance, your surviving Spouse has access to your HSA but cannot make additional contributions to it.

How to Open an HSA

For administrative convenience, the District has arranged to forward pre-tax contributions to HSA accounts established with American Fidelity. Once your HSA is established with American Fidelity, the District will forward the amount you have elected to withhold from your pay into your HSA account.

MEDICAL BENEFIT SUMMARY

MAXIMUM BENEFIT

Unlimited

QHDHP ANNUAL DEDUCTIBLES

	PPO In-Network	Non-PPO Out-of-Network
Individual Deductible	\$3,400	\$3,400
Family Maximum Deductible	\$5,000	\$5,000

Individual Deductible - The Individual Deductible is an amount which a Covered Person must contribute toward payment of eligible medical and prescription expenses.

Family Maximum Deductible - If eligible medical and prescription 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 expenses from two or more family members of the same family coverage unit i.e. a covered Employee and his covered Dependents.

QHDHP ANNUAL OUT-OF-POCKET MAXIMUMS

	PPO In-Network	Non-PPO Out-of-Network
Individual Out-of-Pocket Maximum	\$6,550	\$6,550
Family Out-of-Pocket Maximum	\$13,100	\$13,100

Individual Out-of-Pocket Maximum - Except as noted, a covered individual will not be required to pay more than \$6,550 for PPO (In-Network) provider services and supplies and \$6,550 for Non-PPO (Out-of-Network) provider services and supplies in any Calendar Year towards his 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. PPO (In-Network) and Non-PPO (Out-of-Network) Out-of-Pocket are separate, and do not combine together. Example: expenses applied toward PPO (In-Network) Out-of-Pocket will not also apply to Non-PPO (Out-of-Network) Out-of-Pocket or vice versa.

Family Out-of-Pocket Maximum - Except as noted, a covered family (two or more members of the same family coverage unit i.e. employee and his dependents) will not be required to pay more than \$13,100 for PPO (In-Network) provider services and supplies and \$13,100 for Non-PPO (Out-of-Network) provider services and supplies in any Calendar Year toward their share of 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. PPO (In-Network) and Non-PPO (Out-of-Network) Out-of-Pocket are separate, and do not combine together. Example: expenses applied toward PPO (In-Network) Out-of-Pocket will not also apply to Non-PPO (Out-of-Network) Out-of-Pocket or vice versa.

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

- expenses which are not covered by the Plan, for any reason;
- expenses in excess of Usual and Customary;
- expenses which become the Covered Person's responsibility for failure to comply with the requirements of the **Utilization Management Program**.

IMPORTANT: Certain services may require Pre-Service Review. To avoid benefit reductions see the **UTILIZATION MANAGEMENT PROGRAM** section.

MEDICAL BENEFIT SUMMARY, continued

SCHEDULE OF BENEFIT PERCENTAGES

IMPORTANT INFORMATION: Using a PPO/In-Network provider will reduce your out-of-pocket expenses. PPO/In-Network providers have agreed to provide services at negotiated rates and will not balance bill you for the amount in excess of those negotiated rates. Non-PPO/Out-of-Network provider fees and are subject to Usual and Customary (U&C) allowance and the Non-PPO/Out-of-Network provider may bill you the amount in excess of their billed charges.				
ELIGIBLE MEDICAL EXPENSES	PPO Deductible	PPO In-Network	Non-PPO Deductible	Non-PPO Out-of-Network
Acupuncture	Yes	80%	Yes	60% of U&C
Alternative Medicine	Yes	80%	Yes	60% of U&C
Limited up to \$2,000 in benefits per Calendar Year for, acupressure and homeopathic treatments including, but not limited to, medicines, supplies, remedies or substances. Homeopathic office visit only will be covered under Physician Services below.				
Ambulance	Yes	80%	Yes	80% U&C
Ambulatory Surgical Center	Yes	80%	Yes	60% of U&C
Autism Spectrum Disorder	Yes	80%	Yes	60% of U&C
Limited 1,200 hours per Calendar Year				
Behavioral Health Care				
Outpatient Physician Visits	Yes	80%	Yes	60% of U&C
Inpatient Physician Visits	Yes	80%	Yes	60% of U&C
Inpatient Facility	Yes	80%	Yes	60% of U&C
Chiropractic-type Care / Spinal Manipulation	Yes	80%	Yes	60% of U&C
Limited up to 50 visits per Calendar Year.				
Diabetes Education Program	No	100%	No	100%, up to \$150 per lifetime
Diagnostic Lab & X-ray, Freestanding Facility	Yes	80%	Yes	60% of U&C
Durable Medical Equipment	Yes	80%	Yes	60% of U&C
Genetic Counseling and Testing				
BRCA Counseling	No	100%	Yes	60% of U&C
BRCA1 and BRCA2 mutation test	No	100%	Yes	60% of U&C
ApoE Counseling and test	Yes	80%	Yes	60% of U&C
Pregnancy specific counseling and tests	Yes	80%	Yes	60% of U&C
All other Genetic Counseling and Testing, limited to \$1,000.	Yes	80%	Yes	60% of U&C
All other Genetic Counseling and Testing limited to \$1,000 in benefits per calendar year.				
Hearing Aids	Yes	\$200 co-pay, then 80%	Yes	\$200 co-pay, then 80% of U&C
Limited to two (2) hearing aids per five (5) year period. The initial five (5) year period begins on the purchase date of the first hearing aid and ends on the five (5) year anniversary of that date.				
NOTE: Hearing aid batteries and repairs are <u>not</u> covered.				

IMPORTANT: Certain services may require Pre-Service Review. To avoid benefit reductions see the **UTILIZATION MANAGEMENT PROGRAM** section.

MEDICAL BENEFIT SUMMARY, continued

ELIGIBLE MEDICAL EXPENSES	PPO Deductible	PPO In-Network	Non-PPO Deductible	Non-PPO Out-of-Network
Home Health Care	Yes	80%	Yes	60% of U&C
Limited up to 100 visits per Calendar Year. Each visit by a Home Health Care Agency employee will count as 1 visit. If a visit exceeds 4 hours, each 4 hours or fraction thereof is counted as a separate visit.				
Hospice Care	Yes	100%	Yes	100% of U&C
Hospital Services				
Inpatient Care	Yes	80%	Yes	60% of U&C
Emergency Room	Yes	80%	Yes	80% of U&C
X-ray and Laboratory	Yes	80%	Yes	60% of U&C
Chemotherapy	Yes	80%	Yes	60% of U&C
Radiation Therapy	Yes	80%	Yes	60% of U&C
Infusion Therapy	Yes	80%	Yes	60% of U&C
Other Services and Supplies	Yes	80%	Yes	60% of U&C
Medical Foods for Inherited Metabolic Disorders	Yes	80%		
Medical Nutrition Therapy, per visit	Yes	80%	Yes	60% of U&C
Limited up to 5 visits per Calendar Year.				
Occupational Therapy	Yes	80%	Yes	60% of U&C
Limited up to 50 visits per Calendar Year. See the Utilization Management Program for additional visits.				
Physical Therapy, per visit	Yes	80%	Yes	60% of U&C
Limited up to 50 visits per Calendar Year. See the Utilization Management Program for additional visits.				
Physician Services - In office				
Primary Care Physician, per visit	Yes	80%	Yes	60% of U&C
Specialist Physician, per visit	Yes	80%	Yes	60% of U&C
Specialist visit with Chemotherapy	Yes	80%	Yes	60% of U&C
Specialist visit with Infusion Therapy	Yes	80%	Yes	60% of U&C
Specialist visit with Radiation Therapy	Yes	80%	Yes	60% of U&C
Obstetrics/Maternity Physician Care	Yes	80%	Yes	60% of U&C
Other Physician Services	Yes	80%	Yes	60% of U&C
Behavioral Health Virtual Visit by: LiveHealth Online	No	100%	N/A	No Coverage(N/A)
Primary Care Virtual Visit by: Live Health Online	No	100%	N/A	No Coverage(N/A)
Urgent Care Virtual Visit by: LiveHealth Online	No	100%	N/A	No Coverage (N/A)
Primary Care Physician is a Family Practice, General Practice, Gynecology, Internal Medicine and Pediatrics. Specialist Physicians includes all others unless noted.				

IMPORTANT: Certain services may require Pre-Service Review. To avoid benefit reductions see the **UTILIZATION MANAGEMENT PROGRAM** section.

MEDICAL BENEFIT SUMMARY, continued

ELIGIBLE MEDICAL EXPENSES	PPO Deductible	PPO In-Network	Non-PPO Deductible	Non-PPO Out-of-Net- work
Preventive and Wellness Care focuses on evaluating your current health status when you are symptom free and allows you to obtain early diagnosis and treatment to help avoid more serious health problems. Preventive care services are not provided for specific health issues or conditions, on-going care, laboratory tests or health screenings necessary to manage or treat an already-identified medical issue or health condition. During your preventive care visit, your doctor will determine what tests, health screenings and immunizations are right for you based on many factors such as your age, gender, overall health status, personal health history and your current health condition. Preventive screening services are subject to age and frequency guidelines recommended by the U.S. Preventive Services Task Force (USPSTF) A & B Recommendations and the Center for Disease Control (CDC) Advisory Committee on Immunization Practices (ACIP). A full list of preventive care services is available at http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/preventive-services-covered-under-aca/# or by contacting the Administrator. NOTE: Ultrasound screening for dense breast will be covered. NOTE: There is no age limit for screening mammogram or ultrasound screening for dense breast.				
Preventive and Wellness Care	No	100%	No	100% U&C
Prescription Drug Program using Carelon	Covered Person Pays the following after the Plan Deductible			
Retail Feature - up to a 30 day supply Generic Drug Preferred Brand-Name Drug Non-Preferred Brand-Name Drug	\$ 15 Co-Pay \$ 25 Co-Pay \$ 50 Co-Pay			
Mail-Order Option - up to a 90 day supply Generic Drug Preferred Brand-Name Drug Non-Preferred Brand-Name Drug	\$ 10 Co-Pay \$ 50 Co-Pay \$ 100 Co-Pay			
Specialty Drugs – you may request up to a 90 day supply of specialty medications	Contact Carelon (833)267-2133			
See the “ Prescription Drugs ” section for more details.				

IMPORTANT: Certain services may require Pre-Service Review. To avoid benefit reductions see the **UTILIZATION MANAGEMENT PROGRAM** section.

MEDICAL BENEFIT SUMMARY, continued

ELIGIBLE MEDICAL EXPENSES	PPO Deductible	PPO In-Network	Non-PPO Deductible	Non-PPO Out-of-Net work
Second (& 3 rd) Surgical Opinion	Yes	80%	Yes	60% of U&C
Skilled Nursing Facility	Yes	80%	Yes	60% of U&C
Eligible Expenses for room and board are limited to the facility's Semi-Private Room Charge. Coverage is limited to 120 days per Calendar Year.				
Speech Therapy	Yes	80%	Yes	60% of U&C
Substance Abuse Care Inpatient Care (includes Day Care Center)	Yes	80%	Yes	60% of U&C
Outpatient Visits	Yes	80%	Yes	60% of U&C
Urgent Care Facility, per visit	Yes	80%	Yes	60% of U&C
Wigs	Yes	100%		
Limited to 1 wig with maximum of \$500 in benefits every 3 years				
All Other Eligible Medical Expenses	Yes	80%	Yes	60% of U&C

IMPORTANT INFORMATION

Except where expressly stated otherwise, where rates have been negotiated with providers participating in the PPO network, such rates will be applied to PPO Providers and used as the Usual & Customary (U&C) to services of Non-PPO Providers (Non-PPO).

It is very important to read the entire Plan Document. The **Medical Benefit Summary** provides only the highlights of the Plan and should not be relied on to determine the extent to which a service or benefit is covered or excluded.

See the **ELIGIBLE MEDICAL EXPENSES AND MEDICAL LIMITATIONS AND EXCLUSIONS** Sections for more information. A Covered Person may also contact the Contract Administrator for additional information.

IMPORTANT: Certain services may require Pre-Service Review. To avoid benefit reductions see the **UTILIZATION MANAGEMENT PROGRAM** section.

ELIGIBLE MEDICAL EXPENSES

This section is a listing of those medical services, supplies and conditions which are covered by the Plan. This section must be read in conjunction with the **Medical Benefit Summary** 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**, eligible medical expenses are the Usual, Customary and Reasonable charges for the items listed below and which are incurred by a Covered Person - subject to the **Definitions, Limitations and Exclusions** and all other provisions of the Plan. In general, services and supplies must be provided 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. Medically Necessity, however, does not guarantee that a service or supply is covered under the terms of the Plan.

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

the date a purchase is made; or

the actual date a service is rendered.

NOTE: Except where expressly stated otherwise, where rates have been negotiated with providers participating in the PPO network, such rates will apply to services of ALL providers (PPO and Non-PPO) in lieu of the Usual, Customary and Reasonable allowance.

1. **Acupressure** - See "Alternative Medicine".
2. **Alcoholism** - see "Substance Abuse Care"
3. **Allergy Testing & Serum**
4. **Alternative Medicine** - Acupressure treatment and Homeopathic treatments including, but not limited to, medicines, supplies, remedies or substances.

NOTE: Covered alternative medicine expenses will not include:

expenses for chelation therapy, except as may be Medically Necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.

expenses for prayer, religious healing, or spiritual healing, except for services provided by a Christian Science Practitioner.

expenses for naturopathic or naprapathic treatment or supplies.

5. **Ambulance** - Professional ground or air ambulance service: (1) when necessary to transport a Covered Person from the place where he/she is injured or stricken by a Sickness to the nearest Hospital where treatment can be given, (2) when Medically Necessary to transport a Covered Person to medical facilities and back home, or (3) when used to transport a Covered Person to a PPO Hospital.
6. **Ambulatory Surgical Center** - Services and supplies provided by an Ambulatory Surgical Center (see **Definitions**) in connection with a covered Outpatient Surgery.
7. **Anesthesia** - Anesthetics and services of a Physician or certified registered nurse anesthetist (CRNA) for the administration of anesthesia.

IMPORTANT: Certain **ELIGIBLE MEDICAL EXPENSES** are subject to benefit limits. See the **MEDICAL BENEFIT SUMMARY** for that information.

ELIGIBLE MEDICAL EXPENSES, *continued*

8. **Attention Deficit Disorders (ADD & ADHD)** - Treatment (i.e., periodic Physician check-ups for evaluation and medication management) for attention deficit disorder (ADD) or attention deficit hyperactive disorder (ADHD).

NOTE: See “Behavioral Health Care” for counseling coverage.

9. **Autism Spectrum Disorder** - Screening for and diagnosis of autism spectrum disorders and applied behavior analysis treatment of autism spectrum disorders under the age of 19.

Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavior therapy or therapeutic care that is:

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

As used in this section:

- c. “Applied behavior analysis” means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.
- d. “Autism spectrum disorders” means a neurobiological medical condition including, without limitation, autistic disorder, Asperger’s Disorder and Pervasive Developmental Disorder Not Otherwise Specified.
- e. “Behavioral therapy” means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or certified autism behavior interventionist.
- f. “Certified autism behavior interventionist” means a person who is certified as an autism behavior interventionist by the Board of Psychological Examiners and who provides behavior therapy under the supervision of:
 - A licensed psychologist;
 - A licensed behavior analyst; or
 - A licensed assistant behavior analyst.
- g. “Evidence-based research” means research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.
- h. “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 functioning of a person.

IMPORTANT: Certain **ELIGIBLE MEDICAL EXPENSES** are subject to benefit limits. See the **MEDICAL BENEFIT SUMMARY** for that information.

ELIGIBLE MEDICAL EXPENSES, continued

- i. "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.
- j. "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.
- k. "Prescription care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.
- l. "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
- m. "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
- n. "Screening for autism spectrum disorders" means medically necessary assessments, evaluations or tests to screen and diagnose whether a person has an autism spectrum disorder.
- o. "Therapeutic care" means services provided by licensed or certified speech pathologists, occupational therapists and physical therapists.
- p. "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.

- 10. Behavioral Health Care** - Behavioral health care includes inpatient and outpatient services for a mental disorder identified in the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of Diagnostic and Statistical Manual of Mental Disorders (DSM). Behavioral health disorders may include, but are not limited to: attention deficit disorders (ADD, ADHD), bereavement counseling, bipolar disorder, depression, marriage and family counseling, obsessive-compulsive disorder (OCD), panic disorder, schizophrenia and phobias.
- 11. Birthing Center** - Services and supplies provided by a Birthing Center (see **Definitions**) in connection with a covered Pregnancy.
- 12. Blood** - Blood and blood plasma (if not replaced by or for the patient), including blood processing and administration services. The Plan will also cover processing, up to 8 weeks of storage, and administration services for autologous blood (a patient's own blood) when such Covered Person is scheduled for a surgery that can reasonably be expected to require blood.
- 13. Cardiac Rehabilitation** - A monitored exercise program directed at restoring both physiological and psychological well-being to individuals with heart disease. Services rendered must be:

IMPORTANT: Certain **ELIGIBLE MEDICAL EXPENSES** are subject to benefit limits. See the **MEDICAL BENEFIT SUMMARY** for that information.

under the supervision of a Physician;

in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery;

initiated within twelve (12) weeks after treatment for the medical condition ends; and

provided in a covered medical care facility as defined by the Plan.

See definition of “Cardiac Rehabilitation” in the **Definitions** section.

NOTE: Maintenance care will not be covered.

14. Chemical Dependency - see “Substance Abuse Care”

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

16. Chiropractic-type Care / Spinal Manipulation - Spinal manipulation and all related services and supplies including, but not limited to, application of a modality to one or more areas (e.g., hot or cold packs, mechanical traction, electrical stimulation, vasopneumatic devices, paraffin baths, microwave, whirlpool, diathermy and infrared).

17. Clinical Trials - Cancer and Chronic Fatigue Syndrome - Clinical trials that are allowed by Nevada law when certain criteria is met. See “Experimental/Investigational Treatment” in the **General Exclusions** section.

18. Contraceptive Devices - Physician services and related supplies for the fitting and placement of a intrauterine device.

NOTE: Contraceptives such as skin patch, vaginal ring, diaphragm, cervical cap, female condom, spermicide foam and sponges, with a written prescription from a Physician, can be obtained through the Prescription Drug Program. **See PRESCRIPTION DRUG PROGRAM.**

19. Diabetes Education Program - Diabetes training and education services when requested by a Physician and Medically Necessary (as determined by the Plan Administrator or its designee) for the self-care and self-management of a person with diabetes. Services must be provided by a Certified Diabetes Educator or a Health Care Practitioner approved by the Plan Administrator or its designee and includes counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes.

Retraining when due to new techniques for the treatment of diabetes or when there has been a significant change in the person’s clinical condition or symptoms that requires modifications of self-management techniques.

20. 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, MRIs), electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the United States.

21. Dialysis Services - Dialysis services, 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.

IMPORTANT: Certain **ELIGIBLE MEDICAL EXPENSES** are subject to benefit limits. See the **MEDICAL BENEFIT SUMMARY** for that information.

- 22. 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. Such equipment must be prescribed by a Physician and required for therapeutic use in treatment of an active Sickness or Accidental Injury. The decision to rent or purchase equipment shall be at the option of the Plan. Excess charges for deluxe equipment or devices will not be covered.

Repair of purchased equipment will be covered when necessary to maintain its usability. Replacement of durable medical equipment will be covered only if: (1) needed due to a change in the patient's physical condition, or (2) it is likely to cost less to buy a replacement than to repair existing equipment or rent like equipment.

"Durable medical equipment" includes such items as non-dental braces, crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, intermittent positive pressure breathing machines and dialysis equipment, etc., which: (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.

- 23. Gender Reassignment** - 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

IMPORTANT: Certain **ELIGIBLE MEDICAL EXPENSES** are subject to benefit limits. See the **MEDICAL BENEFIT SUMMARY** for that information.

ELIGIBLE MEDICAL EXPENSES, continued

- 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 Reassignment under **MEDICAL LIMITATIONS AND EXCLUSIONS** for services and procedures that are not covered.

24. Genetic Counseling & Testing - Counseling and testing services as follows:

BRCA1 and BRCA2 genetic test for an individual already diagnosed with breast and/or ovarian cancer where results may affect the course of treatment or where such test is otherwise considered a medically appropriate, preventive care service.

Apo E genetic test to help a Physician identify an individual at high risk for heart disease and to determine the most appropriate dietary and fitness program.

Prenatal genetic testing for pregnant women includes amniocentesis, chorionic villus sampling (CVS, fetoscopy and alpha-fetoprotein (AFP) analysis, Early Screen for Down Syndrome, Trisomy 18 and Trisomy 13, and cystic fibrosis in pregnant women.

Any other physician ordered genetic counseling and testing not specifically listed above is subject to an annual benefit of \$1,000.

25. Hearing Aids & Related Examinations - Hearing examinations, hearing aids and the fitting of hearing aids.

NOTE: Hearing aid batteries and repairs are not covered.

26. Home Health Care - Services and supplies which are furnished to a Covered Person who is confined at home and is under the active medical supervision of the Physician ordering home health care and who is treating the condition for which that care is needed. Home health care services and supplies must be consistent with the patient's health condition, degree of disability and medical needs.

Home health care services and/or supplies must be provided and billed by a Home Health Care Agency. Covered home health care services and supplies include:

services of a registered nurse (RN) or a licensed practical nurse (LPN);

services of physical, occupational and speech therapists;

services of a medical social service worker;

services of home health aides who are employed by (or under an arrangement with) a Home Health Care Agency, provided the patient is also receiving nursing care and care of a therapist (see above). Services must be ordered by the Home Health Agency as a professional coordinator; and

necessary medical supplies provided by the Home Health Care Agency.

27. 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 program charges for:

IMPORTANT: Certain **ELIGIBLE MEDICAL EXPENSES** are subject to benefit limits. See the **MEDICAL BENEFIT SUMMARY** for that information.

ELIGIBLE MEDICAL EXPENSES, continued

Inpatient hospice care;

Physician services;

services of a Home Health Care Agency - see "Home Health Care" (above) for additional information;

drugs and medications; and

homemaker services.

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

NOTE: Comfort or convenience items provided to a Covered Person while hospitalized are not covered.

- 29. Infertility Testing** - Testing that is performed to determine a diagnosis for infertility (i.e., to determine the cause for infertility).

- 30. Marriage & Family Counseling** - see "Behavioral Health Care"

- 31. Medical Foods for Inherited Metabolic Disorders** - Medical foods (also called Special Food Products as defined below) are payable for persons with Inherited Metabolic Disorders (defined below), subject to the following provisions as determined by the Plan Administrator or its designee:

treatment must be prescribed by a Physician; and

documentation to substantiate the presence of an Inherited Metabolic Disorder and that the products purchased are Special Food Products may be required.

For these purposes, "Inherited Metabolic Disorder" means genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates or fats, as diagnosed by a Physician using standard blood, urine, spinal fluid, tissue or enzyme analysis. Inherited Metabolic Disorders are also referred to as inborn errors of metabolism and includes Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance with a diagnosis of Galactosemia is not covered.

A "Special Food Product" is a food product that is specially formulated to have less than one (1) 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 (as that term is defined in this chapter). The term does not include a food that is naturally low in protein or foods or formulas for persons who do not have Inherited Metabolic Disorders.

- 32. Medical Nutrition Therapy** - Medical nutrition therapy when provided on referral from the Covered Person's attending Physician for one of the following chronic medical conditions. Treatment must be provided by a licensed Registered Dietitian (RD):

cancer

chronic obstructive pulmonary disease

coronary artery disease, including hypertension

diabetes mellitus, non-insulin-dependent

IMPORTANT: Certain **ELIGIBLE MEDICAL EXPENSES** are subject to benefit limits. See the **MEDICAL BENEFIT SUMMARY** for that information.

HIV/AIDS

hyperlipidemia

irritable bowel syndrome

morbid obesity

prenatal care, high risk

renal disease, pre-end-stage

NOTE: Except as above, care or services rendered by a nutritionist are not covered.

33. Medical Supplies - Medical supplies such as casts, splints, trusses, surgical dressings, catheters, colostomy bags and related supplies.

34. Medicines - Medicines which are dispensed and administered to a Covered Person during an Inpatient confinement or during a Physician's office visit. See the **Prescription Drugs** section for pharmacy drugs.

35. Midwife - Services of a certified or registered nurse midwife when provided in conjunction with a covered Pregnancy - see "Pregnancy" below.

36. Newborn Care - Hospital nursery and Physician services provided during the birth confinement to a covered well newborn child.

In accordance with the Newborns' and Mothers' Health Protection Act, the Plan will not restrict benefits for a Hospital stay for a newborn (birth confinement) to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean delivery.

NOTE: A covered newborn that is sick or injured is eligible for benefits to the same extent as any other Covered Person.

37. Nursing Services - Services of a registered nurse (RN), licensed vocational nurse (LVN) or licensed practical nurse (LPN) for nursing services when prescribed in writing by the attending Physician or surgeon specifically as to duration and type. Inpatient nursing care is covered only when care is Medically Necessary and not custodial and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit. Outpatient nursing care is covered only as part of "Home Health Care" or "Hospice Care", above.

NOTE: Services of a private surgical scrub nurse are not covered

38. Occupational Therapy - Short-term active, progressive Occupational Therapy performed by a licensed or duly qualified therapist as ordered by a Physician.

Services that are restorative in nature and designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease, or injury and only if there is a reasonable expectation that occupational therapy will achieve measurable improvement in the patient's condition in a reasonable and predictable amount of time.

NOTE: Occupational Therapy will not be covered for the management of chronic diseases, training in non-essential tasks (e.g. homemaking, gardening, recreational activities), therapy related solely to specific employment opportunities, work skills or work settings and maintenance therapy. Maintenance

IMPORTANT: Certain **ELIGIBLE MEDICAL EXPENSES** are subject to benefit limits. See the **MEDICAL BENEFIT SUMMARY** for that information.

ELIGIBLE MEDICAL EXPENSES, *continued*

therapy is defined as ongoing therapy after the patient has reached maximum rehabilitative level, and patient's functionality has not shown significant improvement.

39. Orthognathic Surgery - Surgery to correct a receding or protruding jaw.

NOTE: Plan coverage does not include methods of treatment which are recognized as dental procedures (e.g., extraction of teeth, nightguards and/or the application of braces to the teeth).

40. Orthopedic Shoes & Braces - Orthopedic braces, orthopedic shoes other foot orthotics.

41. Oxygen - see "Durable Medical Equipment"

42. Physical Therapy - Short-term active, progressive Physical Therapy performed by a licensed or duly qualified therapist as ordered by a Physician. Services that are related to an injury, illness, or disease and the diagnosis are consistent with physical therapy treatment. There must be reasonable expectation that the services will produce significant improvement in the patient's condition. Documentation, when requested, must support physical therapy services that contain progress reports, a diagnosis to support the level of care provided, medical necessity of the care provided, the patient's progress toward meeting the goals of the therapy and the results achieved during the physical therapy services.

43. 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" below for requirements applicable to surgery opinion consultations.

44. Pregnancy - Eligible Pregnancy-related expenses are covered to the same extent as any other Sickness. Pregnancy-related expenses include the following, but may include other services which 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;

amniocentesis, chorionic villus sampling (CVS), fetoscopy and alpha-fetoprotein (AFP) analysis, Early Screen for Down Syndrome, Trisomy 18 and Trisomy 13, and cystic fibrosis in pregnant women, but only if the procedure is **Medically Necessary** as determined by her physician;

routine well-baby nursery expenses which are billed by the Hospital and which are incurred during the child's birth confinement and while the mother and child are both confined post-delivery.

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.

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, unless the surrogate mother is a Covered Person under this Plan.

45. Prescription Drugs - Drugs and medicines which are dispensed and administered to a Covered Person during an Inpatient confinement.

IMPORTANT: Certain **ELIGIBLE MEDICAL EXPENSES** are subject to benefit limits. See the **MEDICAL BENEFIT SUMMARY** for that information.

ELIGIBLE MEDICAL EXPENSES, continued

Coverage for Outpatient drugs (i.e., pharmacy purchases) is provided through a separate program. See the **Prescription Drugs** section for additional information.

NOTE: Drugs or medications dispensed from a Physician's office are not covered.

- 46. Preventive Care** - Preventive and Wellness Care focuses on evaluating your current health status when you are symptom free and allows you to obtain early diagnosis and treatment to help avoid more serious health problems. Preventive care services are not provided for specific health issues or conditions, on-going care, laboratory tests or health screenings necessary to manage or treat an already-identified medical issue or health condition. During your preventive care visit, your doctor will determine what tests, health screenings and immunizations are right for you based on many factors such as your age, gender, overall health status, personal health history and your current health condition. Preventive screening services are subject to age and frequency guidelines recommended by the U.S. Preventive Services Task Force (USPSTF) A & B Recommendations and the Center for Disease Control (CDC) Advisory Committee on Immunization Practices (ACIP). A full list of preventive care services is available at <http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/preventive-services-covered-under-aca/#> or by contacting the Administrator.

NOTE: Ultra sound screening for dense breast is covered.

NOTE: There is no age limit for screening mammogram or ultra sound for dense breast.

- 47. Radiation Therapy** - Radium and radioactive isotope therapy.
- 48. 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.
- 49. Second (& 3rd) Surgical Opinion** - A second surgical opinion consultation following a surgeon's recommendation for Surgery. 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.

- 50. Skilled Nursing Facility** - Inpatient care in Skilled Nursing Facility, but only when the admission to the facility or center is Medically Necessary, is in lieu of Inpatient care at a Hospital, and:

the condition requiring Skilled Nursing Facility admission is the same condition as necessitated a prior Hospital confinement;

the Skilled Nursing Facility admission occurs immediately following discharge from such prior confinement;

the attending Physician certifies the need for Skilled Nursing Facility care seven (7) days following admission and for every seven (7) days of confinement thereafter.

- 51. Speech Therapy** - Short-term active, progressive Speech Therapy performed by a licensed or duly qualified therapist as ordered by a Physician. Speech Therapy to restore speech to a person who has lost existing speech function as a result of disease, injury or surgery, such as seizure disorder, CVA or stroke, otitis media, brain injury, hearing loss, Parkinson's disease and paralysis of the vocal cord or larynx, carcinoma of the larynx, trachea, pharynx, lip, head, neck, and dysphasia.

IMPORTANT: Certain **ELIGIBLE MEDICAL EXPENSES** are subject to benefit limits. See the **MEDICAL BENEFIT SUMMARY** for that information.

ELIGIBLE MEDICAL EXPENSES, *continued*

NOTE: Speech Therapy is not covered for non-organic/functional speech and language disorders such as lisping, stuttering and stammering, or speech and language problems that result from noncurable developmental disorders such as, developmental delay, mental retardation, Down's Syndrome. Maintenance therapy is not covered. Maintenance therapy begins when the therapeutic goals of a treatment plan have been met and no further functional progress is expected.

52. Spinal Manipulation - see "Chiropractic-type Care / Spinal Manipulation"

53. 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.

54. Substance Abuse Care - Inpatient and Outpatient treatment of substance abuse including detoxification services.

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.

55. Telemedicine - You may receive 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 telephone, facsimile or email. The Plan will not prevent the use of telemedicine in a course of treatment or evaluation. The Plan will not prevent the use of telemedicine based on where the Provider is located. A Provider who uses telemedicine to provide services is responsible for ensuring he or she complies with all federal and state laws, including licensure, at the location in which the patient is located. The Plan will not pay claims for services provided by Providers who are not licensed in the State where the patient is located. However, the Plan does not control the methods of treatment and business arrangements between third parties. Therefore, you may have to pay both the originating site and the Provider located at the distant site. Additionally, it is the member responsibility to ensure the Providers you use are PPO Providers. Failure to use PPO Providers will result in a higher cost to you.

56. TMJ / Jaw Joint Treatment - Occlusal guards and non-dental 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. Coverage also includes occlusal guards.

NOTE: Plan coverage does not include methods of treatment which are recognized as dental procedures (e.g., extraction of teeth and the application of orthodontic braces).

57. Transplant-Related Expenses (Human Tissue) - Eligible Expenses for a non-investigative and non-experimental organ or tissue transplant for:

a Covered Person who is the transplant recipient;

a Covered Person who is an organ donor. However, Plan benefits will be reduced by any amounts paid or payable by the recipient's coverage; and

an organ or tissue donor who is not a Covered Person when the recipient is a Covered Person. However, Plan benefits will be reduced by any amounts paid or payable by the donor's own coverage.

IMPORTANT: Certain **ELIGIBLE MEDICAL EXPENSES** are subject to benefit limits. See the **MEDICAL BENEFIT SUMMARY** for that information.

ELIGIBLE MEDICAL EXPENSES, continued

In addition to other Eligible Expenses as listed in this section, eligible transplant-related expenses will include those for organ procurement and/or organ and storage costs.

NOTE: Eligible transplant-related expenses will not include travel or lodging costs of the donor or recipient. Xenographic (cross species) transplants are not covered, except for heart valves.

58. Urgent Care Facility - see Definitions

59. Virtual Visit – You can connect with a doctor from your mobile device or computer, usually 24/7. Doctors can diagnose and treat a wide range of non-emergency medical conditions. A Virtual Visit typically provides primary care, urgent care center or non-emergency room services. Virtual Visits are eligible when provided by PPO Providers, see “Virtual Visits” page 13.

60. Wigs - The purchase of one (1) wig up to \$500, for hair loss resulting from medical treatment (i.e., chemotherapy or radiation therapy). One wig every 3 years with prescription.

IMPORTANT: Certain **ELIGIBLE MEDICAL EXPENSES** are subject to benefit limits. See the **MEDICAL BENEFIT SUMMARY** for that information.

MEDICAL LIMITATIONS AND EXCLUSIONS

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

1. **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.

2. **Air Purification Units, Etc.** - Air conditioners, air-purification units, humidifiers and electric heating units.
3. **Biofeedback** - Expenses for treatment using the technique of making unconscious or involuntary bodily processes perceptible to the senses in order to manipulate self by conscious mental control, except for conditions where there is sufficient evidence to establish medical efficacy such as: cancer pain in adults, chronic severe constipation, fecal incontinence due to pelvic floor dysfunction, irritable bowel syndrome, migraine and tension headaches, neurogenic fecal incontinence, neuromuscular rehabilitation of stroke and traumatic brain injury, Raynaud's disease, refractory severe subjunctive tinnitus, Temporomandibular Joint Syndrome and urinary incontinence.
4. **Complications from a Non-Covered Service** - Expenses for care, services or treatment required as a result of complications from a treatment or service not covered under this Plan, except for complications from an abortion.
5. **Cosmetic & Reconstructive Surgery, Etc.** - Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly. Exclusions include but are not limited to surgery for sagging or extra skin, abdominoplasty, blepharoplasty, liposuction, rhinoplasty, epikeratophakia surgery, any augmentation or reduction procedures or correction of facial or breast asymmetry (except as defined below), treatment of male-pattern baldness or hair treatment, keloid scar or other scar revision therapy, any procedures utilizing an implant which cannot be expected to substantially alter physiologic functions, earring injuries and/or earlobe repair. Complications resulting from excluded cosmetic surgery or medical procedures are not covered. Psychological factors (for example, for self-image, difficult social or peer relations) do not constitute a physical bodily function or Medical Necessity.

The following are not subject to this exclusion:

services necessitated by an Accidental Injury or Sickness;

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;

surgery which is necessary to correct a congenital abnormality in a covered Dependent child;

removal of a mastectomy-related prosthesis only if Medically Necessary due to leakage.

6. **Custodial & Maintenance Care** - Care or confinement primarily for the purpose of meeting personal needs (bathing, walking, companionship care, homemaker services, 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.

MEDICAL LIMITATIONS AND EXCLUSIONS, continued

- 7. Dental Care** - Dental care including, but not limited to: treatment to the teeth, extraction of teeth, treatment of dental abscesses or granulomas, treatment of gingival tissues (other than for tumors), dental exams, **orthodontia treatment**, oral surgery, pre-prosthetic surgery, any procedure involving osteotomy to the jaw, any other dental product or service customarily provided by a dentist, treatment to the gums, treatment of pain or infection known or thought to be due to dental causes and in close proximity to the teeth or jaw, braces, bridges, dental plates or other dental orthoses or prostheses, and replacement of metal dental fillings. However, this exclusion will not apply to the following dental/oral-related care:

services of a dentist (DDS or DMD) for treatment and repair of a fractured or dislocated jaw or sound natural teeth damaged in an Accidental Injury, provided such repair is performed within twelve (12) months following the injury and while the person is covered hereunder;

facility fees and anesthesia associated with Medically Necessary dental services if the Utilization Management Organization determines that hospitalization is Medically Necessary to safeguard the health of the patient during the performance of dental services, but only when:

the patient is a child under age seven (7) and has been diagnosed with extensive dental decay substantiated by X-rays and narrative provided by the treating dentist; or

the patient has a documented illness, such as hemophilia or prior tissue or organ transplant requiring a Hospital environment to monitor vital signs; or

the patient has a documented mental or physical impairment requiring general anesthesia in a Hospital setting for the safety of the patient.

Charges by the dentist or any assistant dental provider are not covered.

- 8. Diagnostic Hospital Admissions** - Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting.
- 9. Ecological or Environmental Medicine** - Chelation or chelation therapy, orthomolecular substances, or use of substances of animal, vegetable, chemical or mineral origin which are not specifically approved by the FDA as effective for treatment.
- 10. 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.

- 11. Exercise Equipment / Health Clubs** - Exercising equipment, vibratory equipment, swimming or therapy pools. Enrollment in health, athletic, or similar clubs or programs.
- 12. Fertility and Infertility Services** - Expenses for the treatment of infertility, along with services to induce Pregnancy (and complications thereof), including but not limited to services, prescription drugs, procedures or devices to achieve fertility, in-vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, zygote transfer, surrogate parenting, donor egg/semen, cryostorage of egg or sperm, adoption, ovarian transplant, infertility donor expenses and reversal of sterilization procedures.

NOTE: This exclusion does not apply to testing that is performed to determine a diagnosis for infertility (i.e., to determine the cause for infertility).

- 13. 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).

- 14. Gender Reassignment 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.

- 15. Genetic Counseling and Testing** - Expenses for genetic tests, including obtaining a specimen and laboratory analysis to detect or evaluate chromosomal abnormalities, or genetically transmitted characteristics, including:

Counseling: intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents; and

Testing: prenatal genetic testing intended to determine if a fetus has chromosomal abnormalities that indicate the presence of a genetic disease or disorder, except that payment is made for fluid or tissue samples obtained through amniocentesis, chorionic villus sampling (CVS), fetoscopy and alphafetoprotein (AFP) analysis, Early Screen for Down Syndrome, Trisomy 18 and Trisomy 13, and cystic fibrosis in pregnant women, but only if the procedure is **Medically Necessary** as determined by the physician.

Note: Certain genetic counseling and testing, including items considered medically appropriate preventive care, are covered. See **Eligible Medical Expenses, Genetic Counseling & Testing**.

- 16. Hair Replacement** - 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 (except as noted) relating to baldness or hair loss.

NOTE: The Plan will cover the purchase of a wig for hair loss resulting from medical treatment. See **“Wigs”** in the list of **Eligible Medical Expenses**.

- 17. Hypnotherapy** - Treatment by hypnotism.

- 18. Learning & Behavioral Disorders** - Except as noted, treatment for learning or behavioral disorders, mental retardation, or autism.

NOTE: See “Attention Deficit Disorders (ADD & ADHD)”, “Autism Spectrum Disorder” and “Behavioral Health Care” in the list of **Eligible Medical Expenses** for coverage information.

- 19. Maintenance Care** - see “Custodial & Maintenance Care”

- 20. Massage Therapy** - Massage therapy, except when performed by a Physician.
- 21. Modifications of Homes or Vehicles** - Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Covered Person, including without limitation, any construction or modification (e.g., ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, hand rails, emergency alert systems, etc.).
- 22. Non-Prescription Drugs** - Drugs for use outside of a hospital or other Inpatient facility which can be purchased over-the-counter and without a Physician's written prescription - except as may be included in the prescription coverages of the Plan.
- Drugs for which there is a non-prescription equivalent available.
- 23. Not Medically Necessary / Not Physician Prescribed** - Services for an illness, sickness, injury or condition which are not deemed Medically Necessary by the Plan, even when ordered by a Physician or other Covered Provider.
- 24. Over-the-Counter Supplies** - Supplies that can be obtained without a Physician's prescription are not covered. Such supplies include but are not limited to ace bandages, band-aids, ankle supports, wrist supports, cotton balls, Neosporin, rubbing alcohol, latex gloves, vaseline, toothettes, instant hot/cold packs, tourniquets, cleansing towelettes, thermometers, pant liners/disposable underpads.
- 25. Penile Implants, Etc.** - see "Gender Reassignment Surgery"
- 26. 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) vacuum cleaners, (2) motorized transportation equipment, escalators, (3) waterbeds or non-hospital adjustable beds, (3) hypoallergenic mattresses, pillows, blankets or mattress covers, (4) cervical pillows, (5) whirlpools, exercise equipment, or gravity lumbar reduction chairs, (6) home blood pressure kits, (7) personal computers and related equipment, televisions, telephones, or other similar items or equipment, (8) food liquidizers, or (9) comfort or convenience items while hospitalized.
- 27. Prophylactic Surgery or Treatment** – Expenses for all medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery when the services, procedures, prescription of drugs, or prophylactic surgery is prescribed or performed for the purpose of avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results; or treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of physical or mental disorder. This provision does not apply to high risk individuals who have met the Plan's criteria for a prophylactic mastectomy or prophylactic oophorectomy and it has been authorized as medically necessary for the reduction of risk of cancer by the Plan's Utilization Management. To obtain the Plan's criteria for a prophylactic mastectomy or prophylactic oophorectomy, contact Medical Management.
- 28. Rehabilitation Therapy** (Inpatient or Outpatient) - Services provided on an Inpatient or Outpatient basis for the following:

expenses for educational, job training, vocational rehabilitation, and/or special education for sign language;

expenses for massage therapy, rolfing and related services;

expenses incurred at an Inpatient rehabilitation facility for any Inpatient care provided to an individual who is unconscious, comatose or in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable

MEDICAL LIMITATIONS AND EXCLUSIONS, continued

to learn and/or remember what is taught, including but not limited to coma stimulation programs and services;

expenses for maintenance rehabilitation;

expenses for speech therapy for functional purposes including but not limited to stuttering, stammering and conditions of psychoneurotic origin, or for childhood developmental speech delays and disorders;

expenses for treatment of delays in childhood speech development, unless as a direct result of an injury, surgery or the result of a covered treatment.

29. 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, which 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**.

30. Telecommunications - Advice or consultation given by or through any form of virtual/telecommunication services except as otherwise expressly included in the Medical Benefit Summary and under Eligible Expenses.

31. Telephone Calls - Expenses for any and all telephone calls between a physician or other health care provider, utilization management company, or any representative of the plan for any purpose whatsoever.

32. 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 lasik surgery.

NOTE: This exclusion will not apply to: (1) services necessitated by a Sickness, or (2) up to two pair of glass lenses and one set of frames or up to two pair of contact lenses within one year following intraocular surgery or Accidental Injury.

33. Vitamins or Dietary Supplements - Prescription or non-prescription organic substances used for nutritional purposes, vitamins or vitamin therapy.

34. Vocational Testing or Training - Vocational testing, evaluation, counseling or training.

35. Weight Control - Services or supplies for obesity, weight reduction or dietary control, except as authorized by the **Utilization Management Program**.

- (See also **General Exclusions** section) -

PRESCRIPTION DRUG PROGRAM

The Prescription Drug Program is administered and provided through Carelon, through Anthem Blue Cross Blue Shield. If you are a Medicare Eligible Retiree or dependent refer to **PRESCRIPTION DRUG PROGRAM FOR MEDICARE ELIGIBLE RETIREES** section for additional information on the program.

Access <https://enrollment.anthem.com/WashoeCountySchoolDistrict> to obtain updated information regarding the Formulary list, covered and non-covered drugs, and a list of participating pharmacies along with helpful information on generic equivalent drugs.

Carelon Anthem.com (833) 267-2133	
PRESCRIPTION DRUG PROGRAM	COVERED PERSON PAYS THE FOLLOWING AFTER THE PLAN DEDUCTIBLE
Retail Feature – up to a 30 day supply Generic Drug Preferred Brand-Name Drug Non-Preferred Brand-Name Drug	\$15 Co-Pay \$25 Co-Pay \$50 Co-Pay
Mail-Order for Maintenance Drugs – up to a 90 day supply Generic Drug Preferred Brand-Name Drug Non-Preferred Brand-Name Drug Specialty Drugs	\$ 10 Co-Pay \$ 50 Co-Pay \$100 Co-Pay Specialty Drugs will be filled through Carelon specialty pharmacy with up to a 90-day limit.
Specialty drugs are medications that generally have unique uses, require special dosing or administration, are typically prescribed by a specialist provider and are significantly more expensive than alternative drugs. For additional information contact the Carelon Specialty team at (833) 267-2133 or visit their website at www.Anthem.com	

Specialty medication fulfillment: Specialty medications require mandatory fulfillment through Carelon specialty pharmacy 1-(833)267-2133. Specialty medications are typically high cost injectable medications, and select oral medications for rheumatoid arthritis, HIV, hepatitis C, oncology, growth hormone, multiple sclerosis and other conditions.

The **Brand-Name Co-Pay** will apply to any purchase of a brand-name drug if the prescribing Physician indicates that a brand-name is required and whether or not a generic form of the drug is available. However, if an individual prefers a brand-name drug and there is no medical necessity for its use over a generic drug, the Covered Person will be required to pay the brand-name Co-Pay plus the difference in price between the brand-name drug and its generic equivalent.

COVERED DRUGS

Covered drugs include most prescription drugs (i.e., federal legend drugs and compounded drugs which are prescribed by a Physician and which require a prescription either by federal or state law) and certain non-prescription items.

The following is a list of prescription and non-prescription drugs and supplies which are sometimes excluded by group health plans but which are covered by this Plan. In some instances, coverage may be subject to prior authorization:

Legend drugs on the preferred drug list;

Retin-A (all dosage forms for Covered Persons through age 25);

Insulin on prescription and disposable insulin syringes/needles when prescribed and dispensed at the same time as insulin and in equivalent quantities;

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

Examples of prescription drugs and services not included are:

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.

Immunizations Agents - Serums, toxoids, vaccines.

Investigational Drugs - A drug or medicine labeled: "Caution - limited by federal law to investigational use."

No Charge - A prescribed drug which 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 dispensed in or from a Physician's office.

Non-Prescription Drugs - A drug or medicine that can legally be bought without a written prescription except for any required to be covered as preventive care. This does not apply to injectable insulin.

Outside United States - Prescriptions purchased outside of the United States.

MEDICARE ELIGIBLE RETIREES

Retirees and their dependents who are Medicare eligible will automatically be enrolled in Medicare Part D and covered through **UnitedHealthcare® MedicareRx for Groups (PDP)** plan and **Sav-Rx** prescription drug plan. UnitedHealthcare® MedicareRx plan for Groups is the primary prescription plan and Sav-Rx is the secondary plan.

You will need to present two ID cards when filling your prescription(s), the UnitedHealthcare® MedicareRx for Groups plan ID card and the Sav-Rx ID card. It is important to present both ID cards at the same time to your pharmacy to ensure you receive the maximum benefit

If you have any questions, please call Sav-Rx. Sav-Rx will be the final payer on your prescription drug claims and can give you information about your prescription drug costs.

SAV-RX
1-(800)-228-3108
7 days a week / 24 hours

DENTAL PLAN

The Plan Sponsor has contracted with Anthem Blue Cross Blue Shield for dental services. When obtaining dental care services, a Covered Person has a choice of using any dental provider of his choice, however, by utilizing an Anthem Essential Choice Prime dental provider, you will receive the maximum benefit. Because Anthem providers have agreed to provide dental services at negotiated rates, when a Covered Person uses a Guardian Preferred Select provider his/her out-of-pocket costs may be reduced because he/she will not be billed for expenses in excess of "Usual, Customary and Reasonable" or in excess of the negotiated rates.

Anthem Essential Choice Prime
(844) 729-1565

SCHEDULE OF DENTAL BENEFITS

IMPORTANT: For those services or supplies where rates have been negotiated with providers participating in the dental PPO network, such rates will apply to ALL providers (PPO and Non-PPO) in lieu of the Usual, Customary and Reasonable allowance.

CALENDAR YEAR MAXIMUM BENEFIT	
Dependent children up to age 19	Unlimited
All Others	\$ 2,000
CALENDAR YEAR DEDUCTIBLE	
Individual Deductible	\$50
Family Maximum Deductible	\$100
<u>Individual Deductible</u> - The Individual Calendar Year Deductible is an amount which a Covered Person must contribute toward payment of eligible dental expenses. Usually, the deductible applies before the Plan begins to provide benefits. <u>Family Maximum Deductible</u> - If \$100 in eligible dental expenses is incurred collectively by family members during a Calendar Year and is applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and his covered Dependents.	
Lifetime Orthodontic Maximum	
Dependent children up to age 18 deductible	\$1,000
Child orthodontics (braces)	80% covered up to \$1,000
Preventive Services (Deductible waived)	100%
Limits applicable to certain Preventive Services: - routine oral examinations and cleanings are limited to 2 exams/cleanings per Calendar Year; - fluoride is limited to 1 application per Calendar Year; - sealants are limited to children under the age of 14 and the maximum Eligible Expense is \$20 per tooth; - full-mouth X-rays are limited to once per 3-year period and routine bitewings are limited to 2 sets per Calendar Year.	
Restorative Services	80%
Major Services	80%
Denture relines are limited to 1 laboratory reline per 4-year period.	

DENTAL PRE-TREATMENT ESTIMATE

If extensive dental work is needed, the Plan Administrator recommends that a pre-treatment estimate be obtained prior to the work being performed. 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 Administrator 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 services are actually incurred. The pre-treatment estimate is valid for ninety (90) days from the date of issue.

IMPORTANT: Certain **ELIGIBLE DENTAL EXPENSES** are subject to benefit limits. See the **DENTAL BENEFIT SUMMARY** for that information.

ELIGIBLE DENTAL EXPENSES

Eligible dental expenses are the Usual, Customary and Reasonable charges for the dental services and supplies listed below, which are: (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/she is licensed.

For benefit purposes, dental expenses will be deemed incurred as follows:

for an appliance or modification of an appliance, on the date the final impression is taken;

for a crown, inlay, onlay or gold restoration, on the date the tooth is prepared;

for root canal therapy, on the date the pulp chamber is opened; or

for any other service, on the date the service is rendered.

NOTE: Many dental conditions can be properly treated in more than one way. The Plan is designed to help pay for dental expenses, but not for treatment which 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

1. **Exams & Cleanings, Routine** - Routine oral examinations and routine cleaning and polishing of the teeth.
2. **Fluoride** - Topical application of stannous or sodium fluoride.
3. **Prophylaxis** - see "Exams & Cleanings, Routine"
4. **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 which are free of decay or prior restoration.

Any allowance made for sealants includes any necessary repair or replacement within thirty-six (36) months from time of application.

5. **Space Maintainers** - Fixed and removable appliances to maintain (not change) the space left by a prematurely lost primary or "baby" tooth and to prevent abnormal movement of the surrounding teeth.
6. **X-rays, Routine** - Routine full mouth X-rays, routine bitewing X-rays and supplementary periapical X-rays as necessary. "Full mouth X-rays" means a panorex plus bitewings or fourteen (14) periapical films plus bitewings.

NOTE: X-rays necessary for proper claims adjudication can be requested by the Plan. Periapical X-rays must be submitted for all teeth requiring crowns or teeth that are to be used as abutments for a bridge.

RESTORATIVE SERVICES

1. **Anesthesia** - General anesthesia when administered in connection with oral Surgery.

NOTE: Hypnosis and relative analgesia are not covered unless the patient is completely anesthetized to a state of unconsciousness as with a general anesthetic.

2. **Crowns** - A crown restoration when a tooth cannot be satisfactorily restored with a filling restoration. Coverage for a crown includes a post and core when necessary. The maximum allowance for a crown on a primary tooth will be the allowance for a stainless steel crown.

Replacement of a crown, if the existing crown is at least five (5) years old.

3. **Endodontia** - Endodontic services including but not limited to: root canal therapy (but not on a primary tooth), pulpotomy, apicoectomy and retrograde filling.

4. **Extraction** - see "Oral Surgery"

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

Replacement of a filling if the existing restoration is at least twenty-four (24) months old.

6. **Injections** - Injection of antibiotic drugs.

7. **Mouthguard** - For the treatment of bruxism.

8. **Oral Surgery** - Extraction of teeth, including simple extractions and surgical extraction of bone or tissue-impacted teeth. Biopsy of oral tissue (but not including laboratory costs), and other surgical and adjunctive treatment of disease, injury and defects of the oral cavity and associated structures.

9. **Palliatives** - Emergency treatment for the relief of dental pain.

10. **Periodontia** - Periodontal scaling and root planing and surgical procedures (i.e., gingivectomy, osseous surgery and mucogingival surgery). Any allowance for periodontal surgery includes postoperative care for six (6) months following the surgery.

11. **Visits, Non-Routine** - Office visits other than those covered as "Preventive Services."

12. **X-Rays, Non-Routine** - X-rays other than those covered as "Preventive Services."

MAJOR SERVICES

1. **Implants** - Placement of an implant to replace a missing tooth.
2. **Inlays, Onlays & Gold Restorations** - An inlay, onlay or gold restoration when a tooth cannot be satisfactorily restored with a less costly filling (amalgam, etc.) restoration.

Replacement of an inlay, onlay or gold restoration, if the existing restoration is at least five (5) years old.

3. **Prosthetics** - Initial placement of a full or partial denture or bridge.

Addition of teeth to a partial denture or bridge.

Replacement of an existing full or partial denture or bridgework, but only if the existing denture or bridgework cannot be made serviceable and is at least four (4) years old.

NOTE: Fixed bridges are not covered for a child under sixteen (16) years of age. An allowance will be made for a partial denture.

4. **Repairs & Adjustments** - Repair of bridgework or dentures, the relining of dentures (see NOTE) and prosthetic adjustments.

NOTE: Relines are limited to laboratory relines. Office relines are considered to be temporary and are not covered.

DENTAL LIMITATIONS AND EXCLUSIONS

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

1. **Appliances** - Items intended for sport or home use, such as athletic mouthguards or habit-breaking appliances. See Mouthguard under **Restorative Services**.
2. **Congenital or Developmental Conditions** - Treatment of congenital (hereditary) or developmental (following birth) malformations.
3. **Cosmetic Dentistry** - Treatment rendered purely for cosmetic purposes.
4. **Customized Prosthetics** - Excess charges for precision or semi-precision attachments, overdentures, or customized prosthetics.
5. **Discoloration Treatment** - Teeth whitening or any other treatment to remove or lessen discoloration, except in connection with endodontia.
6. **Excess Care** - Services which 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) which would produce a professionally satisfactory result.

Duplicate prosthetic devices or appliances.

7. **Experimental Procedures** - Services which are considered experimental or which are not approved by the American Dental Association.
8. **Grafting** - Extra oral grafts (grafting of tissue from outside the mouth to oral tissues).
9. **Hospital Expenses** - See **Dental Care** under **Medical Limitations and Exclusions**.
10. **Implant Removal** - The removal of implants.
11. **Lost or Stolen Prosthetics or Appliances** - Replacement of a prosthetic or any other type of appliance which has been lost, misplaced, or stolen.
12. **Medical Expenses** - Any dental-related services to the extent to which coverage is provided under the terms of the medical benefits of this Plan.
13. **Myofunctional Therapy** - Muscle training therapy or training to correct or control harmful habits.
14. **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/she is licensed.
15. **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, waterpiks, and mouthwashes.

16. **Orthodontia, Etc.** - Orthodontia procedures, appliances or restorations used to increase vertical dimension or to restore occlusion.
17. **Orthognathic Surgery** - Surgery to correct a receding or protruding jaw. See **Orthognathic Surgery** under **Eligible Medical Expenses**.
18. **Personalization or Characterization of Dentures** - Excess charges for the personalization or characterization of dentures.
19. **Prescription Drugs** - see the **Prescription Drugs** section
20. **Prior to Effective Date / After Termination Date** - Courses of treatment which began prior to the Covered Person's effective date, including crowns, bridges or dentures which were ordered prior to the effective date. Expenses incurred after termination of coverage.
21. **Replanted / Transplanted Teeth** – Restorations on replanted or transplanted teeth.
22. **Splinting** - Appliances or restorations for splinting teeth.
23. **Temporary Restorations & Appliances** - Excess charges for temporary restorations and appliances. The Eligible Expenses for the permanent restoration or appliance will be the maximum covered charge.
24. **TMJ Treatment** - Procedures, restorations or appliances for the treatment of temporomandibular joint dysfunction syndrome.

- (See also **General Exclusions** section) -

GENERAL EXCLUSIONS

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

1. **Alcohol** - Charges for care, supplies, treatment, and/or services that arise from a Covered Person taking part in any activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Covered Persons other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).
2. **Claims Edit** - Charges identified as not following the Medicare Guidelines bundling and unbundling of CPT code combinations, gender-appropriate procedure codes; appropriateness of multiple office visits;
3. **Court-Ordered Care, Confinement or Treatment** - Any care, confinement or treatment of a Covered Person in a public or private institution as the result of a court order, unless the confinement would have been covered in the absence of the court order.
4. **Drugs in Testing Phases** - Medicines or drugs which are in the Food and Drug Administration Phases I, II, or III testing, drugs which are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

Except as specifically authorized by the United States Food and Drug Administration, any treatment using dimethyl sulfoxide (DMSO), laetrile or gerovital.

5. **Excess Charges** - Charges for care, supplies, treatment, and/or services that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document.
6. **Experimental / Investigational Treatment** - Expenses for treatments, procedures, devices, or drugs which the Plan Administrator 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 Administrator, 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*.

As an exception to the above, Nevada Statutes mandate the following criteria be met in cases of cancer and chronic fatigue syndrome:

a policy of health insurance must provide coverage for medical treatment in a clinical study if:

- treatment is a phase I, II, III, or IV for cancer;
- treatment is a phase II, III, or IV for chronic fatigue syndrome;
- study is approved by Agency of National Institute of Health, a cooperative group (see bill for exact definition), FDA for new investigational drug, US Dept. of Veterans Affairs, US Dept. of Defense;
- health care provider and facility have experience to provide the care;
- no other treatment considered a more appropriate alternative;
- reasonable expectation based on clinical data that treatment will be at least as effective as other treatments;
- study is conducted in Nevada;
- participant signs a statement of consent that he has been informed of: (1) the procedure to be undertaken, (2) alternative methods of treatment, and (3) associated risks of treatment;

coverage for medical treatment is limited to:

- a drug or device approved for sale by the FDA;
- reasonable necessary required services provided in treatment or as a result of complications to the extent that they would have otherwise been covered;
- initial consultation; and
- clinically appropriate monitoring;

treatment not required to be covered if provided free by sponsor;

coverage does not include:

- portions customarily paid by other government or industry entities;
- a drug or device paid for by manufacturer or distributor;
- excluded health care services;
- services customarily provided free in a study;
- extraneous expenses related to study;
- expenses for persons accompanying participant in study;
- any item or service provided for data collection not directly related to study;
- expenses for research management of study.

To determine how to obtain a pre-certification of any procedures that might be deemed to be experimental and/or investigational, see the **Utilization Management Program**.

7. Forms Completion - Charges made for the completion of claim forms or for providing supplemental information.

8. Government-Operated Facilities - Services furnished to the Covered Person in any veterans 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. See NOTE.

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.

9. Illegal Acts - Charges for care, supplies, treatment, and/or services for any Injury or Sickness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to

GENERAL EXCLUSIONS, continued

misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

10. Late Fee's, Interest, Finance Charges, etc...

11. Late-Filed Claims - Claims which are not filed with the Contract Administrator for handling within one (1) year from the date of service. See **Claims Procedures** section for additional information.

12. 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.

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

14. 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 which 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 which is available through the Medical Assistance Act (Medicaid).

15. Not Listed Services or Supplies - Any services, care or supplies which are not specifically listed in the Benefit Document as Eligible Expenses will not be covered unless the expense is substantiated and determined to be Medically Necessary and is approved for coverage by the Contract Administrator.

16. 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.

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

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

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

20. 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.

21. Relative or Resident Care - Any service rendered to a Covered Person by a relative (i.e., a spouse, or a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

- 22. 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 as later amended) or similar surcharges imposed by other states.
- 23. Subrogation, Reimbursement, and/or Third Party Responsibility** - Charges for care, supplies, treatment, and/or services that are of an Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.
- 24. Telecommunications** - Advice or consultation given by or through any form of telecommunication.
- 25. Travel** - Travel or accommodation charges for Covered Person or Covered Provider, (whether or not recommended by a Physician), except for ambulance charges or as otherwise expressly included in the list of **Eligible Medical Expenses**.
- 26. War or Active Duty** - Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications therefrom, or service (past or present) in the armed forces of any country, to the extent not prohibited by law.
- 27. Work-Related Conditions** - Any condition which is covered or subject to any workers' compensation law or federal employer compensation or liability acts, even if the Covered Person or the Employer is not in compliance therewith or has rejected or not applied for such coverage.

COORDINATION OF BENEFITS (COB)

Health care benefits provided under the Plan, including the prescription drug program benefits, are subject to Coordination of Benefits as described below, unless specifically stated otherwise.

The Prescription Drug Program under this Plan does not contain a Coordination of Benefits provision.

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 insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured). A "closed panel plan" is a plan that, except in an emergency, provides coverage only in the form of services obtained through a panel of providers that have contracted with or are employed by the plan;

medical care components of group long-term care contracts, such as skilled nursing care;

medical benefits under group or individual automobile contracts;

auto insurance which is subject to a state "no-fault" automobile insurance law. A Covered Person will be presumed to have at least the minimum coverage requirement of the state of jurisdiction, whether or not such coverage is actually in force;

Medicare or other governmental benefits, as permitted by law. Any benefits covered under both this Plan and Medicare will be covered according to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services guidelines, subject to federal court decisions (i.e. Medicare, ESRD, Medicaid, etc.)

An "Other Plan" does not include: (1) individual or family insurance, (2) closed panel or other individual coverage (except for group-type coverage), (3) school accident type coverage, (4) benefits for nonmedical components of group long-term care policies, (5) Medicare supplement policies, (6) Medicaid policies or coverage under other governmental plans, unless permitted by law.

NOTE: An "Other Plan" includes benefits that are actually paid or payable or benefits which 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 - The coverages of this Plan.

Allowable Expense - A health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans (i.e., This Plan or Other Plan(s)) covering the Claimant. When a plan provides benefits in the form of services (an HMO, for example), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

Any expense or service that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

If a Claimant is confined in a private hospital room, the difference in cost between a semi-private room in the hospital and a private room will not be an Allowable Expense unless the private room accommodation is medically necessary in terms of generally accepted medical practice or unless one

of the plans routinely provides coverage for private rooms.

If a person is covered by two (2) or more plans that compute benefits on the basis of usual and

customary allowances, any amount in excess of the highest usual and customary allowance is not an Allowable Expense.

If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the lowest of the negotiated fee is not an Allowable Expense.

If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary and another plan that provides its benefits or services on the basis of negotiated fees, the negotiated fees shall be the Allowable Expense for This Plan.

NOTE: Any expense not payable by a primary plan due to the individual's failure to comply with any utilization review requirements (e.g., precertification of admissions, second surgical opinion requirements, etc.) will not be considered an Allowable Expense.

Claim Determination Period - A period which 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 (i.e. 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 the 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

Under Order of Benefit Rules, whether This Plan is the “primary” plan or a “secondary” plan is determined in accordance with the following rules in the order specified below.

Medicare as an “Other Plan” when retired - When claimant is a retiree, Medicare Part A (hospital) and Part B (medical) will become the primary payer when claimant obtains Medicare eligibility, regardless of whether or not they enroll in Medicare. If claimant does not enroll in Medicare upon eligibility, this Plan will process eligible expenses at 20% of the allowable amount. This provision also applies to the retiree’s dependent upon reaching Medicare eligibility.

Non-Dependent vs. Dependent - The benefits of a plan which 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 which 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 are not married, are separated (whether or not they have ever been married) or are 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 which has covered the Claimant for the longer period of time will be determined before those of the plan which 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 rule 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 as discussed above under

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. The Plan will not have to pay that amount again.

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 the Claimant. The "amount of the payments made" includes the reasonable cash value of benefits provided in the form of services.

SUBROGATION AND REIMBURSEMENT PROVISIONS

Payment Condition - The Plan, in its sole discretion, may elect to conditionally advance payment of medical 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 or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Plan Beneficiary") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "Coverage").

Plan Beneficiary, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's 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 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 the Plan Beneficiary agrees the Plan shall have an equitable lien on any funds received by the Plan Beneficiary and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Beneficiary agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Plan Beneficiary settles, recovers, or is reimbursed by any third party or Coverage, the Plan Beneficiary agrees to reimburse the Plan for all benefits paid or that will be paid. If the Plan Beneficiary fails to reimburse the Plan out of any judgment or settlement received, the Plan Beneficiary 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, the Plan Beneficiary agrees to subrogate the Plan to 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 the Plan Beneficiary is entitled, regardless of how classified or characterized.

If a Plan Beneficiary receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Plan Beneficiary may have against any party causing the sickness or injury to the extent of such payment by the Plan plus reasonable costs of collection.

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

If the Plan Beneficiary 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 coverages;

the Plan Beneficiary authorizes the Plan to pursue, sue, compromise or settle any such claims in the Plan Beneficiary's and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Beneficiary assigns all rights to the Plan or its assignee to pursue a claim

SUBROGATION AND REIMBURSEMENT PROVISIONS, continued

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 the Plan Beneficiary is fully compensated by his/her 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 interferes with or compromises in any way the Plan's equitable subrogation lien. The obligation 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 the Plan Beneficiary'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 the Plan Beneficiary, whether under the doctrines of causation, comparative fault or contributory negligence, or any 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 the Plan Beneficiary.

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. 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 coverages.

Wrongful Death Claims - In the event that the Plan Beneficiary 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 the Plan Beneficiary's obligation:

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,

SUBROGATION AND REIMBURSEMENT PROVISIONS, continued

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 the Plan Beneficiary and/or his or her 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, the Plan Beneficiary will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Beneficiary.

Offset - Failure by the Plan Beneficiary and/or his or her 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 may be withheld until the Plan Beneficiary satisfies his or her obligation.

Minor Status - In the event the Plan Beneficiary 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 or her 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.

ELIGIBILITY AND EFFECTIVE DATES

Choice of Coverage & Annual Re-Election

The coverages of the Plan include optional schedules from which an Employee must choose at point of initial enrollment in the Plan. An Employee must enroll himself/herself and his/her Dependents (if any are to be enrolled) in the same option(s).

Once in each Plan Year, the Plan Sponsor will hold an annual re-election in conjunction with the Open Enrollment period. At that time, covered Employees and their covered Dependents may change between the coverage options. The newly-elected option will become effective on the date specified by the Plan Sponsor following the re-election period.

Any benefits paid while an individual was covered under one option will be carried forward and applied against the benefits maximums of the newly-elected option.

QHDHP Eligibility Requirements - Employees - An individual eligible to participate in the QHDHP Plan as an "Employee" includes:

- an individual in active employment for the Employer, performing all customary duties of his/her occupation at his/her usual place of employment (or at a location to which the business of the Employer requires him/her to travel) and regularly scheduled to work at least twenty seven and one-half (27 1/2) hours per week;
- an employee designated as eligible by the Washoe County School District ("District") pursuant to an existing collective bargaining agreement;
- a District retiree who receives monthly payments under the State of Nevada Public Employees' Retirement System (PERS) and who elected to continue coverage at retirement pursuant to NRS 287.023 or NRS 287.0205;
- a surviving spouse of a deceased retiree who elects to continue coverage on a contributory basis (see "Survivor Privilege" in the **Extension of Coverage Provisions**) and pursuant to NRS 287.023 or NRS 287.0205;
- a current elected member of the District's Board of Trustees; and
- a retired Trustee pursuant to NRS 287.024.

An Employee will be deemed in "active employment" on each day he/she 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/she 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/she is absent from work during an approved FMLA leave or solely due to his/her 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/her first scheduled workday, he/she will not be considered as having commenced active employment.

Those Employees for whom the Employer cannot in good faith determine whether the Employee's hours are expected to average at least twenty-seven and one-half (27½) hours per week upon hire shall be considered Variable Hour Employees. Variable Hour Employees who average at least twenty-seven and one-half (27½) hours per week during the Initial Measurement Period (IMP) or Standard Measurement Period (SMP) are eligible for benefits during the subsequent Stability Period (SP), subject to an Administrative Period (AP), if any (see Definitions section).

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 eligibility.

Eligibility for an HSA. You must be enrolled in the Qualified High Deductible Health Plan in order to participate in a HSA.

Effective Date - Employees

With the exception of elected members of the District's Board of Trustees, an eligible Employee's coverage is effective, subject to timely enrollment, on the ninety-first (91st) day of eligibility (i.e., after a 90 day waiting period). The effective date of coverage for elected members of the District's Board of Trustees is the day they take office.

Eligibility Requirements – Dependents - An eligible Dependent of an Employee is:

- a legally married spouse. "Legally married" means a legal union as defined by the state in which the legal union took place. In no instance will an eligible spouse include a common law spouse.
- a Domestic Partner. The domestic partnership must be established in Nevada by filing a Declaration of Domestic Partnership with the Secretary of State. All of the following requirements must be met:
 - both persons must be at least 18 years of age;
 - have not terminated that domestic partnership;
 - both persons are competent to consent to the domestic partnership;
 - both persons are not related by blood in a way that would prevent them from being married to each other in this State;
 - neither person is married or a member of another domestic partnership;
 - both persons share a common residence; and
 - both persons sign a declaration that they have chosen to share one another's lives in an intimate and committed relationship of mutual caring.
- a child who is under age 26 (i. e., through the end of the month in which the child turns 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.

A "child" will include:

- a natural child;
- a stepchild;
- a child placed under the court-appointed legal guardianship of the Employee;
- 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;
- any residency or main support and care requirements a child for whom the Employee or covered Dependent spouse is required to provide coverage 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 (which are incorporated herein by reference and which 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 state law;

NOTE: An eligible Dependent does not include:

a grandchild

a spouse following legal separation or a final decree of dissolution or divorce;

a spouse who is eligible for Medicare coverage by reason of age and who has elected Medicare coverage in lieu of Plan coverage;

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 as a Dependent of another Employee under the Plan.

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.

Proof of Dependent Status

Specific documentation to substantiate Dependent status may be requested at any time and may include any of the following:

- marriage - a copy of the certified marriage certificate or passport;
- domestic partnership - a copy of the Declaration of Domestic Partnership with the Nevada Secretary of State;
- birth - a copy of the certified birth certificate or passport;
- adoption or placement for adoption - a copy of the court order signed by the judge. Final adoption decree and/or birth record must be submitted to the District within thirty-one (31) days of issuance;
- dependent age 19 through 25 - a birth certificate (if not already on file);
- legal guardianship - a copy of the legal guardianship court order, signed by the judge, and a copy of the certified birth certificate.

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 and coverage will be effective on the first day of the month following enrollment (see the "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.

Notification of Family & Status Changes

It is an enrolled Employee's responsibility to notify the Benefits Department/Management Office at 425 E. Ninth Street, Reno, NV 89512 (phone (775) 348-0321) promptly, but no later than 30 days from the effective date of whenever he/she has a change in status as described below:

ELIGIBILITY AND EFFECTIVE DATES, continued

he has a Dependent or Dependents who are no longer eligible for coverage under the Plan;

he wishes to add or discontinue Plan coverage for a spouse only or for a spouse and/or a child or children;

any covered Dependent becomes eligible for Medicare's Part A, B, C and D Prescription plan.

NOTE: Failure to report to the Benefits Department any errors or changes in premium contributions could result in loss of contributions. A maximum of two (2) months of contributions will be reimbursed for overpayment due to non-notification.

Dual Coverage Not Permitted

Active Employee: If the individual qualifies as both an Employee and a Dependent, the individual may choose either employee coverage or dependent coverage as eligible spouse or child. No individual may be covered under a Washoe County School District sponsored Plan both as an Employee and as a Dependent.

Dependents: A Dependent may not be covered as the Dependent of more than one Employee or retiree.

Retirees: An Employee who retires and is eligible to participate in the Washoe County School District's Plan as a retiree, may choose either retiree coverage or they may choose dependent coverage if they have a spouse with current District health insurance.

Note: See **Eligibility Requirements-Employee and Eligibility Requirements – Dependents.**

Newborn Children - Limited Automatic 31-Day Initial Coverage Period

An Employee's ill or injured newborn child or the ill or injured newborn child of an Employee's legal spouse will be eligible for benefits for Eligible Expenses which 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. If the dependent is covered by more than one health plan, this Plan reserves the right to coordinate benefits in accordance with the **Coordination of Benefits** section. After the 31-day initial period, coverage for the child will be available only if, within the thirty-one (31) days after the child's birth, the Employee has enrolled the child in the Plan and has made any required contributions for coverage.

NOTE: During the limited 31-day benefit period, an ill or injured newborn child is not a Covered Person. Any extended coverage periods or coverage continuation options which are available to Covered Persons WILL NOT APPLY to a newborn child who is provided with these thirty-one (31) days of limited benefits and who is not enrolled within such 31-day period.

Open Enrollment

If an individual does not enroll when he/she is first eligible to do so or if he/she allows coverage to lapse, he/she may later enroll during an Open Enrollment period which will be held annually. Plan coverage will be effective on the January 1st following the end of the Open Enrollment period. See "**Special Enrollment Rights**" for other opportunities to enroll in the Plan when a qualifying event occurs.

The Open Enrollment period is also a time when Employees are given the opportunity to change their enrollment from one District-sponsored plan to another.

Special Enrollment Rights

A special enrollment period is a time when you may make changes to your health coverage even though it is not an open enrollment period. Normally, you are not allowed to enroll in the Plan or make any health plan changes except during the annual open enrollment period. However, certain qualifying events will trigger a special enrollment right allowing you to make changes for a brief period of time after the triggering

ELIGIBILITY AND EFFECTIVE DATES, continued

event. If you do not make the necessary changes during the special enrollment period, you will have to wait until the next open enrollment period to make any changes.

Qualifying events that trigger a special enrollment right are things that change the size of your family or cause you to lose health coverage. Examples include: divorce, marriage, birth of a child, adoption of a child, death of a spouse leaves you uninsured, loss of your spouse's job-based health insurance, loss of your own job-based health insurance, reduction in work hours makes you ineligible for health insurance, a Qualified Medical Child Support Order or your move outside of your HMO's coverage area. See below for information on specific qualifying events and the notification requirements.

- **Loss of Other Coverage** – the Employee requested Plan enrollment **within thirty-one (31) days** of a qualifying event below:
 - 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 and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
 - loss of eligibility when coverage is offered through an HMO/EPO 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/EPO 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; and

If the above conditions are met, Plan coverage will be effective on the first of the following month after enrollment documentation is received.

NOTE: For a Dependent to enroll under the terms of this provision, the Employee must be enrolled or must enroll concurrently.

NOTE: 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 Acquiring New Dependents(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 must 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. See **NOTE** below:
 - 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 Plan received the completed application;
 - Where birth, adoption or placement for adoption 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 thirty-one (31) days** of birth.

ELIGIBILITY AND EFFECTIVE DATES, continued

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 Administrator's written procedures and provided that a request for coverage is made on a form acceptable to the Plan Administrator within 31 days from the date such order is determined to be qualified. 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.

Children's Insurance Program Reauthorization Act (CHIPRA)

- Loss of Medicaid or CHIP Eligibility: If the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, the Employee may request coverage under the Employer's group health plan coverage within sixty (60) days after Medicaid or CHIP coverage terminates.
- Eligibility for State Premium Assistance: Where a State has chosen to offer premium assistance subsidies for qualified employer-sponsored benefits (see NOTE) and if the Employee or Dependent becomes eligible for such subsidy under Medicaid or CHIP, then the Employee may request coverage under the Employer's group health plan within sixty (60) days after eligibility for the subsidy is determined.

Also, if an Employee's child(ren) becomes eligible for CHIP, Employee has the ability to drop the child(ren) from the group health coverage.

NOTE: CHIPRA allows states to elect to offer premium assistance subsidies to qualified individuals. Such subsidies are not mandated.

A "group health plan" does not include benefits provided under a health FSA or a high deductible health plan.

Open Enrollment - If an individual does not enroll when he/she is first eligible to do so or if he/she allows coverage to lapse, he/she may later enroll during an Open Enrollment period which will be held annually. Plan coverage will be effective on the January 1st following the end of the Open Enrollment period, but any such individual will be considered a "late enrollee."

The Open Enrollment period is also a time when Employees are given the opportunity to change their enrollment from one District-sponsored plan to another.

Reinstatement

If a Monthly Paid Employee returns to an eligible status following an approved leave of absence and elects to re-enroll himself/herself and his/her previously covered Dependents, then Plan coverage will be effective on the first (1st) or sixteenth (16th) day of the month as determined by the date he/she receives his/her first paycheck after return to work. Except for Dependents acquired within thirty-one (31) days of the Employee's coverage effective date, Dependents not covered by the Plan before the lapse in coverage can only be enrolled during an Open Enrollment period or in accordance with the Special Enrollment Rights.

ELIGIBILITY AND EFFECTIVE DATES, continued

If a Biweekly Paid Employee returns to an eligible status following an approved leave of absence and elects to re-enroll himself/herself and his/her previously covered Dependents, then Plan coverage will be effective the day after the previous pay date or the date of return to work, if after the beginning of the pay period. Except for Dependents acquired within thirty-one (31) days of the Employee's coverage effective date, Dependents not covered by the Plan before the lapse in coverage can only be enrolled during an Open Enrollment period or in accordance with the Special Enrollment Rights.

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/her 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/herself and any Dependents who were covered at the point contributions ceased). The Plan Administrator 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 Administrator.

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 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.

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/her eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Except as noted, such new coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

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 the "Extension of Coverage During U.S. Military Service" in the **Extensions of Coverage** section for more information;

at midnight of the last day of the period for which payment of the contribution has been made or employee ceases to be eligible, or ceases to be engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the terms of any **Extension of Coverage** provision;

the date the Employee dies.

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;

at midnight on the last day of the month in which the Dependent ceases to meet 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 which will take effect immediately upon termination and provided that the change is consistent with Cafeteria Plan rules.

(See **COBRA Continuation Coverage**)

EXTENSION OF COVERAGE PROVISIONS

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 Disabled Dependent Children

If an already covered Dependent child is incapable of self-sustaining employment by reason of mental retardation, cerebral palsy, epilepsy, other neurological disorder or physical disability, and:

such condition commenced on or before the child attained the age that would otherwise terminate his eligibility;

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 Plan Administrator within thirty-one (31) days of the child's attainment of the limiting age, and thereafter as may reasonably 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 active employment but is not terminated from employment (e.g., he is absent due to an approved leave, a temporary layoff, etc.), he may be permitted to continue health coverages for himself and his dependents though he could be required to pay full cost of coverage during such absence. Any such extended coverage allowances will be provided on a non-discriminatory basis.

Except where the Family and Medical Leave Act (FMLA) may apply, any coverage which 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 employee communications, if any. Such documents are incorporated into the Plan by reference;

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 engages 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:

EXTENSION OF COVERAGE PROVISIONS, continued

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 or her 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 specific 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 department. Any Plan provisions that 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 incurred in line of duty on active duty in the Armed Forces that may render the service member medically unfit to perform his or her 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

EXTENSION OF COVERAGE PROVISIONS, continued

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 is the lesser of:

18 months (or 24 months for elections made on or after December 10, 2004); 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 under the Plan is reinstated, all provisions and limitations of the Plan 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 or Pre-existing condition exclusion 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.

Survivor Privilege

If a covered Retiree dies, his/her covered spouse may elect to continue coverage pursuant to NRS 287.023 or NRS 287.0205. The survivor will be responsible for the cost of coverage.

WAIVER OF CONTRIBUTIONS

If an active Employee meets all of the following criteria and complies with the procedures described below, he/she shall be eligible for a Waiver of Contribution for his/her District paid Plan contribution for an initial period of up to six (6) months:

has been hurt on or off the job or sustained serious injury or non-induced illness;

has used all of his/her sick leave and vacation leave;

is no longer receiving any income from employment other than Workers' Compensation benefits;

is on an approved Leave of Absence; and

has a reasonable prognosis of returning to full employment with the Washoe County School District within six (6) months from the time the individual went on an approved leave of absence, whether paid or unpaid.

The Waiver of Contribution is not automatic. Failure to follow the procedures described below shall prevent a Waiver of Contribution from being granted.

The active Employee or his/her representative must make a request to the Benefits Department Office at 425 East Ninth Street, Reno, NV 89512 in writing, accompanied by the Employee's Physician's report giving verification of the prognosis of return to work. Such request must be submitted within thirty (30) days after the Employee is no longer in an actively paid status.

At the sole discretion of the Benefits Department, the Waiver of Contribution may be extended for a maximum of an additional six (6) months.

Both the initial and extended Waiver of Contribution will be coordinated with the approved leave of absence, but not be in addition to the provisions of the Family Medical Leave Act.

To obtain an additional Waiver of Contribution, or for an additional six (6) months or 12 months total, the active Employee or his/her representative must make a request to the Benefits Department Office at 425 East Ninth Street, Reno, NV 89512 in writing within thirty (30) days **prior** to the expiration of the initial six (6) month waiver, accompanied by the Employee's Physician's report giving verification of the updated prognosis of return to work. This request will be reviewed, based on the criteria stated above. An Employee may obtain a Waiver of Contribution for a maximum of twelve (12) months within a three (3) year period.

- (See **COBRA Continuation Coverage**) -

CLAIMS PROCEDURES

ADMINISTRATIVE PROCESSES AND SAFEGUARDS

The Plan requires that claims determinations be made in accordance with governing documents of the Plan and that they be applied consistently with respect to similarly situated Claimants. The claims procedures will not be administered in a way that unduly inhibits or hampers the initiation or processing of claims or claims appeals.

AUTHORIZED REPRESENTATIVE MAY ACT FOR CLAIMANT

Any of the following actions which can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf. The 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 the 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.

BENEFIT DETERMINATIONS

Upon the Contract Administrator's receipt of a written claim for benefits and pursuant to the procedures described herein, the Contract Administrator will review the claim submission, proof of claim, and all associated and/or applicable information provided by the Claimant and gathered independently by the Contract Administrator in light of the Benefit Document through which benefits of the Plan are paid. Further, the Contract Administrator will assure that all benefit determinations are applied consistently to similarly-situated Plan participants by maintaining appropriate claim and benefit records which shall be reviewed periodically and on a case-by-case basis to determine past practices in similar claim situations. Should the Contract Administrator at any time during its review period determine that additional information is required from the Employee or Claimant, the Contract Administrator will request such necessary information from the Employee. The Contract Administrator will make every effort to make its benefit determination in as reasonable a time frame as possible.

TIMELY FILING OF CLAIMS

Except for Pre-Service Claims (see "Submitting a Claim" below), proof of loss for claim must be submitted to the claims office within twelve (12) months after the date a service is rendered. The 12-month time limit applies to an original claim submission and to any adjustments or re-processing requests on a previously-submitted claim. It is the Claimant's responsibility for timely submission of all claims.

Failure to furnish proof within the time required will not invalidate nor reduce any claim if it can be shown that it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible. A claim should be submitted to:

Anthem Blue Cross Blue Shield
P.O. Box 5747
Denver, CO 80217-5747

SUBMITTING A CLAIM

A claim is a request for a benefit determination which 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,

CLAIMS PROCEDURES, continued

the address (location) where services are received, and provider name, address, phone number and tax identification number.

For purposes of the Plan, the Plan Administrator, at its discretion, may contract with other entities to handle claims communications and benefit determinations for the Plan. Contact information for such entities is provided below.

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

- 1) **A Pre-Service Claim** is a written or oral request for health care services where the terms of the Plan condition of benefits, in whole or in part, are on prior approval of the proposed care (e.g., a utilization review requirement). 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. **See the Utilization Management Program section for information on the requirements.**
- 2) **A Post-Service Claim** is a written request for benefit determination after a service has been rendered and expense has been incurred. Proof of loss for a Post-Service Claim must be submitted to the Contract Administrator's office within twelve (12) months after the date a service is rendered. The 12-month time limit applies to an original claim submission and to any adjustments or re-processing requests on a previously-submitted claim. It is the Claimant's responsibility for timely submission of all claims. Proof of loss for a claim has not been "furnished" unless and until the Contract Administrator has received all information they reasonably deem necessary to allow processing of the claim. This includes responding to reasonable requests for completion of forms, providing additional information about the claim, or providing of documents in support of the claim. If satisfactory proof of loss is not furnished within the 12-month period after expenses are incurred, benefits will not be available. Failure to furnish proof within the time required will not invalidate nor reduce any claim if it can be shown that it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

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.

Pre-Service and Post- Service Contact Information

Anthem Blue Cross Blue Shield
P.O. Box 5747
Denver, CO 80217-5747

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 the 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.

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 which 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 the Covered Person, as created by an assignment of rights made by the 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.

CLAIMS DENIALS

The Plan shall provide adequate notice of an Adverse Benefit Determination in writing to any Claimant whose claims for benefits under this Plan have been denied in whole or in part. The notice shall be written in a manner calculated to be understood by the Claimant and shall include information sufficient to identify the claim involved, including:

the specific reason for the Adverse Benefit Determination;

the date of service;

the name of the health care provider;

the claim amount (if applicable);

notification that the Claimant may request, and the Plan will provide upon request, the diagnosis code and treatment code along with the corresponding meaning of such codes;

the specific Plan provisions on which the Adverse Benefit Determination is based;

a statement that any internal rules, protocols or similar criterion or guidelines relied upon in making the determination is available free of charge, upon the Claimant's request;

if the Adverse Benefit Determination is based on the or experimental treatment, an explanation of the scientific or clinical judgment for determination or statement that such explanation will be provided free of charge upon request;

a list of any additional material or information necessary to obtain approval of the claim and an explanation of why such information is necessary;

for urgent care claims, the notice will include a description of the expedited review process for those claims;

CLAIMS PROCEDURES, continued

A reminder of the Claimant's right to access and receive copies of relevant documents free of charge upon request;

A description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and

information regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman available to assist with internal claims and appeals and external review processes.

Further, the Plan shall afford a reasonable opportunity to any Claimant whose claim for benefits has been denied for a full and fair review of the decision denying the claim by the person designated by the Employer for that purpose.

Timing of Notification of Benefit Determination

Urgent Care Claims: If the claim involves an urgent care claim, the Claimant will be notified of the benefit determination (whether adverse or not) as soon as possible taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, unless insufficient information to determine whether, or to what extent, benefits are covered or payable under this Plan.

If the Plan receives insufficient information to decide the claim, the Claimant will be notified as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. The Claimant will have a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan will notify the Claimant of the benefit determination as soon as possible, but in no case later than 48 hours after the earlier of:

the Plan's receipt of the specified information, or

The end of the period afforded the Claimant to provide the specified information.

Pre-Service Claims: The Plan shall notify the Claimant of the benefit determination (whether adverse or not) within a reasonable period appropriate to the medical circumstances, but not later than 15 days after receipt of the request. The Plan may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the Plan's control and the Claimant shall be notified prior to the expiration of the initial 15-day period, of the circumstances requiring the extension and the date by which the Plan expects to make a decision. If the extension is necessary due to the Claimant's failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and the Claimant shall have at least 45 days from receipt of the notice to provide the information. Only where prior authorization is required will such a request prior to receiving benefits be an official claim.

Post-Service Claims: The Plan shall notify you of any denial of a Post-Service Claim within a reasonable period, but no later than 30 days after receipt of the Claim. The Plan may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the Plan's control and the Plan shall notify the Claimant prior to the expiration of the initial 30-day period, of the circumstances requiring the extension and the date by which the Plan expect to render a decision. If the extension is necessary due to the Claimant's failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and the Claimant shall be afforded at least 45 days from receipt of the notice to provide the information.

Concurrent Care Claim. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments and reduces or terminates coverage of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of

CLAIMS PROCEDURES, continued

treatments, the Plan will notify the Claimant at a time sufficiently in advance of the reduction or termination to allow the Claimant to Appeal and obtain a determination before the benefit is reduced or terminated. Subject to the following paragraph, such request may be treated as a new Claim and decided within the timeframes applicable to either a Pre-Service Claim or a Post-Service Claim, as appropriate; provided, however, any Appeal of such a determination must be made within a reasonable time and may not be afforded the full 180 day period for Appeal.

Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments for an Urgent Claim will be decided as soon as possible taking into account the medical exigencies, and the Plan shall notify the Claimant of the determination, whether adverse or not, within 24 hours after receipt of the Claim by the Plan, provided that any such Claim is made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If such a request is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as an urgent care claim, and the Plan will notify the Claimant within seventy-two (72) hours after receipt of the Claim by the Plan.

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.

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:

Anthem Blue Cross and Blue Shield
Grievances and Appeals
700 Broadway
Denver, CO 80273

The Contract Administrator will render a decision on an appeal of Post-Service Claim within sixty (60) days of receipt of the appeal letter and will notify, in writing, the Plan Sponsor and Claimant of the findings.

EXTERNAL REVIEW OF THE CLAIM

If, upon a final internal Adverse Benefit Determination, 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:

MAXIMUS Federal Services
Federal External Review Process
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

By Phone: 1-888-866-6205 **By Fax:** 1-888-866-6190 (**Address to Federal External Review Process**)

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 contacting the Contract Administrator. If the Contract Administrator determines that Claimant is not entitled to an expedited internal review, the Contract Administrator will notify the Claimant as expeditiously as possible.

An independent review organization 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.

REVIEW OF THE PRE-CERTIFICATION DENIAL BY THE UTILIZATION REVIEW FIRM

CLAIMS PROCEDURES, continued

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 Adverse Benefit Determination 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 180 days (180) days of the original determination to:

**Anthem Blue Cross Blue Shield
P.O. Box 5747
Denver, CO 80217-5747**

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 5 days 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 45 days, 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, 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.

EXTERNAL REVIEW OF THE PRE-CERTIFICATION DENIAL

If, upon a final internal Adverse Benefit Determination, 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

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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:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
By Phone: 1-888-866-6205 **By Fax:** 1-888-866-6190

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 contacting the Contract Administrator. If the Contract Administrator determines that Claimant is not entitled to an expedited internal review, the Contract Administrator will notify the Claimant as expeditiously as possible.

An independent review organization 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.

DEFINITIONS

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

1. **Accidental Injury** - An injury that results independently of an illness and all other causes and is the result of an externally violent force or accident.
2. **ADA** - The American Dental Association.
3. **Administrative Period (AP)** – The period of time between the IMP or SMP and the SP to determine which ongoing employees are eligible for coverage.
4. **Adverse Benefit Determination** - Any of the following:
 - A denial in benefits;
 - A reduction in benefits;
 - A recession of coverage;
 - A termination of benefits; or
 - A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.
5. **Alternative Medicine** – Medical practices that are not considered a part of conventional medicine.
6. **AHA** - The American Hospital Association.
7. **Allowable Expenses** - The Usual and Customary charge for any Medically Necessary, Reasonable, and eligible items 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 Section herein, 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 the 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.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO Provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO Provider, this Plan will not consider as Allowable Expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO Provider.
8. **AMA** - The American Medical Association.
9. **Ambulatory Surgical Center** - Any public or private establishment which:
 - 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.

- 10. Approved Clinical Trial** - A phase I, II, III or IV trial that is federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, CMS, Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an investigational new drug application reviewed by the FDA (if such application is required).

The Patient Protection and Affordable Care Act requires that if a “qualified individual” is in an “Approved Clinical Trial,” the Plan cannot deny coverage for related services (“routine patient costs”).

A “qualified individual” is someone who is eligible to participate in an “Approved Clinical Trial” and either the individual’s doctor has concluded that participation is appropriate or the participant provides medical and scientific information establishing that their participation is appropriate.

“Routine patient costs” include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan’s network area unless out-of-network benefits are otherwise provided under the Plan.

- 11. Assignment of Benefits** - An arrangement whereby the Covered Person, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Plan benefits, less deductibles, co-payments and the coinsurance percentage that is not paid by the Plan, 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 Covered Person, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an “Assignment of Benefits” and deductibles, co-payments and the coinsurance percentage that is the responsibility of the Covered Person, as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke or disregard an Assignment of Benefits at its discretion and continue to treat the Covered Person as the sole beneficiary.

- 12. Benefit Document** - A document that describes one (1) or more benefits of the Plan.

- 13. Birthing Center** - A special room in a Hospital that exists to provide delivery and pre-natal and post-natal care with minimum medical intervention or a free-standing Outpatient facility which:

is in compliance with licensing and other legal requirements in the jurisdiction where it is located;

is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients;

has organized facilities for birth services on its premises;

provides birth services which are performed by or under the direction of a Physician specializing in obstetrics and gynecology;

has 24-hour-a-day registered nursing services;

maintains daily clinical records.

14. **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.
15. **Cardiac Rehabilitation** - A monitored exercise program directed at restoring both physiological and psychological well-being to individuals with heart disease.
16. **Child** - In addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, or any other Child for whom the Employee has obtained legal guardianship.
17. **CHIP** - 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.
18. **CHIPRA** - 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.
19. **Claimant** - Any Covered Person on whose behalf a claim is submitted for benefits under the Plan.
20. **A 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, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customary, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Covered Person has failed to submit required forms or additional information to the Plan as well.

21. **Contract Administrator** - A company that performs all functions reasonably related to the administration of one or more benefits of the Plan (e.g., processing of claims for payment) in accordance with the terms and conditions of the Benefit Document and 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.

See **General Plan Information section**

22. Convalescent Hospital - see “Skilled Nursing Facility”

23. Covered Person - A covered Employee, a covered Dependent, and a Qualified Beneficiary (COBRA). See **Eligibility and Effective Dates** 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.

24. 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 or her license; or

in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association;

and including, but not limited to a/an:

Acupuncturist (CA) or doctor of Chinese medicine
Audiologist
Certified or Registered Nurse Midwife
Certified Registered Nurse Anesthetist (CRNA)
Chiropractor (DC)
Dentist (DDS or DMD)
Hospitalist
Licensed Clinical Psychologist (PhD or EdD)
Licensed Clinical Social Worker (LCSW)
Licensed Practical Nurse (LPN)
Licensed Registered Dietician (RD)
Licensed Vocational Nurse (LVN)
Marriage Family and Child Counselor (MFCC)
Nurse Practitioner
Occupational Therapist (OTR)
Optometrist (OD)
Physical Therapist (PT or RPT)
Physician - see definition of “Physician”
Podiatrist or Chiropodist (DPM, DSC or PodD)
Psychiatrist (MD)
Registered Dietitian (RD)
Registered Nurse (RN)
Respiratory Therapist
Speech Pathologist
Substance Abuse Counselor

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

facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, Birthing Centers, etc.;

licensed Outpatient mental health facilities;

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facilities for treatment of abuse of alcohol or drugs which are certified by the Bureau of Alcohol and Drug Abuse in the Rehabilitation Division of the Department of Human Resources of Nevada;

health care facilities which are licensed by the Health Division of the Department of Human Resources of Nevada, accredited by the Joint Commission of Accreditation of Hospitals and which provide programs for the treatment of alcoholism or drug abuse as part of their accredited activities;

freestanding public health facilities;
hemodialysis and Outpatient clinics under the direction of a Physician (MD);
enuresis control centers;
prosthetists and prosthetist-orthotists;
portable X-ray companies;
independent laboratories and lab technicians;
diagnostic imaging facilities;
blood banks;
speech and hearing centers;
ambulance companies.

NOTE: A Covered Provider does not include: (1) a Covered Person treating himself/herself or any relative or person who resides in the Covered Person's household - see "Relative or Resident Care" in the list of **General Exclusions**, 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 services.

- 25. Day Care Center** - An Outpatient psychiatric facility which is part of or affiliated with a Hospital. It must be licensed according to state and local laws to provide Outpatient care and treatment of mental and nervous disorders or substance abuse under the supervision of psychiatrists.
- 26. Dependent** - see Eligibility and Effective Dates section
- 27. Eligible Expense(s)** - Expense that is: (1) covered by a specific benefit provision of the Benefit Document and (2) incurred while the person is covered by the Plan.
- 28. Emergency Medical Condition** - A sudden onset of a medical condition with symptoms severe enough to cause a prudent layperson to believe that lack of immediate medical attention could result in serious jeopardy to his/her health, jeopardy to the health of an unborn child and impairment of a bodily organ or part.
- 29. Employee** - see Eligibility and Effective Dates section
- 30. Employer(s)** - The Employer or Employers participating in the Plan as stated in the **General Plan Information** section.
- 31. 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 health treatment; prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic Disease management; and pediatric services, including oral and vision care.
- 32. Exclusive Provider Organization** – see "Health Maintenance Organization (HMO)".
- 33. Experimental and/or Investigational (Experimental)** - Services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term

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outcomes from those services or treatments, and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or

Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A Drug, device, or medical treatment or procedure is Experimental:

If the Drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the Drug or device is furnished;

If reliable evidence shows that the Drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:

maximum tolerated dose;
toxicity;
safety;
efficacy; and
efficacy as compared with the standard means of treatment or Diagnosis; or

If reliable evidence shows that the consensus among experts regarding the Drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:

maximum tolerated dose;
toxicity;
safety;
efficacy; and
efficacy as compared with the standard means of treatment or Diagnosis.

Reliable evidence shall mean:

only published reports and articles in the authoritative medical and scientific literature;

the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same Drug, device, or medical treatment or procedure; or

the written informed consent used by the treating facility or by another facility studying substantially the same Drug, device, or medical treatment or procedure.

Notwithstanding the above, a prescription Drug for a treatment that has been approved by the FDA but is used as a non-approved treatment shall not be considered Experimental/Investigational for purposes of this Plan and shall be afforded coverage to the same extent as any other prescription Drug; provided that the Drug is recognized by one of the following as being Medically Necessary for the specific treatment for which it has been prescribed:

The American Medical Association Drug Evaluations;

The American Hospital Formulary Service Drug Information;
The United States Pharmacopeia Drug Information; or
A clinical study or review article in a reviewed professional journal.

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

- 34. Fiduciary** - A Fiduciary of the Plan is any entity having binding power to make decisions regarding Plan policies, interpretations, practices or procedures.
- 35. FMLA** - The Family and Medical Leave Act of 1993, as amended.
- 36. GINA** - The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and Employers from discriminating on the basis of genetic information.
- 37. Health Maintenance Organization (HMO) or Exclusive Provider Organization (EPO)** - A health care system that assumes both the financial risks associated with providing comprehensive medical services (insurance and service risk) and the responsibility for health care delivery in a particular geographic area to HMO members, usually in return for a fixed, prepaid fee. Financial risk may be shared with the providers participating in the HMO.

Group Model HMO - An HMO that contracts with a single multi-specialty medical group to provide care to the HMO's membership. The group practice may work exclusively with the HMO, or it may provide services to non-HMO patients as well. The HMO pays the medical group a negotiated, per capita rate, which the group distributes among its physicians, usually on a salaried basis.

Staff Model HMO - A type of closed-panel HMO (where patients can receive services only through a limited number of providers) in which physicians are employees of the HMO. The physicians see patients in the HMO's own facilities.

Network Model HMO - An HMO model that contracts with multiple physician groups to provide services to HMO members; may involve large single and multispecialty groups. The physician groups may provide services to both HMO and non-HMO plan participants.

Individual Practice Association (IPA) HMO - A type of health care provider organization composed of a group of independent practicing physicians who maintain their own offices and band together for the purpose of contracting their services to HMOs. An IPA may contract with and provide services to both HMO and non-HMO plan participants.

- 38. HIPAA** - The Health Insurance Portability and Accountability Act of 1996, as amended.

- 39. Home Health Care Agency** - An agency or organization which:

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 which 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;

has a full-time administrator.

In rural areas where there are no agencies which 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.

- 40. 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 which 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.
- 41. Hospital** - A lawfully operated institution engaged primarily in providing care and treatment for sick or injured persons by or under the supervision of a Physician, with 24-hour nursing service by a registered nurse (RN). In addition, it must have organized facilities for diagnosis and major Surgery.

A "Hospital" will also include:

a licensed facility for the care and treatment of mental illness, alcoholism or drug addiction, even if it does not have surgical facilities, as long as it otherwise qualifies as a Hospital;

any facility for treatment of abuse of alcohol or drugs which is certified by the Bureau of Alcohol and Drug Abuse in the Rehabilitation Division of the Department of Human Resources of Nevada;

any health care facility which is licensed by the Health Division of the Department of Human Resources of Nevada, accredited by the Joint Commission of Accreditation of Hospitals and provides a program for the treatment of alcoholism or drug abuse as part of its accredited activities.

NOTE: A "Hospital" does not include a rest home, nursing home, convalescent home, old age home, rehabilitative facility, or Skilled Nursing Facility.

- 42.** 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 to 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.
- 43. Initial Measurement Period (IMP)** – Period of time, to be determined solely at the discretion of Employer, between three and twelve months from employee date of hire to measure completed hours of service for newly hired variable hour and seasonal employees. This period is used to determine whether an employee completed an average of twenty-seven and one-half (27 ½) hours of service per week.
- 44. Inpatient** - A person physically occupying a room and being charged for room and board in a facility (Hospital, Skilled Nursing Facility, etc.) which 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.
- 45. 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, which provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis and which is separated from the rest of the Hospital's facilities.

46. 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.

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

the Usual and Customary amount;

the allowable charge specified under the terms of the Plan;

the Reasonable charge specified under the terms of the Plan;

the negotiated rate established in a contractual arrangement with a Provider; or

the actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount.

The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

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

48. Medical Emergency - See Emergency Medical Condition.

49. Medically Necessary - Any health care treatment, service or supply determined by the Contract Administrator to meet each of the following requirements:

it is ordered by a Physician for the diagnosis or treatment of a Sickness or Accidental Injury;

the prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition;

it is furnished by a provider with appropriate training and experience, acting within the scope of his or her license, and

it is provided at the most appropriate level of care needed to treat the particular condition.

With respect to Inpatient services and supplies, "Medically Necessary" further means that the health condition requires a degree and frequency of services and treatment which can be provided ONLY on an Inpatient basis.

The Plan will determine whether the above requirements have been met based on: (1) published reports in authoritative medical and scientific literature, (2) regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration (FDA), and the Centers for Medicare and Medicaid Services (CMS), (3) listing in the following compendia: The American Hospital Formulary Service Drug Information and The United States Pharmacopoeia Dispensing Information; and (4) other authoritative medical resources to the extent the Plan determines them to be necessary.

50. 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, then the Plan Administrator may determine the **Maximum Allowable Charge** according to the Medical Record Review and audit results.

51. Medicare - Health Insurance for the Aged and Disabled as established by Title I of Public Law 89-98 including parts A, B & D and Title XVIII of the Social Security Act, and as amended from time to time.

52. Mental Health Parity Act (MHPA) of 1996 and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA - In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and

the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

53. Mental or Nervous Disorder - Any Disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

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

55. Partial Hospitalization - A planned partial confinement treatment program of psychiatric services for the treatment of mental health conditions which is given in a Hospital or in a treatment facility on less than a full-time Inpatient basis and which meets the following requirements:

it involves a generally accepted form of evaluation and treatment of a condition diagnosed as a mental illness which does not require full-time confinement in a Hospital or treatment facility;

it is supervised by a psychiatric Physician who both reviews the program and evaluates its effectiveness at least once a week;

for partial day care, the facility's treatment program must be available for at least six (6) hours during the day and at least five (5) days a week;

for night care, the facility's treatment program must be available for at least eight (8) hours a night and at least five (5) nights a week.

56. Participating Employer - An Employer who is participating in the coverages of the Plan. See **General Plan Information** section for the identity of the Participating Employer(s).

CLAIMS PROCEDURES, continued

57. Physician - A Doctor of Medicine, (MD), or Doctor of Osteopathy, (DO), who is licensed to practice medicine or osteopathy where the care is provided and who acts within the scope of his or her license. A Physician will also include a Christian Science practitioner accredited by the Mother Church - The First Church of Christ, Scientist, in Boston, Massachusetts. See NOTE.

NOTE: The term "Physician" will not include the Covered Person himself/herself, relatives (see **General Exclusions**) or interns, residents, fellows or others enrolled in a graduate medical education program.

58. 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.

59. Plan Administrator – The entity with the authority to interpret the Plan and make determinations regarding coverage, eligibility, and benefits. See **General Plan Information** section for further information."

60. 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.

61. Plan Sponsor - The entity sponsoring this Plan and with the authority to modify or amend the Plan. See **General Plan Information** section for further information.

62. Practitioner - See "**Covered Provider**"

63. Pregnancy - Pre-natal and post-natal care during pregnancy, childbirth, miscarriage or complications arising therefrom. See "Pregnancy" in the list of **Eligible Medical Expenses** for further information.

64. Prior to Effective Date or After Termination Date - Dates occurring before a Covered Person gains eligibility from the Plan, or dates occurring after a Covered Person 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.

65. 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 unusual 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 service(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, service(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 consequence 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.

- 66. Rehabilitation Therapy** - Physical, occupational, or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery and that is performed by a licensed therapist acting within the scope of his or her license.

Active rehabilitation refers to therapy in which a patient, who has the ability to learn and remember, actively participates in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

Maintenance rehabilitation refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of active rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonable be prescribed to maintain, support, and/or preserve the patient's functional level. Maintenance rehabilitation is not covered.

Passive rehabilitation refers to therapy in which a patient does not actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive rehabilitation may be covered by the Plan, but only during a course of hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an Outpatient basis with the patient when and until such time as the patient is able to achieve active rehabilitation.

Continued hospitalization for the sole purpose of providing passive rehabilitation is not considered to be Medically Necessary.

- 67. 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 90% of the lowest charge by the facility for single bed room and board accommodations where the facility does not provide any semi-private accommodations.
- 68. Sickness** - Sickness will mean 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.

- 69. Skilled Nursing Facility** - An institution which:

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.

70. Stability Period (SP) – A period of time, to be determined solely at the discretion of Employer, of at least six consecutive calendar months that is no shorter in duration than the IMP or SMP and begins after the IMP or SMP and any applicable Administrative Period for an employee determined to be a full-time employee during the SMP.

71. Standard Measurement Period (SMP) – Period of time, to be determined solely at the discretion of Employer, between three and twelve months from employee date of hire to measure completed hours of service for ongoing variable hour and seasonal employees. This period is used to determine whether an employee completed an average of thirty hours of service per week.

72. Substance Abuse - Any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a Drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as follows:

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12 month period:

Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of Children or household);

Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);

Craving or a strong desire or urge to use a substance; or

Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);

The symptoms have never met the criteria for Substance Dependence for this class of substance.

73. Surgery - Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one (1) surgical procedure is performed through the same incision or operative field or at the same operative session, the Contract Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits.

Allowances for multiple surgeries through the same incision or operational field:

CLAIMS PROCEDURES, continued

the primary procedure is allowed at 100% of Usual and Customary and Reasonable;

the secondary and additional procedures are allowed at 50% of Usual Customary and Reasonable, per procedure.

Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session:

the first site primary procedure is allowed at 100% of Usual and Customary and Reasonable;

the first site secondary and additional procedures are allowed at 50% of Usual and Customary and Reasonable, per procedure;

the second site primary procedure is allowed at 100% of Usual and Customary and Reasonable;

and

the second site secondary and additional procedures are allowed at 50% of Usual and Customary and Reasonable, per procedure.

74. Telemedicine/Virtual Visit - is the remote delivery of health care services and clinical information using telecommunications technology. This includes a wide array of clinical services using internet, wireless, satellite and telephone media.

75. Urgent Care Facility - A facility which is engaged primarily in providing minor emergency and episodic medical care and which 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 which is part of a regular Hospital.

Usual and Customary (U&C) – The amount the Plan Administrator determines to be the general rate to others who render or furnish such treatment, service, or supply to individuals who reside in the same geographic area and whose condition are comparable in nature and severity. When there is not a contracted amount and the service is still covered by the Plan, the lesser of the Usual and Customary amount or the amount Medicare would allow for the service.

GENERAL PLAN INFORMATION

Name of Plan:	Washoe County School District Group Health Plan
Plan Sponsor:	Washoe County School District 425 East Ninth Street Reno, Nevada 89512 (775) 348-0321
Plan Administrator:	Washoe County School District 425 East Ninth Street Reno, Nevada 89512 (775) 348-0321
Participating Employer(s):	Washoe County School District
Plan Year:	January 1 through December 31
Named Fiduciary:	Washoe County School District 425 East Ninth Street Reno, Nevada 89512
Agent for Service of Legal Process:	Washoe County School District 425 East Ninth Street Reno, Nevada 89512
Type of Plan:	This is an employee benefit plan providing group benefits
Plan Benefits Described Herein:	Self-Funded Medical, Dental & Prescription Benefits
Type of Administration:	Contract Administration – see “Administrative Provisions” for additional information
Privacy Officer:	Phone (775) 348-0321
Contract Administrator:	Anthem Blue Cross Blue Shield P.O. Box 5747 Denver, CO 80217-5747 (833) 914-0825

FUNDING - SOURCES AND USES

Employee & Employer Obligations - Plan benefits are paid by Plan Sponsor and employee contributions. The Plan Administrator shall, from time to time, evaluate and determine 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 (NonCOBRA) enrollees, except in special circumstances where a greater cost is allowed by law. See the **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.

Plan Funded Benefits - The contributions will be applied to provide the benefits under the Plan.

Taxes - Any premium or other taxes which may be imposed by any state or other taxing authority and which 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 which 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 which is consistent with applicable law.

ADMINISTRATIVE PROVISIONS

Administration (type of) - Certain benefits of the Plan 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 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 administer the Plan thereafter in strict accordance with the provisions of the Benefit 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:

determine eligibility for benefits or to construe the terms of the Plan;

alter or postpone the method of payment of any benefit;

amend any provision of these administrative provisions;

GENERAL PLAN INFORMATION, continued

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 applicable law; 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/she 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 which 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.

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), any amendment limiting benefits under a Plan shall be universally applicable to all individuals in the same eligible class, shall be based on bona fide employment classifications consistent with the Employer's usual business practices, and shall not be directed at individual participants or beneficiaries based on any health factor of such individual(s). However, a Plan amendment applicable to all individuals in one or more groups of similarly situated individuals and made effective no earlier than the first day of the first Plan Year after the amendment is adopted is not considered to be directed at individual participants and beneficiaries.

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 the booklet(s) provided to Employees (the "Summary Plan Description") and the Benefit Document, the Benefit 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/she 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

GENERAL PLAN INFORMATION, continued

of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Plan Document, even if the terms are found to be ambiguous, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

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 Document will not affect the other provisions, but the Benefit 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 saved 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 Document and 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 the **Claims Procedures** section for more information.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

GENERAL PLAN INFORMATION, continued

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 reduction 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. Such reductions are outlined by the Department of Labor in Section 2520.104b-3(d)(3) of the regulations.

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 the 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 in an enrollment form or claims filing, his/her eligibility, benefits or both, will be adjusted to reflect his/her 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 knowingly 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/her (and his/her 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

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees

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

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 (i.e., the "Privacy Rules") 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 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 which 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 Clerical Error - When, as a result of clerical error, 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/her 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 the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if 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

GENERAL PLAN INFORMATION, continued

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/her Dependents.

Rights Against the Plan Sponsor or Employer - Except as required by law, 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.

Titles or Headings - Where titles or headings precede explanatory text throughout the Benefit 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 Document and will not affect the validity, construction or effect of the Benefit 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 which, in good faith judgment and investigation, he/she knew or should have known, contained false or fraudulent elements under state or federal law.

Termination for fraud will be made in writing and with 31-day notice to the individual

Type of Plan - This Plan is not a plan of insurance. This Plan is a self-funded governmental group health plan which, 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 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.

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, which 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.

If a retired Employee is covered under the Plan and one of his/her Dependents has a Qualifying Event (e.g., divorce, loss of Dependent child eligibility, etc.), 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.

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

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 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 that 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.

NOTE: Federal law does not recognize domestic partners as eligible beneficiaries. Within Federal COBRA law, the word spouse refers only to a person of the opposite sex who is a husband or wife. Therefore, Federal COBRA will not be offered to domestic partners.

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, unless termination is due to any reason other than Employee's gross misconduct as determined by the Employer;

COBRA CONTINUATION COVERAGE, continued

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 or her 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);

for retirees and their Dependent spouses and children, loss of Plan coverage due to the Employer's filing of a bankruptcy proceeding under Title 11 of the U.S. Bankruptcy Code. In order for a Qualifying Event to occur, the Employee must have retired on or before the date of substantial elimination of the Plan's benefits and must be covered under the Plan on the day before the bankruptcy proceedings begin. "Substantial elimination" of the Plan's benefits must occur within 12 months before or after the bankruptcy proceedings begin.

NonCOBRA 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 if the employee is the only qualified beneficiary 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.

COBRA CONTINUATION COVERAGE, continued

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/her spouse. A Qualified Beneficiary is also responsible for other notifications. See the **COBRA Notification Procedures** as included in the Plan's Summary Plan Description (and the Employer's "COBRA General Notice" or "Initial Notice") 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. See NOTE.

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 NonCOBRA 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.

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.

NOTE: See the "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 NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated NonCOBRA 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

COBRA CONTINUATION COVERAGE, continued

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 will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated NonCOBRA 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 NonCOBRA Beneficiaries. Qualified Beneficiaries can be charged up to 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. 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. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period later than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Administrator.

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 if:

- the cost previously charged was less than the maximum permitted by law;

- the increase is due to a rate increase at Plan renewal;

- the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law that 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) that 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 the "Effect of the Trade Act" provision for additional cost of coverage information.

COBRA CONTINUATION COVERAGE, continued

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 Qualifying Event. With a disability extension (see “Disability Extension” information below), 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;

in the case of a bankruptcy Qualifying Event with regard to a retiree, the maximum coverage period is to the date of the retired Employee’s death. The maximum coverage period for a Qualified Beneficiary who is the spouse, surviving spouse or Dependent child of the retired Employee ends on the earlier of: (1) 36 months after the death of the retired Employee, or (2) the date of the Qualified Beneficiary’s death;

for any other Qualifying Event, the maximum coverage period ends 36 months after 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 or a bankruptcy of the Plan Sponsor following any Qualifying Event 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, except in the case of a bankruptcy Qualifying Event with regard to a retiree where the maximum coverage period is to the date of the retired Employee’s death.

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 have been disabled at the time of the Qualifying Event or at any time during 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 periods described. 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 or her 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” above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of 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” above;

COBRA CONTINUATION COVERAGE, continued

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 that does not contain any exclusion or limitation with respect to any Pre-existing condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary;

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 or her 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;

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 NonCOBRA 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, as amended. The Trade Adjustment Assistance Reauthorization Act extended the HCTC until December 31, 2019.

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. 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:

COBRA CONTINUATION COVERAGE, continued

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 six (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.

COBRA NOTIFICATION PROCEDURES

NOTICE RESPONSIBILITIES

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

Notice of Divorce or Separation - Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee from his or her 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 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 has been determined by the Social Security Administration (SSA) 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 SSA 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 PROCEDURES

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 or Means of Notification - Notification of the Qualifying Event must be provided to the District's Benefits Department/Management Office. You may contact the Benefits Department/Management Office to fill out an enrollment form stating the qualifying event.

Content - Notification must include any official documentation showing evidence that a Qualifying Event has occurred such as a copy of a divorce decree, a child's birth certificate, a copy of the Social Security Administration's disability determination, etc.

Delivery of Notification - Notification must be received by the District's Benefits Department/Management Office.

Time Requirements for Notification - Should an event occur (as described in **NOTICE RESPONSIBILITIES** above), the Employee, other Qualified Beneficiary, or a representative acting on behalf of any such person must provide Notice to the designated recipient within a certain time frame.

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 Administrators General COBRA Notice. If Notice is not received within the 60-day period, **COBRA Continuation Coverage** will not be available,

COBRA NOTIFICATION PROCEDURES, continued

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 Summary Plan Description or Benefit 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 SPD or the Plan Administrator'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.

HIPAA PRIVACY

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy 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. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Covered Person's PHI, and inform him/her about:

the Plan's disclosures and uses of PHI;

the Covered Person's privacy rights with respect to his/her PHI;

the Plan's duties with respect to his/her PHI;

the Covered Person's right to file a complaint with the Plan and with the Secretary of HHS; and

the person or office to contact for further information about the Plan's privacy practices.

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 45 CFR Sections 160.103 and 164.501. 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

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is:

to carry out Payment of benefits;

for Health Care Operations;

for Treatment purposes; or

if the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);

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;

establish safeguards for information, including security systems for data processing and storage;

maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;

receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;

not use or disclose genetic information for underwriting purposes;

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;

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;

make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);

make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);

make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);

make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;

train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;

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

ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

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:

Privacy Officer: 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.

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 Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance 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 Contract Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) 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 Standards.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

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 HIPAA Privacy Rule;

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

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

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;

Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

A public health authority or other appropriate government authority authorized by law to receive reports of Child abuse or neglect;

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;

Locate and notify persons of recalls of products they may be using; and

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;

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;

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;

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;

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;

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;

Research: The Plan may use or disclose PHI for research, subject to certain limited conditions;

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;

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

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

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

Disclosures to the Secretary of the U.S. Dept. 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 HIPAA Privacy Rule.

Instances When Required Authorization Is Needed From Covered Persons Before Disclosing PHI

most uses and disclosures of psychotherapy notes;

uses and disclosures for marketing;

sale of PHI; and

other uses and disclosures not described in can only be made with authorization from the Covered Person. The Covered Person may revoke this authorization at any time.

Covered Person's Rights

The Covered Person has the following rights regarding PHI about him/her:

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;

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;

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 Privacy Compliance Coordinator;

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 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 Privacy Compliance Coordinator;

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 Privacy Compliance 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;

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 Privacy Compliance 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

Fundraising contacts: The Covered Person has the right to opt out of fundraising contacts.

Questions or Complaints If the Covered Person wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The 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 Covered Person with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Covered Person for filing a complaint with the Plan or the U.S. Department of Health and Human Services

Contact Information

Washoe County School District
Benefits Department/management
Privacy Officer
Reno, NV 89512
Phone: 775-348-0321

HIPAA SECURITY

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (“SECURITY RULE”)

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions

Electronic Protected Health Information (ePHI), as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.

Security Incidents, as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

- 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;

- ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;

- ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees 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; and

- report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been know

When a breach of unsecured PHI is discovered, the Plan will:

Notify the Covered Person whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. Breach Notification must be provided to individual by:

Written notice by first-class mail to Covered Person (or next of kin) at last known address or, if specified by Covered Person, e-mail;

If Plan has insufficient or out-of-date contact information for the Covered Person, the Covered Person must be notified by a “substitute form”;

If an urgent notice is required, Plan may contact the Covered Person by telephone.

The Breach Notification will have the following content:

Brief description of what happened, including date of breach and date discovered;

Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);

Steps Covered Person should take to protect from potential harm;

What the Plan is doing to investigate the breach, mitigate losses and protect against further breaches;

Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered;

Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than five hundred (500) individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each Calendar Year; and

When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected Covered Persons may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

WASHOE COUNTY SCHOOL DISTRICT

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (QHDHP)

Amendment #1

Effective July 1, 2023

PLAN DOCUMENT and SUMMARY PLAN DESCRIPTION

The Effective Date – Employees listed on page 57 of the Plan Document is amended to read as follow:

With the exception of elected members of the District's Board of Trustees, an eligible Employee's coverage is effective, subject to timely enrollment, on the first day of work in a benefit eligible position (no waiting period). Employees have 30 days from their first day of active employment to provide the necessary documents to enroll their dependents in health coverage. The effective date of coverage for elected members of the District's Board of Trustees is the day they take office.

WASHOE COUNTY SCHOOL DISTRICT

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (QHDHP)

Amendment #2

Effective July 1, 2023

PLAN DOCUMENT and SUMMARY PLAN DESCRIPTION

The Waiver on Contributions on page 67 of the Plan Document is amended to read as follow:

If an active Employee meets all of the following criteria and complies with the procedures described below, he/she shall be eligible for a Waiver of Contribution for his/her District paid Plan contribution for an initial period of up to six (6) months:

has been hurt on or off the job or sustained serious injury or non-

induced illness; has used all of his/her sick leave and vacation leave;

is no longer receiving any income from employment other than Workers'

Compensation benefits; is on an approved Leave of Absence; and

has a reasonable prognosis of returning to full employment with the Washoe County School District within six (6) months from the time the individual went on an approved leave of absence, whether paid or unpaid.

has been employed with WCSD for a minimum of 6 months

The Waiver of Contribution is not automatic. Failure to follow the procedures described below shall prevent a Waiver of Contribution from being granted.

The active Employee or his/her representative must make a request to the Benefits Department Office at 425 East Ninth Street, Reno, NV 89512 in writing, accompanied by the Employee's Physician's report giving verification of the prognosis of return to work. Such request must be submitted within thirty (30) days after the Employee is no longer in an actively paid status.

At the sole discretion of the Benefits Department, the Waiver of Contribution may be extended for a maximum of an additional six (6) months.

Both the initial and extended Waiver of Contribution will be coordinated with the approved leave of absence, but not be in addition to the provisions of the Family Medical Leave Act.

To obtain an additional Waiver of Contribution, or for an additional six (6) months or 12 months total, the active Employee or his/her representative must make a request to the Benefits Department Office at 425 East Ninth Street, Reno, NV 89512 in writing within thirty (30) days prior to the expiration of the initial six (6) month waiver, accompanied by the Employee's Physician's report giving verification of the updated prognosis of return to work. This request will be reviewed, based on the criteria stated above. An Employee may obtain a Waiver of Contribution for a maximum of twelve (12) months within a three (3) year period.

WASHOE COUNTY SCHOOL DISTRICT

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (QHDHP)

Amendment #3

Effective July 1, 2023

PLAN DOCUMENT and SUMMARY PLAN DESCRIPTION

Effective Date – Dependents – Dependents listed on page 58 of the Plan Document is amended to read as follow:

A Dependent who is eligible and enrolled when the Employee enrolls, will have coverage effective on the same date as the Employee. Employees have 30 days from their first day of active employment to provide the necessary documents to enroll their dependents in health coverage.

Dependents acquired later may be enrolled within thirty-one (31) days of their eligibility date and coverage will be effective on the first day of the month following enrollment (see the "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.

WASHOE COUNTY SCHOOL DISTRICT

QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (QHDHP)

Amendment #4

Effective July 1, 2023

PLAN DOCUMENT and SUMMARY PLAN DESCRIPTION

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 the "Extension of Coverage During U.S. Military Service" in the **Extensions of Coverage** section for more information;

at midnight of the last day of the period for which payment of the contribution has been made or employee ceases to be eligible, or ceases to be engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the terms of any **Extension of Coverage** provision; - except when coverage is terminated within the employee's first 30 day window to enroll, the benefits will terminate on the day employment is terminated.

the date the Employee dies.