NYE COUNTY SCHOOL DISTRICT

SUMMARY PLAN DESCRIPTION

January 1, 2008

Amended and Restated as of

January 1, 2019

Benefits Administered by:

Lucent Health
10951 White Rock Rd, Ste 100
Rancho Cordova, CA 95670

916.669.2500
877.789.8488
916.669.0576 fax

ARTICLE I – INTRODUCTION

Whereas, the employer Nye County School District, hereinafter referred to as the "'Employer" hereby establishes the benefits, rights and privileges which shall pertain to participating employees and eligible dependents of participating employees, as defined herein, and which benefits are provided by the Employer and hereinafter referred to as the "Plan".

This summary has been prepared to furnish you with information regarding the medical plan sponsored by Nye County School District. Below is a general outline of the Plan that gives you this information. It has been our objective to describe the Plan clearly and directly; however, if you have any questions concerning the Plan or the information and provisions of the coverage summary, please inquire with Nye County School District. The medical benefits are partially self-funded by your Employer. A policy covering losses exceeding a specific dollar amount has been purchased by Nye County School District.

Note: Benefits are payable according to the terms of the Master Plan Document on file with the Employer. A copy of the Plan Document can be obtained from your employer upon request. Actual payment of your claims can only be determined at the time the claims are submitted and all factors are presented in writing. All benefit payments are governed by the provisions of the Master Plan Document.

1.1 PURPOSE

The purpose of the Plan Document is to set forth the provisions of the Plan that provide for the payment or reimbursement of all or a portion of eligible medical and dental expenses.

1.2 NAME OF PLAN

Nye County School District Health Benefits Plan

1.3 TYPE OF PLAN

Medical and Dental

1.4 EMPLOYER/PLAN SPONSOR

Nye County School District
484 S West Street
Pahrump, NV 89048

(775) 727-7743
Employer Identification Number: 88-6001054

1.5 AGENT FOR LEGAL SERVICES

Nye County School District

Legal process may also be served upon the Plan Administrator or the Plan Trustee.

1.6 PLAN ADMINISTRATOR / NAMED FIDUCIARY

Nye County School District
484 S West Street
Pahrump, NV 89048
(775) 727-7743
Self-Administered by Nye County School District who has appointed a Third Party Administrator to handle the day-to-day operation of the Plan.

THIRD PARTY ADMINISTRATOR/CLAIMS PROCESSOR

Lucent Health
10951 White Rock Rd, Ste 100
Rancho Cordova, CA 95670

916.669.2500
877.789.8488

Fax: 916.669.0575

1.7 NAMED FIDUCIARY, PLAN ADMINISTRATOR, AND PROCEDURE FOR ALLOCATION OF RESPONSIBILITIES

The named Fiduciary and Plan Administrator is Nye County School District who shall have the authority to control and manage the operation and administration of the Plan. . The fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan. The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The Plan Administrator may at any time delegate the exercise of any portion of its authority under this Section to another person or entity. The decisions of the Plan Administrator will be final and binding on all interested parties.

The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The Employer shall have the authority to amend the Plan, to determine its policies, to appoint and remove other supervisors, fix their compensation (if any), and exercise general administrative authority over them.

The Claims Processor is not a Fiduciary under the plan by virtue of paying claims in accordance with Plan's rules as established by the Plan Administrator.

1.8 SOURCES AND METHODS OF CONTRIBUTIONS TO THE PLAN

The employer and employee share in the cost of the Plan.

1.9 DETERMINATION AND AMOUNT OF CONTRIBUTIONS

The amounts of contributions are to be made on the following basis:

The Employer shall from time to time evaluate the cost of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed (if any) by each covered participant.

1.10 FUNDING

Self-funded with Employer and Employee contributions.

Employer Contributions

The Employer makes contributions, as needed, to pay benefits from its general assets and purchases insurance for catastrophic claims.

Employee Contributions

Established as required, from time to time, by the Employer.

Benefits are paid directly from the Plan through the Claim Processor.

Retired Employees Health Insurance

For retired employees of the Nye County School District who have been with the District 15 years or more, and who will be receiving benefits from PERS, the District will contribute not to exceed $190.00 per month to its carrier for continued coverage until they are 65 years of age and eligible for Medicare.

This coverage will include medical, dental, vision and prescriptions only.

For retired employees of the Nye County School District who have been with the District 15 years or more, who are 65 years old or older, and will be receiving benefits from PERS, but are not eligible for Medicare, may petition the Nye County School District for continued financial assistance for District insurance coverage. The District may contribute, but will not exceed $100.00 per month, to its carrier for continued coverage for those qualifying employees who are not eligible for Medicare.

Once an employee becomes eligible for Medicare, the District will no longer make contributions toward the cost of covering a retired employee under the District group health plan. The District will offer a Medicare supplement for the retired employee. If the employee chooses to enroll in this supplementary program, the district will not exceed $100.00 per month to the supplementary insurance carrier toward the premium.

The District on an annual basis will review this policy. The District reserves the right to amend, modify, or terminate this policy. The Nye County School District will notify in writing the retired employee whenever the Board of Trustees makes a change in this policy.

1.11 PLAN YEAR

January 1 through December 31.

1.12 PLAN NUMBER

501

1.13 THE PLAN IS NOT A CONTRACT

The plan shall not be deemed to constitute a contract between the Company and any Employees or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in the Plan 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.

1.14 PLAN AMENDMENTS

Changes in the terms and conditions of the present Nye County School District group insurance plan may only be made with mutual consent of:

1. the Nye County School District Board of Trustees and
2. the Joint Insurance Committee of the NCCTA Board of Directors and NCSSO Board of Directors

Membership on the Joint Insurance Committee will be proportioned between NCCTA and NCSSO based on the number of employees represented by each group who are covered by insurance.

TIME LINE AND DISTRIBUTION REQUIREMENTS

SPD new Member	Within 90 days of the effective date
SPD if new plan	Within 12 days of the effective date
Summary of Material Modification affecting any information in the Summary of Benefits and Coverage (SBC	60 days in advance of the change
Summary of Material Modification Notification that does not affect the information in the Summary of Benefits and Coverage (SBC)	60 days after the effective date of change
Summary of Material Modification Notification for a material reduction that does not affect the information in the Summary of Benefits and Coverage (SBC)	60 days in advance of change
SPD for amended plans	Every 5 years
SPD if not amended	Every 10 years
SPD if not amended	Within 30 days of a written request

1.15 CLAIM PROCEDURE

The Employer shall provide adequate notice in writing to any covered Participants whose claims for benefits under this Plan have been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the Participant. Further, the Employer shall afford a reasonable opportunity to any Participant 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 – See Procedures for Filing a Claim (Article 4)

1.16 TERMINATION OF PLAN

The Employer reserves the right at any time to terminate the Plan. Upon termination, the rights of the Plan Participants to benefits are limited to claims incurred up to the date of termination. Any termination of the Plan will be communicated to Plan Participants.

All previous contributions by the Employer shall continue to be issued for the purpose of paying benefits under the provisions of this Plan with respect to claims arising before such termination, or shall be used for the purpose of providing similar health benefits to covered Participants, until all contributions are exhausted.

Neither the establishment nor maintenance of the Plan or the trust shall be construed as:

1. Conferring upon any Participant, beneficiary or any other person or organization any right or claim against the Employer, the Plan Administrator, or against any officer; and any and all such rights and claims are expressly waived and released by every Participant on behalf

of himself, his beneficiaries, and any and all persons or organizations who might claim through or by reason of any right or claim of the Participant under the Plan as a condition of any as part of the consideration for the Employer contributions under the Plan;

2. An agreement, consideration, or inducement of employment, or as affecting in any manner or to any extent whatsoever the rights or obligations of the Employer or any Participant to continue or terminate employment at any time;

3. Creating any responsibility or liability of the Employer, the Plan Administrator, or the Third Party Administrator of the Plan, for the validity or effect of the Plan.

ARTICLE II - ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE

2.1 EMPLOYEE COVERAGE

Only those regular status employees who are regularly scheduled to work at least 30 hours per week for Nye County School District are eligible to participate in this Plan.

There is no waiting period for all new employees and their dependents to be eligible for the Plan. Employees must enroll their dependents within 31 days of the date they are first eligible. If application for coverage is made beyond this 31-day period coverage can become effective only in accordance with the Open Enrollment (2.3) or Special Enrollment Periods (2.4) provisions.

An employee will be considered to be actively at work on each day of a regular paid vacation or on a regular non-working day provided he or she was actively at work on the last preceding regular work day. An Employee will also be considered to be actively at work on any day on which he is absent from work during an approved FMLA leave or solely due to his own health status. An exception applies only to an employee's first scheduled day of work. If an employee does not report for employment on his first scheduled workday, he will not be considered as having commenced active employment.

2.2 DEPENDENT COVERAGE

Dependents of employees shall become eligible on the later of the following dates:

1. the date the employee becomes eligible, or
2. the date the employee acquires the dependent.

A Dependent is any of the following persons:

(1) A covered Employee's Spouse.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives or was married.

The term "Spouse" shall also mean the person who is currently registered. Pursuant to NRS 122A.100 as the domestic partner of the Employee. Domestic Partners must file a Declaration of Domestic Partnership with the Nevada Secretary of State per NRS 122A.100:

(a) Members of the same or opposite sex who have registered as Domestic Partners with the Secretary of State in Nevada and that Domestic Partnership has not terminated, that domestic partnership pursuant to NRS 122A.100

(2) A covered Employee's Child(ren).

An Employee's "Child" includes his (or domestic partner's) natural child, stepchild, foster child, adopted child, or a child placed with the Employee (or domestic partner) for adoption. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the child's birthday.

The phrase "placed for adoption" refers to a child whom the Employee (or domestic partner) intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee (or domestic partner) 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 commenced.

If a covered Employee (or domestic partner) is the Legal Guardian of a child or children, these children may be enrolled in this Plan as covered Dependents.

Any Child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

(3) An Employees (or domestic partners) child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

A covered dependent who voluntarily terminates their coverage or does not elect to continue coverage for which they are eligible under COBRA rules as stated under "Continuation of Health Coverage" will not be eligible to reenter this health plan except during the open enrollment period. The open enrollment period will be the month of November. Coverage effective date for such dependent(s) will be January 1st.

In all instances, dependents will be eligible for coverage provided the dependent, other than a newborn child, is not confined in a hospital or an institution that is a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a convalescent hospital, a nursing home, or a similar institution on the date such dependent's coverage would otherwise become effective. Such dependent's coverage shall not become effective until the date following the end of confinement.

An employee's (or domestic partner) newborn child is covered for dependent health benefits from the moment of birth for the first 31 days following the date of birth whether or not dependent coverage is applied for. To continue coverage after this 31-day period, application for dependent coverage must be made within the first 31 days following the date of birth.

Dependents must enroll for benefits within 31 days of the date they are first eligible.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; any former domestic partner or any person who is covered under the Plan as an Employee. If both parents are eligible for coverage, only one may enroll for Dependent coverage.

2.3 LEGALLY ADOPTED CHILDREN

A child legally adopted by a Covered Employee (or domestic partner) will become eligible for coverage on the date the child is placed in the physical custody of the covered person. Application must occur within 31 days from the date of eligibility.

2.4 OPEN ENROLLMENT

If an individual does not enroll when he is first eligible to do so or if he allows coverage to lapse, he may later enroll during an Open Enrollment period.

NOTE: See Special Enrollment Periods for exceptions to this provision.

2.5 SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days after the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.

2.6 SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage.

(1) Individuals losing other coverage creating a Special Enrollment right. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(2) For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(a) The Employee or Dependent has a loss of eligibility on the earliest date a claim is denied that would meet or exceed a lifetime limit on all benefits.

(b) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).

(c) The Employee or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(d) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(e) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(3) Dependent beneficiaries. If:

(a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, registration of domestic partnership, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse or domestic partner of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse or domestic partner is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 31-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received; or in the case of domestic partner relationship, on the date of registration of the domestic partner relationship; or

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(4) Medicaid and State Child Health Insurance Programs. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day following the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

2.7 MEDICAL CHILD SUPPORT COURT ORDER

The child(ren) of a covered individual subject to a Qualified Medical Child Support Order issued by a domestic relations court will be covered subject to the terms of that court order. This Plan will continue to follow the most current regulations contained within the Omnibus Budget Reconciliation Act (OBRA) of 1993.

2.8 NON-DISCRIMINATION DUE TO HEALTH STATUS

(1) In General - Subject to paragraph (2), a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the Plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

A. Health status
B. Medical condition (including both physical and mental illnesses)
C. Claims experience
D. Receipt of health care
E. Medical history
F. Genetic Information
G. Evidence of Insurability (including conditions arising out of acts of domestic violence)
H. Disability

(2) No Application to Benefits or Exclusions - To the extent consistent with section 701, paragraph (1) shall not be construed-

a. to require a group health plan, or group heath insurance coverage, to provide particular benefits other than those provided under the terms of such plan coverage, or

b. to prevent such a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

2.9 NON-DISCRIMINATION IN PREMIUM CONTRIBUTIONS

(1) In General - A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health status-related factor in relation to the individual or to an individual enrolled under the plan as a dependent of the individual.

(2) Construction - Nothing in paragraph (1) shall be construed –

a. to restrict the amount that an employer may be charged for coverage under a group health plan; or
b. to prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable co-payments or deductibles in return for adherence to programs of health promotion and disease prevention.

2.10 CHANGE IN STATUS

If an Employee's coverage changes from single to dependent or dependent to single, the employer must be notified within 31 days of the change. This usually occurs if a person has a newborn baby, acquires stepchildren, adopts a child or changes marital status.

An employee may transfer to dependent status and become an eligible dependent of an employee when terminated as an employee as long as that person meets the definition of an eligible dependent. A dependent may transfer to employee status when hired as an employee for the firm. No waiting period will be required and benefits will continue from the prior status under the Plan without additional requirements.

An employee who experiences a reduction in hours is eligible for Continuation of Health Coverage and there would be no break in coverage if eligible hours are resumed prior to expiration of the 18-month continuation period. (Refer to Continuation of Health Coverage Option.)

2.11 FAMILY AND MEDICAL LEAVE

This Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

2.12 EMPLOYEE CONTRIBUTIONS

Coverage for employees is non-contributory. Coverage for eligible dependents may require an employee contribution. Coverage for retirees and their eligible dependents may require a contribution.

2.13 TERMINATION OF BENEFITS

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. The employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Dependent's paid contributions.

Benefits for eligible covered employees will terminate:

1. when the Plan is terminated;
2. on the last day in which membership in an eligible class of employees terminates;
3. on the last day in which full-time active employment terminates for whatever reason;
4. for medical benefits: the date the employee becomes covered under another group medical plan offered by the Employer;
5. on the date the employee enters any military, naval or air force of any country or international organization on an active basis other than scheduled drills or other training not exceeding one month in any calendar year;
6. on the date in which full-time residency in the United States of America or Canada is not maintained.
7. If an Employee commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

Benefits for an eligible dependent will terminate:

1. when an employee's coverage terminates;
2. on the date the dependent is no longer an eligible dependent as defined;
3. on the date the dependent enters the military, naval or air force of any country or international organization on an active basis other than scheduled drills or other training not exceeding one month in any calendar year;
4. on the date in which full-time residency in the United States of Canada is not maintained;
5. on the date required contribution for dependent coverage is not made;
6. on the date the covered employee ceases to be in a class of employees eligible for dependent coverage;
7. on the date dependent coverage is discontinued on the Plan.
8. If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively, the Plan will provide at least 30 days' advance written notice of such action.

2.14 COVERAGE OUTSIDE THE UNITED STATES

Coverage is provided for employees and eligible dependents traveling outside of the United States. Conversion factors to U.S. currency is the responsibility of the claimant when filing the claim. However, coverage is not provided for services out of the United States if the covered person traveled to such location to obtain medical services, drugs or supplies.

2.15 CONTINUATION OF HEALTH COVERAGE

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under Nye County School District Health Benefits Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary

fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The Plan Administrator is Nye County School District, 484 S. West Street, Pahrump, Nevada, 89048, (775) 727-7743. COBRA continuation coverage for the Plan is administered by Capitol Administrators, P.O. Box 2318, Rancho Cordova, California 95741-2318, (877) 789-8488. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Participants who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse, or Domestic Partner of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, or Domestic Partner, surviving Spouse, Domestic Partner or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, or Domestic Partner, surviving Spouse, Domestic Partner or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the

individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is treated as a Qualified Beneficiary. This gives the domestic partner the contractual rights outlined in this document but does not extend statutory provisions to the domestic partner.

Each Qualified Beneficiary (including a domestic partner or child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

(2) The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse or domestic partner. If the Employee reduces or eliminates the Employee's Spouse's or domestic partners Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's or domestic partner's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

(6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered Spouse, or Domestic Partner or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or Domestic Partner, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if

they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the employee,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee, spouse, or domestic partner or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60

days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse, domestic partner or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

ARTICLE III - PROCEDURE FOR FILING A CLAIM

3.1 HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the Personnel Office, Human Resources Office or the Plan Administrator.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Administrator at this address:

Capitol Administrators, Inc.
P.O. Box 2318
Rancho Cordova, California 95670
(877) 789-8488

3.2 WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 90 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

3.3 CLAIMS PROCEDURE

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. However, this rule may not apply if the Plan Administrator has not complied with the procedures described in this Section. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as soon as practical and not later than the time shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. The Urgent Care Claim rules do not apply to claims involving urgent care where Plan benefits are not conditioned on prior approval. These claims are subject to the rules on Post-Service Claims described below.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, responses must be made as soon as possible consistent with the medical urgency involved, and no later than the following times:

Notification to claimant of Claim determination	24 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	48 hours
Notification of Adverse Benefit Determination on Appeal	72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

In the case of a Concurrent Care Claim, the following timetable applies:

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days

Notification of determination on Appeal of Urgent Care Claims	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	15 days
Notification of Adverse Benefit Determination on Appeal for Rescission Claims	30 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Predetermination of Benefits, pre-certification or mandatory second opinions. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Notification of Adverse Benefit Determination on Appeal	15 days per benefit appeal
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not an Urgent Care Claim or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of Adverse Benefit Determination	30 days
Extension due to matters beyond the control of the Plan	15 days

Extension due to insufficient information on the Claim	15 days
Response by claimant following notice of insufficient information	45 days
Notification of Adverse Benefit Determination on Appeal	30 days per benefit appeal

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external Appeal procedures, incorporating any voluntary appeal procedures offered by the Plan. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following a Final Adverse Benefit Determination.

(6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

ARTICLE IV - APPEAL PROCEDURES

4.1 When claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records, and other information relating to the Claim.

If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and the treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request..

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(3) Reference to the specific Plan provisions on which the determination was based.

(4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(5) A description of the Plan's internal and external review procedures, incorporating any voluntary appeal procedures offered by the Plan and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

(6) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(7) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(8) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

(9) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process. In addition, a statement that "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office4.2 Voluntary appeals

In addition to the Claims and Appeals Procedures described above, the Plan permits voluntary dispute resolution procedures. If a claimant agrees in writing to use these procedures, any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending.

The Plan will not assert that a claimant has failed to exhaust administrative remedies merely because he or she did not elect to submit a benefit dispute to the voluntary appeal provided by

the Plan. A claimant may elect a voluntary appeal after receipt of a Final Adverse Benefit Determination.

The Plan will provide to the claimant, at no cost and upon request, sufficient information about the voluntary appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the claimant's rights to any other benefits under the Plan; will list the rules of the appeal; state the claimant's right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the claimant as part of the voluntary level of appeal, and the claimant will be told this.

4.3 EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. For requests made on or after September 20, 2011, the External Review process is available only where the Final Adverse Benefit Determination is denied on the basis of (1) a medical judgment (which includes but is not limited to, Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit), (2) a determination that a treatment is experimental or investigational, or (3) a rescission of coverage. The request for External Review must be filed in writing within 4 months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator will determine whether the Claim is eligible for review under the External Review process. This determination is based on the criteria described above and whether:

(1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;

(2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;

(3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

(4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4 month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the Plan; and

(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

(1) A general description of the reason for the External Review, including information sufficient to identify the claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the claimant; and

(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

(1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

(2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission,

availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Plan.

4.4 When the Named Fiduciary is a Committee or Board of Trustees

If the Joint Insurance Committee of Nye County School District holds regularly-scheduled meetings at least quarterly, the Joint Insurance Committee of Nye County School District shall make a benefit determination not later than the meeting date that immediately follows the Plan's receipt of an appeal, unless the appeal is filed within thirty (30) days preceding the date of such meeting. In that case, a benefit determination may be made not later than the date of the second meeting following the Plan's receipt of the appeal. If special circumstances (such as the need to hold a hearing as is permitted by the Plan) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting following the Plan's receipt of the appeal. If such an extension of time for review is required because of special circumstances, the Employee will be provided with written notice of the extension describing the special circumstances and the date on which the benefit determination will be made. Such notice will be provided prior to the commencement of the extension. When benefit determination is made, notice of the decision will be provided to the Employee not later than five (5) days thereafter.

4.5 STATEMENT OF RIGHTS

As a participant in this Plan, an individual is entitled to certain rights and protections. All Plan participants shall be entitled to:

examine, without charge, at the Plan Administrator’s office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor;

obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies;

receive a summary of the Plan’s annual financial report.

continue health care coverage for himself, spouse, or domestic partner or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. The employee or his Dependents may have to pay for such coverage. See the Continuation of Health Coverage (COBRA) section for additional details about these rights;

In addition to creating rights for Plan participants, the law imposes duties upon the people who are responsible for the operation of the Plan (the Fiduciaries). Fiduciaries have a duty to operate the Plan prudently and in the interest of Plan participants and beneficiaries. No one, including the Employer, may fire a Plan participant or discriminate against him to prevent him from obtaining a welfare benefit or exercising his rights.

If an individual's claim for a welfare benefit is denied in whole or in part, he must receive a written explanation of the reason for the denial. He has the right to have the Plan review and reconsider his claim.

There are steps he can take to enforce the above rights. For instance, if he requests materials from the Plan and does not receive them within 30 days, he may file suit in a court of law. In such a case, the court may require the Plan Administrator to provide the materials. If he has a claim for benefits which is denied or ignored, in whole or in part, he may file suit in a court of competent jurisdiction. In addition, if he disagrees with the Plan Sponsor's decision or lack thereof, concerning the qualified status of a medical child support order (QMCSO), he may file suit in court of competent jurisdiction. If it should happen that Plan Fiduciaries misuse the Plan's money, or if he is discriminated against for asserting his rights, he may seek assistance and may file suit in a court of competent jurisdiction. The court will decide who should pay court costs and legal fees. If he is successful, the court may order the person he has sued to pay these costs and fees. If he loses, the court may order him to pay these costs and fees, for example, if it finds his claim is frivolous.

If an employee or Plan participant has any questions about the Plan, he should contact the Plan Administrator.

ARTICLE V - DEFINITIONS

5.1 **"Accident"** shall mean an event occurring by chance, from an unknown cause or unexpected, unplanned event causing loss or injury. It would not include conditions caused by routine bodily movements.

5.2 **"Actively At Work"** You will be considered Actively At Work on each day you are actually performing services for the Employer on a full time basis either at your Employer's place of business or at some location to which you are required to travel for your Employer's business and on each day of a regular paid vacation or on a regular non-working day, provided you were actively at work on the last preceding regular working day. You will also be deemed in "active employment" on any day on which you are absent from work during an approved FMLA leave or solely due to your own health status. An exception applies only to your first scheduled day of work. If you do not report for employment on your first scheduled workday, you will not be considered as having commenced active employment.

5.3 **"Alternative Birthing Centers"** and like terms means an institution, which is not a Hospital, but a place where births take place following normal, uncomplicated pregnancies. Such centers must be:

a. constituted, licensed, and operated as set forth in the laws that apply, where required;
b. equipped with those items needed to provide low risk maternity care;
c. adequately staffed with personnel who are qualified and, where required, licensed, and who:
    i. provide care at childbirth; and
    ii. are practicing within the scope of their training and experience; and
d. equipped and ready to initiate emergency procedures in life threatening events to mother and baby.

5.4 **"Coronary Care Unit"** means a special ward in a hospital which has been designated as a Coronary Care Unit by the hospital, maintained on a 24 hour basis, operating solely for the accommodation of acute cardiac patients, equipped to provide those special nursing, cardiac monitoring and medical services which are not available in the hospital's surgical recovery room or regular public, semi-private rooms. The patient's confinement must be dependent upon his need for all of these services available in the Coronary Care Unit and is not primarily dependent upon his need for certain of these services such as private nursing care.

5.5 **"Cosmetic Surgery or Treatment"** means surgery or other treatment for the purpose of Improving one's appearance.

5.6 **"Custodial Care"** means care provided primarily for the maintenance of the patient or which is designed essentially to assist the patient in meeting his activities of daily living, and which is not primarily provided for its therapeutic value in the treatment of a sickness or accidental bodily injury. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medications not requiring constraint.

5.7 **"Deductible"** means a set amount of covered charges that must be paid by the covered individual.

5.8 **"Dependent"** as used herein means an employee's legal spouse, registered domestic partner and an employee's unmarried dependent child (natural, adopted, stepchild and legal ward) from birth to age 26. In no event shall a person be considered a dependent if they are a member of the armed forces.

5.9 **"Employee"** as used herein means any employee who is or becomes eligible in accordance with the eligibility requirements of the Group Plan.

5.10 **"Enrollment Date"** is the date an individual becomes covered under the Plan or the first day of the waiting period for such coverage, if any.

5.11 **"Evidence of Good Health"** means the process of completing a medical questionnaire to determine the medical condition of the applicant.

5.12 **"Experimental or Investigational"** means care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical treatment under the standards of the case and by standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. When making an independent evaluation of the experimental/non experimental standings of specific technologies, the Plan Administrator will be guided by the following principles:

a. the device, drug or medicine cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing the condition being treated has not been given at the time the device, drug or medicine is furnished; or
b. the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, if federal law requires such review or approval; or
c. reliable evidence shows the treatment, procedure, device, drug or medicine is 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 diagnosis; or
d. reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

5.13 **"Hospital"** means:

a. an institution operated pursuant to law for the care and treatment of sick and injured persons, under the supervision of one or more licensed physicians, which:
    i. provides 24 hour nursing care on a resident inpatient basis; and

ii. has organized facilities both for diagnosis and for surgery (for mental and nervous conditions only, surgical facilities are not necessary); or

b. a properly licensed alcoholism or substance abuse treatment facility.

The term "Hospital" is not meant to include:

a. a rest home, nursing home, place for custodial care, home for the aged, or
b. an institution operated by a state, county or city for the care of the mentally ill, or any governmental agency of the United States or Canada.

5.14 **"Injury"** means bodily injury caused by an accident resulting directly and independently of all other causes of loss covered by this Plan.

5.15 **"Intensive Care Unit"** means a special ward in a hospital which has been designated as an Intensive Care Unit by the hospital, maintained on a 24 hour basis, operating solely for the accommodation of acutely ill patients, equipped to provide those special nursing and medical services which are not available in the hospital's surgical recovery room or regular public, semi-private or private rooms. The patient's confinement must be dependent upon his need for all of these services available in the Intensive Care Unit and is not primarily dependent upon his need for certain of these services such as private nursing care.

5.16 **"Intermediate Care Unit"** means a special ward in a hospital which has been designated as an Intermediate Care Unit by the hospital, maintained on a 24 hour basis, operating solely for the accommodation of patients who do not require the care and monitoring available in Intensive or Coronary Care Units, but do require special nursing and monitoring which is not available in the hospital's surgical recovery room or regular public semi-private or private rooms. The patient's confinement must be dependent upon his need for all the services available in the Intermediate Care Unit and is not primarily dependent upon his need for certain of these services such as private nursing care.

5.17 **"Late Enrollee"** is an eligible individual who declines coverage at the time of initial enrollment and subsequently requests enrollment in the Plan.

5.18 **"Life Threatening"** is the sudden onset of a medical condition with symptoms so severe that failure to secure immediate medical attention could result in:

a. a person's life being in immediate jeopardy; or
b. serious medical consequences/repercussions; or
c. serious impairment of bodily functions; or
d. serious and permanent dysfunction of an organ or body part.

5.19 **"Lifetime"** in reference to benefit maximums and limitations, means while covered under this Plan. Under no circumstances does "Lifetime" mean during the lifetime of the Covered Person.

5.20 **“Material modification”** includes any modification to the coverage offered under a plan or policy that, independently, or in conjunction with other contemporaneous modifications or changes, would be considered by an average plan participant (or in the case of individual market coverage, an average individual covered under a policy) to be an important change in covered benefits or other terms of coverage under the plan or policy. A material modification could also be a material reduction in covered services or benefits (as defined in Department of Labor Reg. Section 2520.104b-3(d)(3)) or more stringent requirements for receipt of benefits. As a result, this includes changes or modifications that reduce or eliminate benefits, increase premiums and cost-sharing, or impose a new referral requirement.

5.21 **“Medical Emergency”** means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular, accidents,

poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

5.22 **"Medically Necessary or Medical Necessity"** means health care services, supplies or treatment which, in the judgment of the attending Physician, is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the Covered Person's condition or the quality of medical care provided.

5.23 **"Mental or Nervous Disorder"** means an emotional or mental condition characterized by abnormal functioning of the mind or emotions, and in which psychological, intellectual, and emotional disturbances are the dominating factor. For the purpose of determining benefits, "Mental or Nervous Disorder'' also includes drug addiction and alcoholism.

5.24 **"Morbid Obesity"** is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the covered person.

5.25 **"Other Providers"** includes licensed vocational nurse; licensed practical nurse, registered nurse; licensed psychiatric nurse; visiting nurse association; certified nurse anesthetist; certified nurse midwife; prosthetist or prosthetist-orthotist; approved surgi-center; hemodialysis or physician directed outpatient clinic; alternative birthing center; portable x-ray company; lay-owned independent laboratory; laboratory technician; blood bank; licensed physical therapist; licensed occupational therapist; licensed speech therapist or pathologist; licensed acupuncturist; speech and hearing center; dental laboratory; dental supply company; dental technician; home health agency; ambulance company; marriage, family, child counselor (MFCC); licensed clinical social worker (LCSW).

5.26 **"Physician"** means a legally qualified physician or surgeon licensed by the recognized licensing authority of the state in which he/she practices and acting within the scope of his/her license. The term also includes a licensed dentist, podiatrist, chiropractor, psychiatrist, psychologist and Christian Science practitioners practicing within their respective fields.

5.27 **"Plan Year"** is 12 months after the Effective Date and then each year thereafter.

5.28 **"Preventative Care"** means treatment where no illness or injury is present, including well childcare and routine physical exams.

5.29 **"Reliable Evidence"** means 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 treatment procedure, device, drug or medicine; or written' informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

5.30 **"Sickness"** means disease, illness, bodily infirmity, pregnancy, hernia of any kind, or infection other than that occurring with and as result of an injury.

5.31 **"Skilled Nursing Facility"** means licensed institution (other than a Hospital, as defined) that specializes in:

a. physical rehabilitation on an inpatient basis; or
b. skilled nursing and medical care on an inpatient basis; but only if that institution:
    i. maintains on the premises all facilities necessary for medical treatment;
    ii. provides such treatment, for compensation, under the supervision of Physicians; and
    iii. provides Nurses' services.

5.32 **"Total Disability or Totally Disabled"** means a physical or mental state resulting from an illness or injury which wholly prevents:

a. in the case of an employee, that employee from engaging in his/her own business or occupation for profit;
b. in the case of a dependent(s), the dependent(s) from performing the normal activities of a person of like age and sex.

5.33 **"Usual and Customary"** services and / or materials shall mean services and materials that are generally accepted in the United States as being necessary and appropriate for the treatment of the sickness or injury. Usual and Customary charges shall mean the general level of charges being made by other providers of similar standing in the locality where the charge is incurred when furnishing comparable treatment, services or supplies.

ARTICLE VI - MEDICAL PLAN FOR ELIGIBLE EMPLOYEES AND DEPENDENTS

Anthem Blue Cross - PANEL PROVIDER PROGRAM

FOR PPO VERIFICATION OF A PHYSICIAN, YOU MAY ACCESS THE ANTHEM WEBSITE AT:
www.anthem.com

This Plan provides a Panel Provider Option. Covered employees and dependents retain complete freedom to visit any health care facility and still be covered under the group benefits. Employees can go on line to obtain a directory of physicians and hospitals associated with Anthem. However, increased benefits may apply only when Anthem affiliated doctors, hospitals and other professional providers (hereafter referred to as PPO providers) are used.

The Hospital Pre-Certification requirements described herein apply to both PPO and Non-PPO hospitals.

Refer to the Schedule of Benefits for deductible and benefit percentage information.

6.1 TREATMENT BY NON-PPO PROVIDERS

Benefits for persons who live within the PPO Service Area and do not utilize PPO providers will be paid at the Non-PPO Provider percentage shown in the Schedule of Benefits.

Under the following circumstances, the higher PPO Provider percentage will be made for certain Non-PPO Participating services:

- Benefits for persons who live within the PPO Service Area and do not utilize a PPO provider because of a non-scheduled, life-threatening emergency, (including when traveling outside the PPO Service Area) will be paid at the PPO Provider percentage shown in the Schedule of Benefits.

- Benefits for persons who live inside the PPO Service Area or do not utilize a PPO provider because after thorough evaluation by the Plan it is determined that there is no PPO provider which can provide the required level of medical care, will be paid at the PPO provider percentage shown in the Schedule of Benefits.

- If a person, while using PPO providers (i.e., hospital and surgeon), incurs Non-PPO expenses, those Non-PPO expenses will be paid at the PPO percentage shown in the Schedule of Benefits. This pertains only to expenses incurred in a PPO hospital (inpatient or outpatient).

Benefits for persons who live outside the PPO Services Area and do not utilize PPO providers will be paid at the Non-PPO provider percentage shown in the Schedule of Benefits.

Referrals to a Non-PPO provider are covered as Non-PPO services or supplies. It is the responsibility of the patient to assure services to be rendered are performed by PPO physicians and facilities in order to receive the PPO level of benefits.

6.2 INPATIENT HOSPITAL PRE-CERTIFICATION / CONTINUED STAY REVIEW

Pre-Certification by Anthem on all non-emergency inpatient admissions is required prior to admission. Emergency admissions require notification within **48 HOURS** or no later than the second business day following weekend or holiday admissions.

Note: Emergency admissions means an admission which occurs suddenly or unexpectedly and the covered individual must be treated within 48 hours to avoid an immediate threat to his or her life, limb or organ function.

The covered person, or his doctor must also initiate a continued stay review whenever it is medically necessary to change the authorized length of a hospital stay. This must be done before the end of the previously authorized length of stay.

OUTPATIENT SURGERY PRE-CERTIFICATION

Pre-Certification by Anthem on certain Outpatient Surgical Procedures is required prior to services rendered.

If the covered individual does not obtain certification for a covered medical expense as required, benefits will be reduced or not paid as set forth in the plan document. Furthermore, the difference between the amount paid by the plan on the covered expense cannot be used to satisfy the covered individual's maximum out-of-pocket for covered medical expenses limitation.

Pre-Certification does not guarantee benefit payment. Benefits are subject to covered person's eligibility and all provisions of the plan.

MATERNITY / DELIVERY ADMISSIONS - No pre-certification is required for a minimum length of stay of 48 hours following normal delivery, or a 96 hour hospital stay following a caesarean section delivery. If additional days are medically necessary, pre-certification must be obtained. *Federal law generally does not prohibit the mother's or newborn attending physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours as applicable.*

BENEFIT PERCENTAGES WILL BE REDUCED
IF REQUIRED PRE-CERTIFICATIONS ARE NOT OBTAINED

The Pre-Certification Telephone Number is: (800) 274-7767

6.3 DESCRIPTION OF MEDICAL BENEFITS

If the covered person incurs charges for necessary medical care, services or supplies as the result of sickness or accidental bodily injury, and when the services and supplies are under the direction of a physician, the Plan will pay benefits as indicated below subject to the deductible and eligible charge provisions.

Usual, Customary and Reasonable Provision

Benefits will not be paid for charges in excess of the Usual, Customary and Reasonable charge, as determined by the Plan Administrator, and amounts over and above the benefit limits.

In the event of discounted billings where neither the Plan nor the Covered Individual is responsible for the discounted amount, the adjusted total shall be the amount subject to this Usual, Customary and Reasonable provision.

SCHEDULE OF MEDICAL BENEFITS PPO PLAN

If the covered person incurs charges for necessary medical care, services or supplies as the result of sickness or accidental bodily injury, and when the services and supplies are under the direction of a physician, the Plan will pay benefits as indicated below subject to the deductible and eligible charge provisions.

MAXIMUM LIFETIME BENEFIT PER PERSON ..... Unlimited

Major Medical Benefits

Covered expenses are subject to the deductible and applicable benefit percentage (unless otherwise noted).

DEDUCTIBLE PER PERSON PER CALENDAR YEAR IN NETWORK $1,000
DEDUCTIBLE PER PERSON PER CALENDAR YEAR OUT OF NETWORK $2,000

DEDUCTIBLE PER FAMILY PER CALENDAR YEAR IN NETWORK $2,000
DEDUCTIBLE PER FAMILY PER CALENDAR YEAR OUT OF NETWORK.....$4,000

BENEFIT PERCENTAGES

Eligible Expenses:
(unless otherwise noted)

PPO Provider 90%
Non-PPO Provider 70%

The calendar year individual out of pocket limit when using PPO providers is $2,400. The calendar year family out of pocket limit when using PPO providers is $4,800. The calendar year individual out of pocket limit when using non-PPO providers is $4,800. The calendar year family out of pocket limit when using non-PPO providers is $9,600.

After the out of pocket limit has been reached, eligible medical expenses incurred by a covered individual during that same calendar year are paid at 100% of covered charges.

In Network expenses incurred for the following **CANNOT** be applied toward the out-of-pocket limit:

1. the penalty amount;
2. any charge excluded in Limitations and Exclusions;

Out of Network expenses incurred for the following **CANNOT** be applied toward the out-of-pocket limit:

1. the deductible;
2. co-payments;
3. the penalty amount;
4. any charge excluded in Limitations and Exclusions;

Note: The deductible, out-of-pocket limit and maximums are separate for the PPO and Non-PPO providers.

BENEFIT PERCENTAGES WILL BE REDUCED
IF COST CONTAINMENT FEATURES ARE NOT FOLLOWED

The Pre-Certification Telephone Number is: (800) 274-7767
FOR PPO VERIFICATION OF A PHYSICIAN, YOU MAY ACCESS THE ANTHEM WEBSITE AT:
www.anthem.com

SCHEDULE OF MEDICAL BENEFITS PPO PLAN

Benefit Description	Annual Deductible	PPO Plan Pays	Non-PPO Plan Pays	Limitations Or Explanations
Alcoholism & Substance Abuse	Yes	90%	70%	Inpatient Care **Admission to a Non-PPO hospital is subject to a $2,500 co-pay per admission.** **Pre-Certification required.** Office Care
Office Visit	Yes	100% after a $20 co-pay	70%	**Pre-Certification is not required for Office Care.**
Mental / Nervous Conditions	Yes	90%	70%	Inpatient Care **Admission to a Non-PPO hospital is subject to a $2,500 co-pay per admission.** **Pre-Certification required.** Office Care
Office Visit	Yes	100% after a $20 co-pay	70%	**Pre-Certification is not required for Office Care.**
Autism Spectrum Disorder	Yes	90%	70%	Inpatient Care **Admission to a Non-PPO hospital is subject to a $2,500 co-pay per admission.** **Pre-Certification required.** Office Care
Office Visit	Yes	100% after $20 co-pay	70%	**Pre-Certification is not required for Office Care.**

Note: In a case of a hospitalization consisting of "partial" days, 2 partial days will be considered as 1 full day of inpatient care. A partial day is defined as a minimum of 6 hours per day of hospitalization. Anything less than 6 hours per day will be paid under the outpatient benefits of the Plan.

SCHEDULE OF MEDICAL BENEFITS PPO PLAN

Benefit Description	Annual Deductible	PPO Plan Pays	Non-PPO Plan Pays	Limitations or Explanations
Inpatient Hospital Services	Yes	90%	70%	**Admission to a Non-PPO hospital is subject to a $2,500 co-pay per admission.** **Pre-Certification required.**
Outpatient Hospital Services	Yes	90%	70%	**Pre-Certification required for certain Outpatient Surgeries**
Emergency Room Visit	Yes	90%	90%	Simple x-rays due to an accidental injury occurring after 5:00 PM will be covered at 100% after a $25 copayment.
Urgent Care Centers **PPO** **Non-PPO**	 No Yes	100% after a $50 co-pay	70%	This benefit applies to all services rendered in an Urgent Care Facility. The $50 co-pay does not apply toward the deductible. If a Non-PPO provider is used, the Plan pays subject to the deductible and benefit percentage.

MAXIMUM COVERED CHARGES FOR ROOM AND BOARD

Hospital Room..... Semi-Private Rate

- A private room will be covered only when medically necessary.

Intensive Care Unit, Coronary Care Unit, or Intermediary Care……Usual and Customary

Skilled Nursing Facility ……..... Semi-Private Rate

- Coverage limited to 90 days of confinement during any one calendar year. Confinement must begin within 14 days of a hospital stay of at least 3 consecutive days.

ALL INPATIENT HOSPITAL STAYS REQUIRE PRE-CERTIFICATION:

- MANDATORY INPATIENT HOSPITALIZATION REVIEW - With Hospital pre-certification, regular plan benefits apply; **without Hospital pre-certification benefits are subject to an ADDITIONAL DEDUCTIBLE of $500.00 per admission.**

- CONTINUED STAY REVIEW - For any hospital admission, if a covered person stays in the hospital longer than UHN authorized, **benefits for covered hospital charges incurred after the authorized length of stay WILL BE REDUCED by 50%.**

BENEFIT PERCENTAGES WILL BE REDUCED IF REQUIRED PRE-CERTIFICATIONS ARE NOT OBTAINED

The Pre-Certification Telephone Number is: (800) 274-7767

FOR PPO VERIFICATION OF A PHYSICIAN, YOU MAY ACCESS THE ANTHEM WEBSITE AT: www.anthem.com

SCHEDULE OF MEDICAL BENEFITS PPO PLAN

Benefit Description	Annual Deductible	PPO Plan Pays	Non-PPO Plan Pays	Limitations or Explanations
Ambulance **PPO** **Non-PPO**	 No Yes	100% after $250 co-pay	 70%	Air and/or ground.
Chiropractic Care **PPO** **Non-PPO**	No Yes	100% after a $20 co-pay	 70%	Only initial x-rays are covered – x-rays are subject to a $25 co-pay
Acupuncture **PPO** **Non-PPO**	No Yes	100% after a $20 co-pay	 70%	Benefits are subject to a calendar year maximum of $1,500.
Nutritional Counseling **PPO** **Non-PPO**	 Yes Yes	90%	 70%	
Clinical Trials	Yes	90%	70%	
Diagnostic X-Ray and Laboratory **PPO** **Non-PPO**	 No Yes	100% after a $25 co-pay	 70%	Services provided at a hospital or freestanding facility

Benefit Description	Annual Deductible	PPO Plan Pays	Non-PPO Plan Pays	Limitations or Explanations
High Tech Radiology (including MRI's and Cat Scans)				
PPO	No	100% after a $100 co-pay		
Non-PPO	Yes		70%	
Sleep Studies	Yes	90%	70%	
Durable Medical Equipment	Yes	90%	70%	Rental not to exceed purchase price.
Home Health Care	Yes	90%	70%	
Hospice Care				
Inpatient	Yes	90%	70%	Includes family bereavement counseling ($500 Calendar Year maximum).
Outpatient	Yes	90%	70%	
Immunizations/ Inoculations	No	100%	100%	
Maternity	Yes	90%	70%	Treated the same as any other illness. Not a benefit for dependents other than the spouse.
Office Visits				This benefit applies to all services rendered in a physician's office.
PPO	No	100% after a $20 co-pay		
Non-PPO	Yes		70%	The $20 co-pay does not apply toward the deductible or the out-of-pocket maximum. If a Non-PPO provider is used, the Plan pays subject to the deductible and benefit percentage.
Pre-Admission Testing	No	100%	100%	Must be performed within 2 weeks of the admission.

SCHEDULE OF MEDICAL BENEFITS PPO PLAN

Benefit Description	Annual Deductible	PPO Plan Pays	Non-PPO Plan Pays	Limitations or Explanations
Outpatient Rehabilitation (Occupational, Physical and Speech Therapy)	Yes	90%	70%	
Preventive Health Services As stated under the United States Preventive Services Task Force recommendations.	No	100%	100%	Includes the following genetic tests when billed as preventive: BRAC testing and HPV DNA for participants over age 30
Mammograms	No	100%	100%	Baseline mammograms for covered females aged 35 through 39, and annual mammograms for covered females aged 40 and over
Well Baby Care	No	90%	70%	Benefits are for newborn charges in the hospital.
Well Child Care	No	100%	100%	Benefits are payable for covered individuals with no age limit.
Second Surgical Opinion	No	100%	100%	Includes the exam and required testing. Service is required at the discretion of Anthem.
Skilled Nursing Facility	No	90%	70%	Confinement must begin within 14 days of a hospital stay of at least 3 consecutive days.
Surgery (In or Outpatient)	Yes	90%	70%	Pre-Certification Required for certain surgeries
TMJ	Yes	90%	70%	Requires pre-authorization.
Family Planning for Women:	PPO Services – No Non-PPO Services - Yes	100%	70%	All forms of contraceptive services performed in a Physician's or Surgical Facility. Services include Tubal Ligation.
All Other Covered Medical Expenses	Yes	90%	70%	Includes but is not limited to hospital and physician charges out of the network area, and any other covered plan service.

SCHEDULE OF PHARMACY BENEFITS PPO PLAN

	Retail Pharmacy 34 Day Supply	Kroger affiliated Retail - Option 90 Day Supply	Postal Prescription Services Mail Order	Specialty Medications 30 Day Supply
Generic copay	$10.00	$20.00	$20.00	$50.00
Preferred Brand Copay	$25.00	$50.00	$50.00	$100.00
Non-Formulary Brand Copay	$45.00	$90.00	$90.00	$150.00

Kroger Adhere 90 Program (Residence of the Greater Las Vegas Metropolitan Area and any Kroger Affiliated Pharmacies)

Maintenance medications are commonly prescribed and taken continuously to manage chronic conditions such as high blood pressure, asthma, diabetes and high cholesterol. Adhere 90 is a program that requires members to receive a 90-day supply for certain maintenance medications. Visit our website at www.kpp-rx.com to view the list of Adhere 90 maintenance medications.

Adhere 90 Day Supply medications are required to be filled at Kroger affiliated Retail Option 90 Day Supply Pharmacy or through Postal Prescriptions Mail Order. You are allowed 2 grace fills at a retail pharmacy. Your plan offers reduced copays for a 90 Day Supply which will save you and your plan money.

Visit our website at www.kpp-rx.com and use the pharmacy locator tool to find a Kroger affiliated Pharmacy near you.

To register for mail order, visit www.ppsrx.com to create an account or call 800.552.6694. Once you are registered, your doctor can submit your prescriptions or send in your prescription by mail.

Brand drugs with Generic Equivalents
There are several Brand medications on the market that have generic equivalents. The generic equivalents have the same active ingredients as their brand counterparts. If you or your physician choose a brand drug with a generic equivalent, you will pay the brand copay plus the difference in cost between the brand medication and the generic equivalent. Consider talking to your physician to see if the generic equivalent is an option for you. The generic equivalent is offered under the generic copay.

Reference Bases Pricing Program (RBP)
Many brand and generic medications have lower cost alternative(s) that are FDA-approved that provide therapeutically similarly results. This program applies to only certain drug conditions such as cholesterol, heartburn, high blood pressure, migraines, osteoporosis, muscle relaxers, and acne. View our website at www.kpp-rx.com, login and/or register to view the formulary with the table of Reference Based Pricing Preferred alternatives. See the following options below:

Your Option	Things to Consider	What You Will Pay
1) **Continue to use your current prescription**	• **You may have to pay more** • **Your costs will change as the price of the medication changes**	• **The plan will contribute a set amount towards your medication. You will be responsible for the copay plus remaining cost of the medication.**
2) **Switch to a lower-cost therapeutic alternative or preferred medication**	• **You may have several options, depending on the condition** • **Talk to your provider**	• **If you choose the preferred medication, you pay the regular copay**

3) **Ask your provider to file a Medication Request Form**	• **If you have tried the alternative, or there are contraindications, you or your provider may request an exception**	• **If your Medication Request Form is approved, you pay the regular copay**

Why these changes were made
Rising drug cost place a strain on the health care system, including employers and consumers. Our goal is to provide high-quality, high-value benefits plans for our members. We want to keep prescription coverage affordable for everyone.

What can you do
Consider asking your pharmacist or physician if a generic option is available to you. Generics are proven to be safe, effective, less expensive and readily available. Did you know generic drugs have the same active ingredients and are approved by the FDA as their brand counterparts? Generics can save you and your employer money. Visit our website at www.kpp-rx.com to learn more about generics.

If you have questions, please reach out to Kroger Prescription Plans Member Services at 800.482.1285.

SCHEDULE OF MEDICAL BENEFITS HRA PLAN

If the covered person incurs charges for necessary medical care, services or supplies as the result of sickness or accidental bodily injury, and when the services and supplies are under the direction of a physician, the Plan will pay benefits as indicated below subject to the deductible and eligible charge provisions.

HEALTH REIMBURSEMENT ACCOUNT

INTRODUCTION

Effective January 1, 2011, the Employer has established a Health Reimbursement Account (the "HRA") in conjunction with **the Plan** to provide Covered Persons with additional health coverage benefits under the Plan. The benefits available under the HRA are outlined below. The HRA is not insured and benefits are paid from the general assets of the Employer.

I. ELIGIBILITY

1. What Are The Eligibility Requirements For The HRA?

Employees or Dependents who enrolled in the HRA medical benefits Plan and their dependents who are eligible to receive medical benefits under the Plan will be automatically enrolled in the Health Reimbursement Account once you have satisfied the conditions for coverage and become enrolled under the Plan. If an employee has family coverage under the medical benefits, then their Covered Dependents will be enrolled in the HRA at the same time.

2. When Is a Plan Participant's Entry Date?

Once the eligibility requirements are met, the entry date will be the day coinciding with the date the Plan Participant meets the eligibility requirements and becomes covered under the Plan.

3. Are There Any Employees Who Are Not Eligible?

Employees or Dependents who *are not* enrolled in the HRA Plan are not eligible to join the HRA.

4. Are There Any Dependents Who Are Not Eligible?

Dependents who *are not* eligible to receive medical benefits under the Plan are not eligible to join the HRA.

II. BENEFITS

1. What Benefits Are Available?

For Plan participants, the Employer is setting aside funds in an employer held account on January 1st of each year. If Plan Participants are participating in the health Plan on January 1st, Plan Participants will have access to the full amount of the funds set aside on the Employee's and Dependent's behalf. If the Employee is employed or participates in the plan after January 1st, the Employee will receive a prorated amount based on the Employee's date of hire or date the Plan Participants began participating in the Plan. The prorated formula will provide 1/12 of the amount times the number of full and partial months that remain in the Calendar Year as of the Employee's date of hire or the date the Plan Participants participate in the Plan if after January 1st of each year. Currently, the Employer sets aside $1,000 for single members and $2,000 for families per Calendar Year. The HRA allows Plan Participants to be reimbursed from this account for certain out-of-pocket medical, pharmacy, dental and vision expenses which are incurred by Plan Participants. The expenses which qualify for reimbursement are those permitted by Section 213 of the Internal Revenue Code, without regards to the limitation contained in subsection (a).

2. What Expenses Will the HRA Reimburse?

The HRA will reimburse Plan coinsurance, deductibles and Usual and Reasonable charges for Plan Participants. Listed below are some-additional Section 213 expenses that qualify for reimbursement:

Acupuncture
Alcoholism Treatment
Ambulance
Artificial Limb
Artificial Teeth
Bandages
Birth Control Pills
Breast Reconstruction Surgery - (post-mastectomy only)
Chiropractor
Contact Lenses & Solution
Crutches
Dental/Orthodontic Treatment
Diagnostic Devices (i.e. blood Sugar test kits for diabetics)
Drug Addiction Treatment
Eyeglasses
Eye Examinations
Eye Surgery
Psychoanalysis
Fertility Enhancement (some treatments excluded)
Guide Dog or Guide Animal
Hearing Aids
Hospital Service
Laboratory Fees
Laser Eye Surgery
Medicare Part A and B
Medicines (prescribed)
Nursing Home
Nursing Services
Operations
Optometrist
Organ Donors
Osteopath
Oxygen
Prosthesis
psychiatric Care (including cost for residential care)
X-Rays
Psychologist
Sterilization
Stop-Smoking Programs
Surgery
Therapy
Transplants
Transportation (treatment related)
Trips (for treatment)
Tuition (special education only)
Vasectomy
Vision Correction
Weight-loss programs – (only if prescribed)
Weight-loss foods (only if prescribed)
wheelchair
Wheelchair Maintenance

The maximum allowed reimbursement is the Plan Participant's accumulated account balance. Account balances accumulate at $1,000 for one or more dependents. If the employee has the HRA Plan, the maximum reimburse for single coverage is $1,000 and family coverage is $2,000.

New Plan Participants and Plan Participants who had previously waived coverage and then joined the Plan mid-year will have pro-rated benefits.

The pro-rated formula will provide 1/12 of the amount times the number of full and partial months the Covered Person is on the Plan.

Any unused amounts from a prior Coverage Period carry over to the next Coverage Period. Once the account balance is depleted, no further reimbursement will be made until additional funds accumulate. If an Employee terminates employment, Plan Participants will lose any unused amounts unless you are eligible for and elect COBRA coverage in accordance with the COBRA procedures set forth under the Plan and by the Plan Administrator.

3. When Must Expenses Be Incurred?

Expenses are considered "incurred" when the service is performed, not necessarily when it is paid. Any amounts reimbursed to Plan Participants under the HRA may not be claimed as a deduction on personal income tax returns nor reimbursed by other health plan coverage.

Plan Participants may submit expenses that you incur each "Coverage Period." A new "Coverage Period" begins each Plan Year. Plan Participants are not eligible for reimbursement under the HRA for expenses incurred in a prior Plan Year.

4. When Will Plan Participants Receive Payments From the Plan?

During the course of the Coverage Period, Plan Participants may submit requests for reimbursement of expenses Plan Participants have incurred. In addition, Plan Participants must submit to the Plan Administrator proof of the expenses Plan Participants have incurred and that Plan Participants have not been paid by any other health plan coverage. If the request qualifies as a benefit or expense under the HRA Plan Participants or Plan Participants' providers will receive a reimbursement payment.

Reimbursements made from the HRA are generally not subject to federal income tax or Social Security taxes.

5. How to Submit a Claim under the HRA

Any claims submitted under the Medical and Dental Plans will automatically be submitted to the HRA Account for reimbursement if any portion of the claim is the Plan Participant's liability.

All Claims for a Coverage Period must be submitted no later than March 31 following the end of the Coverage Period for which the Claim was incurred. The following are the claims procedures to follow for reimbursement of expenses under the HRA.

When Plan Participants have a Claim to submit for payment, Plan Participants must:

(1) Obtain a claim form from the Plan Administrator.

(2) Complete the Employee portion of the form.

(3) Attach copies of all bills from the service provider for which Plan Participants are requesting reimbursement.

6. What are Plan Participant's appeal rights if their HRA Claim is denied?

A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit Claims.

7. COBRA

COBRA continuation coverage is available for the HRA in conjunction with the Medical Plan, subject to the provisions and requirements set forth under the Plan, the Continuation Coverage Rights under the COBRA section of the Summary Plan Description, and rules established by the Plan Administrator.

SCHEDULE OF MEDICAL BENEFITS HRA PLAN

MAXIMUM LIFETIME BENEFIT PER PERSON ..... Unlimited

Major Medical Benefits

Covered expenses are subject to the deductible and applicable benefit percentage (unless otherwise noted).

DEDUCTIBLE PER PERSON PER CALENDAR YEAR IN NETWORK $3,000
DEDUCTIBLE PER PERSON PER CALENDAR YEAR OUT OF NETWORK $6,000

DEDUCTIBLE PER FAMILY PER CALENDAR YEAR IN NETWORK $6,000
DEDUCTIBLE PER FAMILY PER CALENDAR YEAR OUT OF NETWORK.....$12,000

BENEFIT PERCENTAGES

Eligible Expenses:
(unless otherwise noted)

PPO Provider 90%
Non-PPO Provider 70%

The calendar year individual out of pocket limit when using PPO providers is $4,800. The calendar year family out of pocket limit when using PPO providers is $9,600. The calendar year individual out of pocket limit when using non-PPO providers is $9,600. The calendar year family out of pocket limit when using non-PPO providers is $19,200.

After the out of pocket limit has been reached, eligible medical expenses incurred by a covered individual during that same calendar year are paid at 100% of covered charges.

In Network expenses incurred for the following **CANNOT** be applied toward the out-of-pocket limit:

3. the penalty amount;
4. any charge excluded in Limitations and Exclusions;

Out of Network expenses incurred for the following **CANNOT** be applied toward the out-of-pocket limit:

5. the deductible;
6. co-payments;
7. the penalty amount;
8. any charge excluded in Limitations and Exclusions;

Note: The deductible, out-of-pocket limit and maximums are combined for both PPO and Non-PPO providers.

BENEFIT PERCENTAGES WILL BE REDUCED
IF COST CONTAINMENT FEATURES ARE NOT FOLLOWED

The Pre-Certification Telephone Number is: (800) 274-7767
FOR PPO VERIFICATION OF A PHYSICIAN, YOU MAY ACCESS THE ANTHEM WEBSITE AT: www.anthem.com

SCHEDULE OF MEDICAL BENEFITS HRA PLAN

Benefit Description	Annual Deductible	PPO Plan Pays	Non-PPO Plan Pays	Limitations Or Explanations
Alcoholism & Substance Abuse	Yes	90%	70%	Inpatient Care **Admission to a Non-PPO hospital is subject to a $2,500 co-pay per admission.** **Pre-Certification required.** Office Care
Office Visit	Yes	90%	70%	**Pre-Certification is not required for Office Care.**
Mental / Nervous Conditions	Yes	90%	70%	Inpatient Care **Admission to a Non-PPO hospital is subject to a $2,500 co-pay per admission.** **Pre-Certification required.** Office Care
Office Visit	Yes	90%	70%	**Pre-Certification is not required for Office Care.**
Autism Spectrum Disorder	Yes	90%	70%	Inpatient Care **Admission to a Non-PPO hospital is subject to a $2,500 co-pay per admission.** **Pre-Certification required.**
Office Visit	Yes	90%	70%	Office Care **Pre-Certification is not required for Office Care.**

Note: In a case of a hospitalization consisting of "partial" days, 2 partial days will be considered as 1 full day of inpatient care. A partial day is defined as a minimum of 6 hours per day of hospitalization. Anything less than 6 hours per day will be paid under the outpatient benefits of the Plan.

SCHEDULE OF MEDICAL BENEFITS HRA PLAN

Benefit Description	Annual Deductible	PPO Plan Pays	Non-PPO Plan Pays	Limitations or Explanations
Inpatient Hospital Services	Yes	90% **Services at CHW hospitals in Las Vegas are excluded unless deemed a true medical emergency. Patient must be transferred to an approved network facility as soon as the patient is medically stabilized.**	70%	**Admission to a Non-PPO hospital is subject to a $2,500 co-pay per admission.** **Pre-Certification required.**
Outpatient Hospital Services	Yes	90% **Services at CHW hospitals in Las Vegas are excluded unless deemed a true medical emergency. Patient must be transferred to an approved network facility as soon as the patient is medically stabilized.**	70%	**Pre-Certification required for certain Outpatient Surgeries.**
Emergency Room Visit	Yes	90%	90%	
Urgent Care Centers	Yes	90%	70%	

MAXIMUM COVERED CHARGES FOR ROOM AND BOARD

Hospital Room....…..........……………………..................……………………….……....... Semi-Private Rate

- A private room will be covered only when medically necessary.

Intensive Care Unit, Coronary Care Unit, or Intermediary Care………………………Usual and Customary

Skilled Nursing Facility ……………………………..............…………………….............. Semi-Private Rate

- Coverage limited to 90 days of confinement during any one calendar year. Confinement must begin within 14 days of a hospital stay of at least 3 consecutive days.

ALL INPATIENT HOSPITAL STAYS REQUIRE PRE-CERTIFICATION:

- MANDATORY INPATIENT HOSPITALIZATION REVIEW - With Hospital pre-certification, regular plan benefits apply; **without Hospital pre-certification benefits are subject to an ADDITIONAL DEDUCTIBLE of $500.00 per admission.**

- CONTINUED STAY REVIEW - For any hospital admission, if a covered person stays in the hospital longer than Anthem authorized, **benefits for covered hospital charges incurred after the authorized length of stay WILL BE REDUCED by 50%.**

BENEFIT PERCENTAGES WILL BE REDUCED IF REQUIRED PRE-CERTIFICATIONS ARE NOT OBTAINED

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SCHEDULE OF MEDICAL BENEFITS HRA PLAN

Benefit Description	Annual Deductible	PPO Plan Pays	Non-PPO Plan Pays	Limitations or Explanations
Ambulance	Yes	90%	70%	Air and/or ground.
Chiropractic Care	Yes	90%	70%	Only initial x-rays are covered.
Acupuncture	Yes	90%	70%	Benefits are subject to a calendar year maximum of $1,500.
Nutritional Counseling	Yes	90%	70%	
Clinical Trials	Yes	90%	70%	
Diagnostic X-Ray and Laboratory	Yes	90% **Services at CHW hospitals in Las Vegas are excluded unless deemed a true medical emergency. Patient must be transferred to an approved network facility as soon as the patient is medically stabilized.**	70%	
High Tech Radiology (including MRI's and Cat Scans)	Yes	90%	70%	**Pre-Certification required.**
Sleep Studies	Yes	90%	70%	
Durable Medical Equipment	Yes	90%	70%	Rental not to exceed purchase price.

Benefit Description	Annual Deductible	PPO Plan Pays	Non-PPO Plan Pays	Limitations or Explanations
Home Health Care	Yes	90%	70%	
Hospice Care				
Inpatient	Yes	90%	70%	
Outpatient	Yes	90%	70%	Includes family bereavement counseling ($500 Calendar Year maximum).
Immunizations/ Inoculations	No	100%	100%	
Maternity	Yes	90%	70%	Treated the same as any other illness. Not a benefit for dependents other than the spouse.
Office Visits	Yes	90%	70%	
Pre-Admission Testing	No	90%	70%	Must be performed within 2 weeks of the admission.

SCHEDULE OF MEDICAL BENEFITS HRA PLAN

Benefit Description	Annual Deductible	PPO Plan Pays	Non-PPO Plan Pays	Limitations or Explanations
Preventive Health Services As stated under the United States Preventive Services Task Force recommendations.	No	100%	100%	Includes the following genetic tests when billed as preventive: BRAC testing and HPV DNA for participants over age 30
Mammograms	No	100%	100%	Baseline mammograms for covered females aged 35 through 39, and annual mammograms for covered females aged 40 and over
Well Baby Care	No	90%	70%	Benefits are for newborn charges in the hospital.
Well Child Care	No	100%	100%	Benefits are payable for covered individuals with no age limit.
Second Surgical Opinion	No	100%	100%	Includes the exam and required testing. Service is required at the discretion of Anthem.
Skilled Nursing Facility	No	90%	70%	Confinement must begin within 14 days of a hospital stay of at least 3 consecutive days.
Surgery (In or Outpatient)	Yes	90%	70%	Pre-Certification Required for certain surgeries.
TMJ	Yes	90%	70%	Requires pre-authorization.
Family Planning for Women:	PPO Services – No Non-PPO Services – Yes	100%	70%	All forms of contraceptive services performed in a Physician's or Surgical Facility. Services include Tubal Ligation.
All Other Covered Medical Expenses	Yes	90%	70%	Includes but is not limited to hospital and physician charges out of the network area, and any other covered plan service.

SCHEDULE OF PHARMACY BENEFITS HRA PLAN

	Retail Pharmacy 34 Day Supply	Kroger affiliated Retail - Option 90 Day Supply	Postal Prescription Services Mail Order	Specialty Medications 30 Day Supply
Generic copay	$10.00	$20.00	$20.00	$50.00
Preferred Brand Copay	$25.00	$50.00	$50.00	$100.00
Non-Formulary Brand Copay	$45.00	$90.00	$90.00	$150.00

Kroger Adhere 90 Program (Residence of the Greater Las Vegas Metropolitan Area and any Kroger Affiliated Pharmacies)

Maintenance medications are commonly prescribed and taken continuously to manage chronic conditions such as high blood pressure, asthma, diabetes and high cholesterol. Adhere 90 is a program that requires members to receive a 90-day supply for certain maintenance medications. Visit our website at www.kpp-rx.com to view the list of Adhere 90 maintenance medications.

Adhere 90 Day Supply medications are required to be filled at Kroger affiliated Retail Option 90 Day Supply Pharmacy or through Postal Prescriptions Mail Order. You are allowed 2 grace fills at a retail pharmacy. Your plan offers reduced copays for a 90 Day Supply which will save you and your plan money.

Visit our website at www.kpp-rx.com and use the pharmacy locator tool to find a Kroger affiliated Pharmacy near you.

To register for mail order, visit www.ppsrx.com to create an account or call 800.552.6694. Once you are registered, your doctor can submit your prescriptions or send in your prescription by mail.

Brand drugs with Generic Equivalents
There are several Brand medications on the market that have generic equivalents. The generic equivalents have the same active ingredients as their brand counterparts. If you or your physician choose a brand drug with a generic equivalent, you will pay the brand copay plus the difference in cost between the brand medication and the generic equivalent. Consider talking to your physician to see if the generic equivalent is an option for you. The generic equivalent is offered under the generic copay.

Reference Bases Pricing Program (RBP)
Many brand and generic medications have lower cost alternative(s) that are FDA-approved that provide therapeutically similarly results. This program applies to only certain drug conditions such as cholesterol, heartburn, high blood pressure, migraines, osteoporosis, muscle relaxers, and acne. View our website at www.kpp-rx.com, login and/or register to view the formulary with the table of Reference Based Pricing Preferred alternatives. See the following options below:

Your Option	Things to Consider	What You Will Pay
4) **Continue to use your current prescription**	• **You may have to pay more** • **Your costs will change as the price of the medication changes**	• **The plan will contribute a set amount towards your medication. You will be responsible for the copay plus remaining cost of the medication.**
5) **Switch to a lower-cost therapeutic alternative or preferred medication**	• **You may have several options, depending on the condition** • **Talk to your provider**	• **If you choose the preferred medication, you pay the regular copay**

6) **Ask your provider to file a Medication Request Form**	• **If you have tried the alternative, or there are contraindications, you or your provider may request an exception**	• **If your Medication Request Form is approved, you pay the regular copay**

Why these changes were made
Rising drug cost place a strain on the health care system, including employers and consumers. Our goal is to provide high-quality, high-value benefits plans for our members. We want to keep prescription coverage affordable for everyone.

What can you do
Consider asking your pharmacist or physician if a generic option is available to you. Generics are proven to be safe, effective, less expensive and readily available. Did you know generic drugs have the same active ingredients and are approved by the FDA as their brand counterparts? Generics can save you and your employer money. Visit our website at www.kpp-rx.com to learn more about generics.

If you have questions, please reach out to Kroger Prescription Plans Member Services at 800.482.1285.

6.4 COST CONTAINMENT FEATURES FOR PPO AND HRA PLANS

The Major Medical Benefits in this Plan have been designed to encourage the covered individual to seek quality health care at a lower cost. The specific cost containment features under Major Medical Benefits are as follows:

1. **MANDATORY INPATIENT HOSPITALIZATION REVIEW** – With Hospital pre-certification, regular plan benefits apply; **without Hospital pre-certification benefits are subject to an ADDITIONAL DEDUCTIBLE of $500.00 per admission.**

2. **CONTINUED STAY REVIEW** – For any hospital admission, if a covered person stays in the hospital longer than authorized, **benefits for covered hospital charges incurred after the authorized length of stay WILL BE REDUCED by 50%.**

3. **OUTPATIENT SERVICES –** With pre-certification, regular plan benefits apply to services for TMJ treatment, Certain Outpatient Surgery, and Mental Health or Substance Abuse. Without pre-certification, benefits for covered services **WILL BE REDUCED by 50%.**

4. **SECOND SURGICAL OPINION – CALL ANTHEM** – The Second Surgical Opinion Benefit Percentage is 100% and is not subject to the annual deductible. This benefit includes the doctor's exam of the patient and required diagnostic testing.

    a. The consulting doctor must not be associated or in partnership with the original surgeon recommending the surgery.

    b. If a second surgical opinion is not obtained as required, the benefit percentage will **NEVER BE MORE THAN 50% for the surgeon's, assistant surgeon's and anesthesiologist's fees.** If Anthem Network waives the second opinion, the penalty will not apply.

BENEFIT PERCENTAGES WILL BE REDUCED IF COST CONTAINMENT FEATURES ARE NOT FOLLOWED

The Pre-Certification Telephone Number is: (800) 274-7767

6.5 SPECIAL CARE CASE MANAGEMENT

Special care case management is designed to help manage the care of patients who have special or extended care illnesses or injuries.

The primary objective of special care case management is to identify and coordinate cost effective medical care alternatives meeting accepted standards of medical practice. Special care case management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among health care providers, patients and others.

Benefits may be modified by the plan administrator to permit a method of treatment not expressly provided for, but not prohibited by law, rules or public policy, if the plan administrator determines that such modification is medically necessary and is more cost effective than continuing a benefit to which you or your eligible dependents may otherwise be entitled. The plan administrator also reserves the right to limit payment for services to those amounts that would have been charged

had the service been provided in the most cost effective setting in which the service could safely have been provided.

Examples of illnesses or injuries that may be appropriate for special care case management include, but are not limited to:

- Terminal Illnesses such as:
    - Cancer
    - AIDS
- Chronic Illnesses such as:
    - Multiple sclerosis
    - Renal failure
    - Obstructive pulmonary disease
    - Cardiac conditions
- Accident Victims Requiring Long-Term Rehabilitative Therapy
- Newborns with High Risk Complications or Multiple Birth Defects
- Diagnosis Involving Long-Term IV Therapy
- Illnesses Not Responding to Medical Care
- Child and Adolescent Mental / Nervous Disorders

6.7 **COVERED MEDICAL CHARGES**

1. Room and board and routine nursing for confinement in a Hospital or Skilled Nursing Facility as shown in the Schedule of Benefits;
2. Intensive, Coronary and Intermediate Care Units for each day of confinement in a hospital as shown in the Schedule of Benefits;
3. Medical services, supplies and medication furnished by the hospital;
4. Anesthetics and their administration;
5. Medical treatment given by or in the presence of a doctor if such treatment is within the scope of his or her license;
6. Services of a registered nurse (R.N) or licensed vocational nurse (L.V.N} for private duty nursing services;
7. Services of a licensed vocational nurse (L.V.N.) for private duty nursing services in a hospital;
8. Services of a licensed physiotherapist, licensed physical therapist or licensed occupational therapist;
9. Charges by a doctor or speech therapist for speech therapy due to an illness (other than a functional nervous disorder), or due to surgery on account of an illness. If the speech therapy

is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy;

10. X-ray exams (other than dental), lab tests and other diagnostic services;

11. X-ray and radiation therapy and chemotherapy;

12. Elective sterilization is covered as any other illness;

13. Charges for the repair of natural teeth (including their replacement) which are a result of and within 12 months of an accidental bodily injury which occurs while the person is covered;

14. Transportation provided by professional ambulance service or air ambulance to the nearest hospital able to provide the needed treatment;

15. Medical Supplies as follows:

    a. unreplaced blood and other fluids to be injected into the circulatory system;
    b. artificial limbs and eyes (initial purchase only of basic prosthetic devices) when necessitated as the result of an illness or injury, including 2 prosthetic devices following a mastectomy. Charges for replacement will be covered only when required because of a pathological change or the natural growth process, whether or not the original purchase occurred while covered. Charges for repair or maintenance are not included;
    c. casts, splints, trusses, braces, crutches and surgical dressings and supplies, when necessitated by an illness or injury while covered under this plan;
    d. purchase or rental of hospital-type equipment for kidney dialysis for the personal and exclusive use of the patient. The total purchase price to be eligible will be on a monthly pro-rata basis during the first 24 months of ownership but only so long as dialysis treatment continues to be medically required. The Plan will consider as eligible all charges for supplies, materials and repairs necessary for the proper operation of such equipment and also usual and necessary expenses for the training of a person to operate and maintain the equipment for sole benefit of the patient;
    e. rental or purchase (rental not to exceed purchase price) of medical equipment including, but not limited to, wheelchair, hospital bed, respiratory and oxygen equipment, and other durable medical equipment prescribed by a physician, except as excluded herein. Charges for the replacement of durable medical equipment will only be covered when required because of pathological change, or the natural growth process of a child under age 19. Charges for repair or maintenance are not covered;
    f. insulin and needles, and colostomy supplies;

16. Drugs which require a written prescription and must be dispensed by a licensed pharmacist or doctor

    a. Members living in the Greater Las Vegas Metropolitan Area or Pahrump are required to utilize the Adhere90 Program through Kroger.

       Maintenance medications are drugs that are taken regularly to manage chronic conditions such as high blood pressure, asthma, diabetes and high cholesterol. Adhere 90 is a program that requires members to receive a 90-day supply for certain maintenance medications. Adhere 90 medications are required to be filled at a Kroger affiliated Retail Pharmacy or through Postal Prescriptions Mail Order.

    b. All members are in the Reference Based Pricing Program
       The benefit applies to certain drug categories that have one or more similarly effective and lower cost drugs available. The benefit plan will only pay the amount it would have paid for the lower-cost drug and patients will pay the difference in cost between the

higher-cost drug and the lower-cost drug in form of a higher co-payment when choosing a higher-cost drug in the drug category. The drug categories include but are not limited to cholesterol, heartburn, high blood pressure, migraines, osteoporosis, muscle relaxers and acne. Patients will benefit from a lower copay by choosing the lower-cost generic in the therapeutic class.

17. Routine charges for a newborn child including nursery care; pediatric visits while hospital confined; and circumcisions;

18. Acupuncture treatment by a Physician, or by a licensed acupuncturist. Moxibustion and the like, herbs, teas, or dietary items prescribed or provided by an acupuncturist are not covered;

19. Screening or diagnostic mammography upon the referral of a physician, whether or not an actual disease of the breast is present;

20. Alternative Birthing Centers and certified nurse midwife;

21. Medical treatment of Temporomandibular Joint Dysfunction, Myofascial Pain Dysfunction, upper or lower jaw augmentation or reduction procedures (Orthognathic surgery). Dental services and procedures are not covered – including but not limited to the extraction of teeth and the application of orthodontic devices and splints (requires pre-authorization);

22. Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary". Benefits will be proved on the same basis as for any other illness or injury under the plan. If a covered individual is eligible for mastectomy benefits under this plan, and breast reconstruction is elected in connection with such mastectomy, the following is also covered:

    a. reconstruction of the breast on which mastectomy has been performed;
    b. surgery and reconstruction on the other breast to produce a symmetrical appearance;
    c. prostheses; and
    d. treatment for physical complications of all stages of mastectomy, including lymphedemas.

23. Outpatient cardiac rehabilitation services prescribed by a physician, rendered under a physician's supervision and provided by a cardiac rehabilitation facility.

    Note: This Summary Plan Description is an outline of information as to how this Plan works. It does not provide all of the information contained in the actual Plan Document. Your particular situation may not be addressed herein. If you do not understand a portion of this Summary Plan Description, a copy of the entire Plan is available to review at the personnel office of your Plan Sponsor.

    After a review of the Plan Document, if you still have concerns and / or questions, please contact your Plan Sponsor.

24. Coverage for Autism Spectrum Disorders**.** Covered for screening, diagnosis, and treatment of autism spectrum disorders for persons covered by the policy under the age of 26. 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 or behavior therapy.

HOME HEALTH CARE BENEFITS

Benefits will be paid under the Major Medical portion of the plan if an eligible individual has covered Charges for Home Health Care.

- Each visit of 4 hours or less is considered a single visit.

Covered charges are those that **MEET ALL THREE** of the following requirements:

1. They are medically necessary for the care of a covered individual who is totally disabled and who would otherwise have been confined as a bed patient in a Hospital or Skilled Nursing Facility, **PROVIDED**:

    a. the covered individual is under the direct care of a doctor;
    b. the plan of treatment for the Home Health Care is established in writing by the attending doctor prior to the start of such treatment;
    c. the plan of treatment for Home Health Care is certified by the attending doctor at least once each month, and
    d. the covered individual is examined by the attending doctor once every 60 days.

2. They are for services provided by a Home Health Agency. A "Home Health Agency" means an agency which meets the following requirements:

    a. its primary services are those listed in #3 below;
    b. it is federally certified as a home health agency; and
    c. it is licensed, if licensing is required.

3. They are for one or more of the following:

    a. part-time or intermittent nursing care by a licensed vocational nurse (L.V.N.) or a registered nurse (R.N.);
    b. part-time or intermittent Home Health Aide services;
    c. social work performed by a licensed social worker;
    d. nutrition services performed by a licensed nutritionist;
    e. special meals;

HOME HEALTH CARE BENEFITS EXCLUSIONS

No Home Health Care Benefits will be paid for:

1. general housekeeping services; or
2. services for custodial care.

HOSPICE BENEFITS

Benefits are provided under the Major Medical portion of the plan and will be paid if an eligible individual has covered charges for services and supplies furnished directly by a hospice.

<u>COVERED HOSPICE CHARGES</u>

1. Room and board for confinement in a hospice;
2. Services and supplies furnished by the hospice while the patient is confined therein;
3. Part-time nursing care by or under the supervision of a registered nurse (R.N.);
4. Home health aide services;
5. Nutrition services;
6. Special meals;
7. Counseling services by a licensed social worker or a licensed pastoral counselor;

8. Bereavement counseling by a licensed social worker or licensed pastoral counselor for the patient's immediate family. Counseling must take place between the date the Hospice Care begins, and within 6 months after the death of the terminally ill patient. Bereavement counseling is limited to a calendar year maximum benefit of $500.00.

HOSPICE BENEFIT LIMITATIONS

Hospice Benefits will only be paid if the covered individual's attending doctor certifies that:

1. the covered individual is terminally ill; and
2. the covered individual is expected to die within six months or less.

HOSPICE DEFINITIONS

"Hospice" means an agency that provides counseling and medical services and may provide room and board to a terminally ill individual and which meets all of the following tests:

1. it has obtained any required State or governmental Certificate of Need approval;
2. it provides services 24 hours a day, 7 days a week;
3. it is under the direct supervision of a doctor;
4. it has a nurse coordinator who is a registered nurse (R.N.)

REPLACEMENT OF ORGANS OR TISSUE

The following organ or tissue transplants or any combination thereof, are covered on the same basis as any other illness:

1. Artery or vein
2. Cornea
3. Heart
4. Heart – Lung
5. Implantable prosthetic lenses in connection with cataracts
6. Joint replacement
7. Kidney
8. Liver
9. Non-autologous bone marrow
10. Pancreas
11. Prosthetic by-pass or replacement vessels
12. Skin

However, no coverage is provided for a transplant procedure that is classified as "Experimental." The transplant must be performed to replace an organ or tissue of the Covered Person.

If the expenses incurred for an eligible transplant recipient are determined to be covered expenses under this Plan, the following provision will apply to donor expenses:

> The necessary medical expenses incident to obtaining the transplanted material from a living donor or an organ transplant "bank" will be covered and charged against the recipient's maximum benefit when the recipient is a Covered Person. Benefits payable on the donor's behalf will be reduced by any amount payable under any other public, group or private plan.

Donor charges include those for:

1. evaluating the organ;
2. removing the organ from the donor; and

3. transportation of the organ from within the United States and Canada to the place where the transplant is to take place.

No transportation charges will be considered.

6.7 MEDICAL LIMITATIONS AND EXCLUSIONS

UNLESS OTHERWISE SPECIFICALLY INCLUDED – BENEFITS WILL NOT BE PAID FOR CHARGES:

1. in excess of the Usual, Customary and Reasonable charge, as determined by the Plan Administrator, and amounts over and above the benefit limits shown in the Schedule of Benefits;

2. resulting from sickness or injury covered by a Worker's Compensation Act or similar law;

3. resulting from war, declared or undeclared, any act of war, or any type of military conflict, riot or civil disturbance;

4. resulting from any intentionally self inflicted injury while sane or insane. This exclusion will not apply where such self-inflicted injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g., depression);

5. for services while confined in an institution owned or operated by the United States Government. However, the Plan will reimburse to the extent of plan benefits, for medical care rendered to a veteran by the Veterans Administration for non-service connected disabilities. The Plan will also reimburse to the extent of plan benefits for inpatient care only, provided in a military or other Federal Government hospital to dependents of active duty armed services personnel or armed services retirees and their dependents;

6. for hearing examinations or hearing aids; Covers preventive services as recommend by the U.S. Preventive Services Task Force: www.uspreventiveservicestaskforce.org, all other services are not covered.

7. for vision therapy or orthoptics; or eye refractions or eye examinations for the correction of vision or fitting of glasses or contact lenses, furnishing or replacement of glasses or contact lenses, except the first pair of either glasses or contact lenses if provided in connection with cataract surgery, radial keratotomy or keratoplasty;

8. for dental treatment, except necessary repair due to an accidental injury that occurs while covered hereunder in which the jaw is broken or sound natural teeth are injured. Treatment must be performed within 6 months of the accidental injury, surgical removal of impacted teeth or other surgical treatment of the mouth or jaw, but not teeth;

9. resulting from weak, unstable or flat feet, or bunions, unless an open cutting operation is performed; or for treatment of corns, calluses or toenails, unless at least part of the nail root is removed, or purchase of orthopedic shoes, orthotics or other devices for support of the feet;

10. for any treatment for cosmetic purposes or for cosmetic surgery, unless such treatment or surgery:

    a. is required because of a accidental injury which occurs while covered hereunder;
    b. is required because of a congenital malformation of a dependent child who has been covered under this plan since birth;

c. is incidental to or follows surgery resulting from an illness, including reconstructive surgery following a mastectomy on one or both breasts to re-establish symmetry between the 2 breasts, including but not limited to, augmentation, mammoplasty, reduction mammoplasty and mastopexy ;

11. resulting from complications of cosmetic treatment of surgery;

12. for health check-ups, routine physical examinations, which includes office visit visits, tests and immunizations beyond the limits specified in the Schedule of Benefits;

13. resulting from care or treatment not reasonably necessary for the care and treatment of sickness or accidental injury, including but not limited to housekeeping and custodial care. Eligible charges must be incurred on the advice of a licensed physician who is present and consulting with the covered person;

14. Charges incurred as the result of participation (whether taking part as a principal or as an accessory) in:

    a. A riot or civil disturbance;
    b. or while committing or attempting to commit a felony;
    c. or an illegal occupation.

This exclusion applies whether or not a criminal conviction is entered provided that it is established by the Plan Administrator by a preponderance of the evidence that the exclusion applies.

Charges incurred for care required while incarcerated in a federal, state, or local penal institution or while in custody of federal, state or local law enforcement authorities, including work release programs. Also excluded are any charges incurred due to complications relating to or resulting from these conditions or services.

15. enrollment in a health, athletic, or similar club or a weight loss, non-smoking or similar program;

16. purchase or rented supplies of common use such as: physical fitness / exercise equipment, air purifiers, air conditioners, water purifiers, hypoallergenic pillows or mattress or waterbeds;

17. purchase or rental of: motorized transportation equipment, escalators or elevators, saunas, steam baths, swimming pools, blood pressure kits, blood sugar kits;

18. infertility, correction of asymptomatic anatomic conditions associated with infertility; invitro fertilization; GIFT (Gamete Intrafallopian Transfer) procedures and all related services; artificial insemination, surgical reversal of elective sterilization, and fertility drugs;

19. vitamins or dietary supplements;

20. sex transformation and hormones related to such treatment, and treatment for sexual dysfunction or inadequacy which includes implants and related hormone treatment;

21. any treatment of obesity, weight control, diet control or nicotine addiction, and any complications resulting from such treatment;

22. hypnotism, biofeedback, recreational, educational or non-medical self-care or self-help training or behavior modification therapy;

23. chelation (metallic ion) therapy;

24. for experimental and investigational services and procedures as determined by the American Medical Association (AMA);

25. for the initial Friday, Saturday and Sunday room and board charges incurred for hospital confinement that begins on Friday, Saturday or Sunday. This exclusion does not apply to emergency admissions or scheduled surgery within the 24-hour period immediately following hospital admission;

26. incurred for treatment or care by a physician, R.N., L.V.N., licensed or certified practitioner if the physician, nurse or practitioner is related by blood, marriage, or by legal adoption to either the covered person, a spouse, domestic partner or treatment or care provided by any person who ordinarily resides with the covered person;

27. for treatment for which the Covered Person has no legal duty to pay;

28. for treatment of hyperkinetic syndromes; learning disabilities, behavioral problems, mental retardation, autistic diseases of childhood or hospitalization for environmental change;

29. for massage therapy;

30. for abortions which are not medically necessary to preserve the life of the mother. If complications arise after the performance of an elective abortion, any eligible expenses incurred to treat those complications will be considered, but the initial cost relating to the abortion (except as stated above, when medically necessary) will not be considered;

31. for wigs, hair or scalp prosthesis regardless if prescribed by a physician;

32. charges for any device or procedure, except elective sterilization as specified, used for the direct purpose of birth control;

33. for illness or injury caused by or contributed to by engagement in an illegal occupation or by committing or attempting to commit a felony. This exclusion will not apply where such self-inflicted injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g., depression);

34. charges for maternity expenses incurred by a dependent other than an employee's spouse, domestic partner.

35. charges for services provided by Catholic Healthcare West facilities (San Martin, St. Rose, and St. Rose De Lima) unless deemed a true emergency.

ARTICLE VII - DENTAL BENEFITS FOR ELIGIBLE EMPLOYEES AND DEPENDENTS

7.1 DENTAL PREFERRED PROVIDER ORGANIZATION (DPPO)

WHAT IS A DPPO

A *dental preferred provider organization (DPPO)* has made agreements with *dentists* to discount the services they provide.

WHO IS YOUR DPPO

Nye County School District has chosen Diversified Dental PPO Network to provide *DPPO* services for you and your eligible dependents. You can get more detailed information about this *DPPO* and its most up-to-date list of participating *dentists* at www.ddsppo.com . A *dentist* directory is also available, without charge, from your *employer* as a separate document.

ABOUT YOUR DPPO

Diversified Dental PPO Network has selected the participating *dentists* after carefully reviewing their qualifications. Each *dentist* has agreed to reduced amounts in payment for their services. Consequently, you and your dependents will typically be provided quality care at a fee significantly less than is common in the geographic area in which you live. Additionally, you cannot be "balance billed" for the difference between the *usual and customary charge* for a particular service and the negotiated *DPPO* fee.

Utilization of a Preferred Provider Dentist is NOT mandatory. The covered person may still see any *dentist* of their choice. The final choice of dentists is yours. However, if you receive services from a *dentist* included in the DPPO, it may decrease the amount you must pay.

SCHEDULE OF DENTAL BENEFITS

Annual Deductible
(for those employees hired after January 1, 1999)

$50.00 per person per calendar year	$100 per family per calendar year

Lifetime Deductible
(for those employees hired before January 1, 1999)

$50.00 per person	$100 per family

Maximum Annual Benefit	$1,500 per person per calendar year

7.2 BENEFIT PERCENTAGES

Preventive Services…….....100%
(deductible waived)

1. Prophylaxis treatment, including scaling and polishing, not to exceed two such procedures per covered person in any calendar year;
2. Two dental exams per covered person per calendar year;
3. Two series of bitewing x-rays per covered person per calendar year;
4. One full mouth x-ray per covered person during any one period of 3 calendar years;
5. Two full mouth fluoride treatments per calendar year for dependent children aged 18 and under;
6. Emergency exams / visits, palliative treatment to relieve pain and other x-rays;
7. Application of sealants to the permanent molars of a covered dependent child, if 6 years old but less than 14 years old, limited to 1 application every 3 years; and
8. Space maintainers for deciduous teeth..

General Services .....……..... 80%

1. Fillings;
2. Extractions (non-orthodontic};
3. Endodontics treatment including root canal, if tooth is opened while covered under this Plan;
4. Anesthetics;
5. Consultations and office visits other than those covered under preventive;
6. Prescription medication;
7. Surgery to prepare dental ridges for prosthetic appliances;
8. Periodontics;
9. Relining or rebasing after 6 months from the date of denture replacement, limited to 1 relining or rebasing in a consecutive 36 month period; and

Major Services .....……..... 60%

1. Inlays, onlays;
2. Gold restorations;
3. Crowns;
4. Fixed bridgework, prosthetics, and dentures; and
5. Repair and recementing of crowns, inlays, onlays and dentures.

7.3 ELIGIBLE DENTAL CHARGES

If the covered individual incurs charges for necessary dental care, services or supplies as the result of the recommendation of and performed under the direct supervision of a legally qualified dentist, and the charges are reasonably priced as determined by the Plan, the Plan will pay benefits as indicated below subject to the eligible charge provisions and limitations.

Any dental claim which is payable under any benefits in this Plan other than Dental Benefits will be paid under the other benefits first; then the dental claim will be calculated under Dental Benefits. The amount paid under Dental Benefits will only be the amount, if any, which exceeds the amount paid under the other benefits.

A covered individual has free choice of any legally qualified physician (i.e., a dentist). If a covered individual has charges from more than one physician for the same dental treatment, material or supplies, payment of such charges will be determined on the basis that only one of the physicians furnished the treatment, material or supplies.

IF AN EMPLOYEE OR DEPENDENT IS NOT ENROLLED FOR DENTAL COVERAGE WITHIN 31 DAYS OF ELIGIBILITY, COVERAGE WILL BE LIMITED AS FOLLOWS:

DURING THE FIRST 24 MONTHS there will be **NO COVERAGE** for periodontal treatment, crowns or inlays, dentures and bridgework.

7.4 **THE FOLLOWING ARE NOT COVERED DENTAL EXPENSES**

1. Charges for treatment by other than a licensed dentist except cleaning or scaling of teeth by a dental hygienist, if such treatment is rendered under the supervision and direction of the dentist;

2. Charges for services and supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures;

3. Charges for prosthetic devices (including bridges and crowns) and the fitting thereof which were ordered while the covered person was not covered for dental coverage, or which were ordered while the covered person was enrolled for dental coverage but are finally installed or delivered to such person more than 2 calendar months after termination of such coverage;

4. Charges for any replacement of an existing partial or full removable denture or fixed bridgework, or the addition of teeth to an existing partial removable denture or to bridgework to replace extracted natural teeth unless satisfactory evidence is presented that:

   a. the existing denture or bridgework was installed at least three years prior to its replacement and that the existing denture or bridgework cannot be made serviceable; or
   b. the existing denture is an immediate temporary denture and replacement by a permanent denture is required and takes place within twelve months from the date of installation of the immediate denture.

5. Charges for the replacement of a lost or stolen prosthetic device;

6. Charges for treatment for which the covered person is entitled to benefits under any Worker's Compensation law for treatment of an injury arising out of, or in the course of, employment;

7. Charges for failure to keep a scheduled visit with the dentist;

8. Charges for services and supplies that are not necessary for the treatment of the injury or disease or are not recommended and approved by the attending dentist, or charges that are unreasonable;

9. Charges that would not have been made if a dental program did not exist, or charges that neither the covered individual or any of his dependents are required to pay;

10. Charges for services or supplies which are furnished or paid for by reason of the past or present service or any person in the armed forces of a government;

11. Charges for services or supplies which are paid for or otherwise provided for under any law of a government; except where the payments or benefits are provided under a plan specifically established by a government for its own civilian employees and their dependents;

12. Charges for any services or supplies that are for orthodontic treatment (including correction of malocclusion);

13. Charges for Temporomandibular Joint (TMJ) Syndrome;

14. Appliances, restorations or procedures for altering vertical dimension, restoring or maintaining occlusion, or replacing tooth structure lost from abrasion or attrition;

15. Implants, nightguards and splinting;

16. Charges for dietary planning, plaque control or oral hygiene instruction;

17. Charges incurred for services or supplies rendered by the employee, employee's spouse, domestic partner or children, brothers, sisters, parents and grandparents of either the employee or employee's spouse or domestic partner.

PRE-DETERMINATION OF DENTAL BENEFITS

Before beginning a course of treatment for which the charge is expected to be $300 or more, a description of that course of treatment should be submitted to the Plan Administrator before treatment is begun. The Plan Administrator will provide an estimate of the benefits payable for the planned course of treatment of a covered individual.

In providing a predetermination of benefits, the Plan Administrator may require an oral examination of the covered individual, at its own expense. The covered individual requesting predetermination of benefits must furnish the Plan Administrator with existing diagnostic and evaluative material that the Plan Administrator, in its sole judgment, may require in order to provide the requested estimate of payment.

If such diagnostic and evaluative materials are not furnished, the Plan Administrator will not be able to determine the liability of the Plan until such material is submitted.

ALTERNATE BENEFIT PLAN

Recognizing that many dental problems can be solved in more than one way, the Plan Administrator will process payment in an amount equal to that applicable for that generally accepted treatment which it determines will provide adequate dental care at the lowest cost to the covered individual. In determining the liability of the Plan, the Plan Administrator will be guided by nationally established standards of the dental profession.

If a covered individual pursues the most expensive course of treatment, the Plan may pay the equivalent of the less expensive treatment that adequately restores the mouth to normal form and function. This payment may be applied toward a more expensive course of treatment.

WHEN AN ELIGIBLE CHARGE IS INCURRED

A charge will be deemed incurred as of the date the service is rendered or the supply is furnished except that such charge will be deemed incurred:

- for a full or partial denture, the date the first impression is taken;
- for a fixed bridge, crown, inlay or onlay, the date the teeth are first prepared;
- for root canal therapy, the date a canal is first explored;
- for periodontal surgery, the date the surgery is actually performed.

A dental service is considered to be completed as follows:

- for a full or partial denture, the date a final completed appliance is first inserted in the mouth;
- for a fixed bridge, crown, inlay or only, the date an appliance is cemented in place;
- for root canal therapy, the date a canal is permanently filled.

ARTICLE VIII - GENERAL PROVISIONS

8.1 COORDINATION OF BENEFITS

The Plan contains a non-profit provision coordinating it with other plans under which an individual is covered so that total benefits available will not exceed 100% of the allowable expense.

An "Allowable Expense" is any necessary, usual and customary expense covered by one of the plans.

"Plan" means any plan providing benefits or services for or by reason of health service, for which benefits or services are provided by:

1. group, blanket, employer, trustee, or franchise insurance coverage;
2. group practices and other group pre-payment coverage;
3. any coverage under labor-management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans;
4. any coverage under governmental programs such as Medicare and any coverage required or provided by any statute, such as no-fault auto insurance;
5. automobile medical benefit insurance; and
6. homeowners insurance.

COORDINATION OF BENEFITS - ORDER OF BENEFIT DETERMINATION

A plan without a coordination provision is always the primary plan. If all plans have such a provision:

1. The plan covering the patient directly rather than as a dependent is primary and the others are secondary.

2. If a child is covered under both parents' plans, the Plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that has covered the parent longer is primary. A person's year of birth is not relevant in applying this rule.

3. Transitional Rule: Until the State whose law applies to the other plan changes to rule 2 above (the birthday rule), the plan covering the father of the dependent will pay first and the plan covering the mother of the dependent will pay second. During the transition period, if one plan uses rule 2 and the other does not, both plans will follow this Transitional Rule.

4. If neither rule 1, 2, nor 3 applies, the plan covering the patient the longest is primary.

The order of benefit determination will be decided as outlined above except:

1. When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody;

2. When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the step-parent, and the benefits of a plan which covers that child as a dependent of the step-parent will be determined before benefits of a plan which covers that child as a dependent of the parent without custody.

Notwithstanding 1 and 2 above, if there is a court decree which would otherwise establish responsibility for the medical, dental or other health care expenses with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent.

8.2 COORDINATION OF BENEFITS - MEDICARE

In order to comply with TEFRA and COBRA changes to Medicare, the following verbiage regarding Medicare is now in effect:

1. For those active employees, their spouses, or domestic partners age 65 and over, who have chosen to participate in this Plan, this Plan will be the primary coverage, with Medicare being secondary.

2. Active employees, their spouses, or domestic partner age 65 and over who chose Medicare as their primary payor will not be covered by this Plan.

3. For employees and dependents that are eligible for Medicare due to End Stage Renal Disease, after that person has been eligible for Medicare for 30 months, this plan will be secondary.

4. For employees and dependents whose Employer has fewer than 100 employees, and where the employee or dependent is eligible for Medicare due to disability, this Plan will be secondary.

If Medicare is primary as noted in item 3 and 4, above, the following will apply: From the date a covered person becomes eligible for Medicare, the Plan will reduce its benefits by the amount that could have been received under Medicare Parts '"A" and "B" regardless of whether (1) the covered person has applied for Medicare; or (2) Medicare has paid for the medical expenses.

8.3 PROOF OF CLAIMS

Written proof of claims for health services incurred must be furnished to the Plan by the Plan Participant or the provider within 9 months after the date such claims are incurred. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim, if it was not reasonably possible to furnish the information within the time frame specified.

8.4 PAYMENTS DIRECTLY TO PROVIDERS

The Plan shall pay a provider directly for health services rendered by such provider to a Participant when there is a written assignment of benefits.

8.5 OTHER SERVICE PLAN CONTRACTS

If any Plan Participant is covered under more than one Plan, the coverage that would be provided under this Plan in the absence of this provision shall be reduced to the extent necessary so that the sum of such reduced coverage, together with the benefits, if any, that are paid or payable under such other Plan contract for health service shall not exceed the total charges for the health service.

8.6 PHYSICAL EXAMINATION

This Plan may, at its own cost, require physical examinations of the covered person as often as reasonably necessary while a claim is pending.

8.7 NOTICE

The Plan is not in lieu of, is not in any way subject to, and does not affect any requirements for coverage by Workers' Compensation insurance.

8.8 RIGHT OF RECOVERY

Whenever payments have been made by the Plan with respect to covered services in a total amount in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of whom paid, the Plan shall have the right to recover such payments to the extent of such excess from among one or more of the following, as the Plan shall determine: any persons to or for or with respect to whom such payments were made, any insurance companies, any other organizations or persons.

8.9 RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

The Plan has the right to obtain or give information needed to coordinate benefit payments with other Plans. This can be from or to any insurance company, organization or person. This Plan need not give notice or get anyone's consent to do this. Any person who submits claims must give this Plan the information needed in order to coordinate benefit payments.

8.10 RIGHT TO AMEND OR MODIFY THE PLAN

The Employer reserves the right at any time or from time to time (and retroactively, if necessary) to modify or amend, in whole or in part, any or all provisions of the Plan, provided however, that no modifications or amendments shall divest an employee of a right to those benefits to which he or she has become entitled under the Plan.

The procedure for such amendment shall consist of:

1. Amendment drafted and approved by the Plan Administrator;
2. Amendment submitted for approval to the Nye County School District Board of Trustees and the Joint Insurance Committee of the NCCTA Board of Directors and the NCSSO Board of Directors;
3. Approval notification provided to the Third Party Administrator by the Nye County School District Board of Trustees and the Joint Insurance Committee of the NCCTA Board of Directors and the NCSSO Board of Directors;
4. Insurance Company review process occurs which determines acceptability or denial.
5. Appropriate notification as determined by the Division of Insurance to all Plan participants of the amendment to Plan.

Any changes so made shall be binding on each Plan participant and on any covered persons referred to in this Document.

8.11 FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan, this Plan shall have the right, exercisable alone and at its sole discretion, to pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts so paid shall be deemed to be benefits paid under this Plan and to the extent of such payments for covered services, the Plan shall be fully discharged from liability.

8.12 RETURN OF OVERPAYMENT AND THIRD PARTY LIABILITY

Payment made for charges must be returned to the Plan if:

1. it is found that such charges were paid in error;
2. or a third party is determined to be liable for such charges.

If an individual covered under this Plan has incurred charges as a result of the negligence or intentional act of a third party, and makes a claim to the Plan for benefits under the Plan for such charges, the covered individual (or legal representative of a minor incompetent) must agree in writing to repay the Plan from any amount of money received by the covered individual from the third party, or its insurer. The repayment will be to the extent of the benefits paid under the Plan, but will not exceed the amount of the payment received by the covered individual from the third party, or its insurer. However, the reasonable expenses, such as lawyer's fees and court costs, incurred in effecting the third party payment reimbursed to the Plan may be deducted from the repayment to the Plan.

The repayment agreement will be binding upon the covered individual (or legal representative of a minor incompetent) whether:

1. the payment received from the third party, or its insurer, is the result of:

    a. a legal judgment,
    b. an arbitration award,
    c. a compromise settlement,
    d. any other arrangement; or

2. the third party, or its insurer, has admitted liability for the payment, or

3. the medical or dental charges are itemized in the third party payment.

If a person covered by the Plan is injured through the fault of another person (third party), benefits of the Plan are not applicable unless the covered person agrees to reimburse the Plan, and / or its sponsors or agent, for the benefits provided for treatment of the injury or from any damage or bodily injury which may be collected. Reimbursement shall be made to the party or parties making payment.

8.13 SUBROGATION

Subrogation is the Employer's limited right to be substituted for a Covered Person in a claim for damages for willfully or negligently caused Injury. If payment is made for services on behalf of a Covered Person under this Plan, the Employer will be subrogated to all rights of recovery which the Covered Person, or his or her representative, may have against any other party or liability insurer, but only to the extent of such payments.

The Covered Person must do whatever is reasonably necessary to secure the Employer's rights and will do nothing to damage the Employer's rights.

PRIVACY RULES

On or before April 14, 2003, the Plan will comply with the Standards for Privacy of Individual Identifiable Health Information (i.e., the Privacy Rule) of the Health Insurance Portability and Accountability Act (HIPAA). Such standards control the dissemination of "protected health information" of Plan Participants.

I. GHP's Designation of Person/Entity to Act on its Behalf

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates The Chief Financial Officer to take all actions required to be taken by the GHP in connection with the HIPAA Privacy Rule (*e.g.,* entering into business associate contracts; accepting certification from the Plan sponsor).

II. Definitions

All terms defined in the HIPAA Privacy Rule, shall have the meaning set forth therein. The following additional definitions apply to the provisions set forth:

A. **Plan** (also referred to as "GHP") means the Nye County School District Employee Health Benefit Plan.

B. **Plan Documents** mean the GHP's governing documents and instruments (*i.e.,* the documents under which the GHP was established and is maintained), including but not limited to the Nye County School District Employee Health Benefit Plan Document.

C. **Plan sponsor** means Nye County School District.

III. The GHP's disclosure of Protected Health Information to the Plan sponsor – Required Certification of Compliance by Plan sponsor

A. Except as provided below with respect to the GHP's disclosure of summary health information, the GHP will (a) disclose Protected Health Information to the Plan sponsor or (b) provide for or permit the disclosure of Protected Health Information to the Plan sponsor by a health insurance issuer or HMO with respect to the GHP, *only if* the GHP has received a certification (signed on behalf of the Plan sponsor) that:

1. the Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan sponsor, consistent with the "504" provisions;

2. the Plan Documents have been amended to incorporate the Plan provisions set forth; and

3. the Plan sponsor agrees to comply with the Plan provisions as modified.

IV. Permitted disclosure of individuals' Protected Health Information to the Plan sponsor

A. The GHP (and any business associate acting on behalf of the GHP), or any health insurance issuer or HMO servicing the GHP will disclose individuals' Protected Health Information to the Plan sponsor only to permit the Plan sponsor to carry out plan administration functions.

B. All disclosures of the Protected Health Information of the GHP's individuals by the GHP's business associate, health insurance issuer, or HMO to the Plan sponsor will comply with the restrictions and requirements set forth in the "504" provisions.

C. The GHP (and any business associate acting on behalf of the GHP), may not, and may not permit a health insurance issuer or HMO, to disclose individuals' Protected Health Information to the Plan sponsor for employment-related actions and decisions *or* in connection with any other benefit or employee benefit plan of the Plan sponsor.

D. The Plan sponsor will not use or further disclose individuals' Protected Health Information other than as described in the Plan Documents and permitted by the "504" provisions.

E. The Plan sponsor will ensure that any agent(s), including a subcontractor, to whom it provides individuals' Protected Health Information received from the GHP (or from the GHP's health insurance issuer or HMO), agrees to the same restrictions and conditions that apply to the Plan sponsor with respect to such Protected Health Information.

F. The Plan sponsor will not use or disclose individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.

G. The Plan sponsor will report to the GHP any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the "504" provisions, of which the Plan sponsor becomes aware.

V. Disclosure of individuals' Protected Health Information – Disclosure by the Plan sponsor

A. The Plan sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. § 164.524.

B. The Plan sponsor will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with 45 C.F.R. § 164.526.

C. The Plan sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with 45 C.F.R. § 164.528.

D. The Plan sponsor will make its internal practices, books and records relating to the use and disclosure of individuals' Protected Health Information received from the GHP available to the U.S. Department of Health and Human Services for purposes of determining compliance by the GHP with the HIPAA Privacy Rule.

E. The Plan sponsor will, if feasible, return or destroy all individuals' Protected Health Information received from the GHP (or a health insurance issuer or HMO with respect to the GHP) that the Plan sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the

Plan sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

F. The Plan sponsor will ensure that the required adequate separation, described in paragraph VII below, is established and maintained.

VI. Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan sponsor

A. The GHP, or a health insurance issuer or HMO with respect to the GHP, may disclose summary health information to the Plan sponsor without the need to amend the Plan Documents as provided for in the "504" provisions, if the Plan sponsor requests the summary health information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under the GHP; or

2. Modifying, amending, or terminating the GHP.

B. The GHP, or a health insurance issuer or HMO with respect to the GHP, may disclose enrollment and disenrollment information to the Plan sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

[***Please note***: In the self-funded environment, most mid-size plans will not be able escape the need to amend Plan Documents if managerial personnel – handling both GHP and Plan sponsor functions – receive Protected Health Information. These "exceptions" to the amendment requirement will apply only where persons acting *solely* for the GHP receive Protected Health Information and persons acting *solely* for the Plan sponsor receive only summary health information (for the purposes specified) or enrollment or disenrollment information. A Plan sponsor's receipt of *any* Protected Health Information will invalidate the exceptions set forth in this section VI, and the Plan sponsor will be required to amend the Plan Documents as prescribed by the "504" provisions.]

VII. Required separation between the GHP and the Plan sponsor

A. In accordance with the "504" provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan sponsor who may be given access to individuals' Protected Health Information received from the GHP or from a health insurance issuer or HMO servicing the GHP. (Classes may include, for example: Analyst/Administrators; Service Personnel; Information Technology Personnel; Clerical Personnel; Supervisors/Managers; Quality Assurance Unit)

1. Insurance Clerk
2. Chief Financial Administrative Officer

B. This list reflects the employees, classes of employees, or other workforce members of the Plan sponsor who receive individuals' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan sponsor provides for the GHP. These individuals will have access to individuals' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan sponsor) for any use or disclosure of individuals' Protected Health Information in violation of, or noncompliance with, the Protected Health Information provisions.

C. The Plan sponsor will promptly report any such breach, violation, or noncompliance to the GHP and will cooperate with the GHP to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

VIII. COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

VIII. GENERAL PLAN INFORMATION

8.14 TYPE OF PLAN

Nye County School District Employee Health Benefit Plan

8.15 TYPE OF ADMINISTRATION

The Plan Administrator has contracted with Capitol Administrators (a Third Party Administrator), certain non-discriminatory, non-fiduciary functions. Their address is:

Lucent Health
P.O. Box 2318
Rancho Cordova, California 95741-2318
(877) 789-8488

8.16 PLAN ADMINISTRATOR

Nye County School District
484 S. West Street
Pahrump, NV 89048

(775) 727-7743

Employer Identification Number: 88-6001054

8.17 PLAN SPONSOR

Nye County School District

8.18 AGENT FOR LEGAL SERVICES

Nye County School District

Legal process may also be served upon the Plan Administrator or the Plan Trustee.

8.19 SOURCES AND METHODS OF CONTRIBUTIONS TO THE PLAN

The employer and employee share in the cost of the Plan.

8.20 ENDING DATE OF THE PLAN'S FISCAL YEAR

June 30.

Note: This Summary Plan Description is an outline of information as to how this Plan works. It does not provide all of the information contained in the actual Plan Document. Your particular situation may not be addressed herein. If you do not understand a portion of this Summary Plan Description, a copy of the entire Plan is available to review at the personnel office of your Plan Sponsor.

After a review of the Plan Document, if you still have concerns and / or questions, please contact your Plan Sponsor.

BY THIS AGREEMENT, Nye County School District Health Benefits Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Nye County School District on or as of the day and year first below written.

By _____
Nye County School District

Date_____

Witness _____

Date_____