TEACHERS HEALTH TRUST

Plan Document

APRIL 2016

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Contents

Preface

Performance Plus Benefit Plan

Trust Mission Statement

The mission of the Teachers Health Trust is to achieve proven excellence in delivering the highest quality of health and welfare benefits for our Participants.

Board of Trustees

The Clark County Education Association (CCEA) formed the Teachers Health Trust (Trust) and established a Board of Trustees as the governing body. The Trustees are appointed by the CCEA President to serve a three-year term. (They may serve consecutive terms as well.)

The Trustees establish policies and direct overall Trust operations, including employing professional staff and outsourcing services to run the day-to-day operations, considering and approving benefit plan changes, managing Trust funds, and approving Trust expenditures.

A list of your current Trustees can be found on the Trust's website at **www.teachershealthtrust.org**.

Plan Information

Name of Plan:	Teachers Health Trust
Name and Address of Plan Sponsor/Plan Fiduciary/Plan Administrator:	Teachers Health Trust Board of Trustees PO Box 96238 Las Vegas, NV 89193-6238
Performance Plus Plan Number:	20660
Type of Plan:	Welfare Benefit Plan
Type of Administration:	Self-funded
Performance Plus Plan Medical, Dental, Vision and Prescription Plan:	Administered by the Teachers Health Trust
Employee Life Insurance:	Group Insurance Policy No. 01-016918-00 Issued to the Teachers Health Trust by Symetra Life Insurance Company
Agent for Service of Legal Process:	Teachers Health Trust Chief Executive Officer
Plan Benefit Year:	January 1 - December 31

The following benefits are described in more detail later in this Plan Document and include:

Medical and Prescription Coverage
Dental and Vision Coverage
Employee Life Insurance

This Plan Document was created to provide you and your Dependents with easy-to-understand information that will help you in deciding how best to address your personal health needs. The Trust provides you with:

- Freedom of choice–There are many Providers from a variety of specialties to choose from to treat your health care needs.
- Access to Emergency health care when and where it is needed.
- Services designed to encourage early health care intervention.

The Teachers Health Trust also:

- Provides financial security to you and your Dependents by keeping health care costs low.
- Promotes full participation by all Participants as partners.
- Treats all Participants with respect.
- Allows you access to all information concerning yourself and the Trust.

We understand that navigating through the health care system can be quite confusing and sometimes frustrating. While we hope this Plan Document is useful in helping you understand the best way to obtain quality health care services, our Service Department will be happy to assist you. We urge you to call the Trust Service Department whenever you have questions or need an explanation of your benefit program. Please note, all calls are recorded for quality assurance and training purposes.

Teachers Health Trust

Phone: 702-794-0272/800-432-5859, outside of Nevada
Fax: 702-794-2093
Hours: Monday through Friday: 7 a.m. to 5:45 p.m. (PST)
E-mail: serviceteam@teachershealthtrust.org

You should rely on the written information describing the Plan and not on oral statements made about the Plan.

The Summary Plan Description is not a contract of employment, nor does it give any rights to a job or continued employment.

This Health Plan is considered a legal entity, separate from the Plan Sponsor.

Teachers Health Trust is the Plan Sponsor and Plan Administrator and, as the Plan Administrator, has the final discretionary authority to interpret 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: a) construe and interpret the terms and provisions of the Plan; b) make determinations regarding issues which are related to eligibility for Benefits; c) decide disputes which may arise relative to your rights; and d) decide questions of Plan interpretation and those of fact relating to the Plan. The decision of the Plan Administrator will be final and binding on all interested parties. Benefits under the Plan will be paid only if the Plan Administrator decides, in its discretion, that you are entitled to them.

Although the Plan was established for the exclusive benefit of Employees with the intention that it will continue indefinitely, Teachers Health Trust has the right to amend or discontinue the Plan at any time.

The words “you” and “your” may mean the Participant who is any covered Employee or any covered Dependent that are enrolled in this Plan, or individuals participating in the Plan under COBRA (or their legal representatives as appropriate), depending on the content and purpose of the surrounding provisions.

The Benefit Services Administrator is not a fiduciary with respect to claims determinations or interpreting terms of the Plan.

Copayment and Coinsurance Overview

TEACHERS HEALTH TRUST
PERFORMANCE PLUS MEDICAL PLAN
GROUP NUMBER: THT206660
EFFECTIVE DATE: JANUARY 1, 2016

	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible		
Per Individual Per Calendar Year	$600	$2,500
Per Family Per Calendar Year	$1,800	$10,000
Calendar Year Total Out-of-Pocket		
Per Individual Per Calendar Year	$6,850	No Maximum
Per Family Per Calendar Year	$13, 700	No Maximum

PATIENT CENTERED MEDICAL HOME SERVICES	
The Patient Centered Medical Home (PCMH) is a health care delivery model that provides primary health care that is coordinated and focuses on quality and safety while improving accessibility. It is not a physical place; it is the way your healthcare is accessed. See 89-95 for more information. Your assigned/chosen PCMH provider will be a Primary Care Physician (PCP), Family Practice, Internal Medicine, or Pediatrician Provider. Women may also choose to have an OB/GYN as her second PCMH physician. Services provided within the PCMH by your PCMH Provider are defined only as approved office, consult, and preventive services. Services included in the 'Office Visit Co-Pay' include charges for the office visit or consult only. 20% coinsurance applies to all other services such as, but not limited to, urinalysis, pulse oximetry, administration of injections, medications, procedures, surgery, and testing.	
	IN-NETWORK
Preventive Care (Available Only at PCP unless services can not be performed; in which case another in-network provider may be used.)	$0 copay for office visit (deductible does not apply)
PCP Provider (Inpatient or Outpatient Services)	$10 copay for office visit (deductible does not apply); and 20% coinsurance for all other services (deductible does not apply).
Specialist Physician (In Physician's Office)	$20 copay for office visit **with referral** (deductible does not apply); and 20% coinsurance for all other services (deductible does not apply).
Specialist Physician (Out of Physician's Office)	20% coinsurance after $600 deductible.
Medical Home Identified Chronic Condition Patients (Primary Care or Specialist Physician Office Visit - Diabetes, High-Risk Pregnancy, Cardiovascular, COPD and Asthma)	$0 copay for office visit (deductible does not apply) 20% coinsurance for all other services (deductible does not apply).
In-Office Surgery	20% coinsurance **with referral** from PCMH PCP (deductible does not apply)
Obstetrician Services - PCMH OB/GYN, Inpatient or Outpatient Services (pregnancy, prenatal, delivery and post-natal: Normal Pregnancy)	$10 copay for office visits applies, if billed separately from complete delivery services; 20% coinsurance for all other services (deductible does not apply)

ALL OTHER SERVICES PROVIDED OUTSIDE OF THE MEDICAL HOME		
	IN-NETWORK	**OUT-OF-NETWORK**
Preventive Care (Available Only at PCP unless services can not be performed; in which case another in-network provider may be used.)	Not Covered	Not Covered
Primary Care Physician (Other than your chosen PCP)	20% coinsurance after deductible	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Specialist Physician	WITHOUT REFERRAL 20% coinsurance after deductible	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Office Surgery	WITHOUT REFERRAL 20% coinsurance after deductible	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Obstetricians Services Other than Your Chosen PCMH (pregnancy, prenatal, delivery and post-natal)	20% coinsurance after deductible	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Anesthesia	WITH OR WITHOUT REFERRAL 20% coinsurance after deductible	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Facility (Includes Skilled Nursing and Mental Health/Chemical Dependency Facilities, Inpatient, Outpatient, Ambulatory Surgical Center, Long-Term Acute Care, or Acute Rehabilitation) **When there is no facility copay; applicable copay and or coinsurance will apply:** **Outpatient services** (such as but not limited to; clinics; radiation; radiology services; chemotherapy; sleep studies; physical, occupational and speech therapy; and testing) **Dialysis** **Diabetic Education**	WITH OR WITHOUT REFERRAL $400 per day; $800 Max Per Stay (deductible does not apply) 20% coinsurance (deductible does not apply) $20 copay (deductible does not apply) $0 copay (deductible does not apply)	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Home Health/Hospice/Infusion	WITH OR WITHOUT REFERRAL 20% coinsurance (deductible does not apply)	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Durable Medical Equipment - prosthetics and orthotics, including foot orthotics	WITH OR WITHOUT REFERRAL 20% coinsurance (deductible does not apply)	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Ambulance	NO REFERRAL REQUIRED 20% coinsurance (deductible does not apply)	20% coinsurance (deductible does not apply)
Urgent Care	NO REFERRAL REQUIRED $50 copay (deductible does not apply)	NO REFERRAL REQUIRED $75 copay (deductible does not apply)
Minute Clinics	NO REFERRAL REQUIRED $15 copay (deductible does not apply)	NO REFERRAL REQUIRED $15 copay (deductible does not apply)

ALL OTHER SERVICES PROVIDED OUTSIDE OF THE MEDICAL HOME		
	IN-NETWORK	**OUT-OF-NETWORK**
Emergency Room - True Emergency	$250 True Emergency (deductible does not apply)	$250 True Emergency (deductible does not apply)
Emergency Room - Non-emergency	$400 non-emergency (deductible does not apply)	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Laboratory	WITH OR WITHOUT REFERRAL $0 copay at Quest Diagnostics	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Radiology	**Freestanding Diagnostic Facility:** $0 copay (deductible does not apply) **Hospital/Facility:** 20% coinsurance (deductible does not apply) Radiology coinsurance only applies when Facility copay does not **PCP Office:** 20% coinsurance - X-rays of chest, spine, pelvis and extremities, abdomen; ultrasound of abdomen, dexa bone density (deductible does not apply) All other radiology services in PCP office are not covered **All Other In-Network Providers:** 20% coinsurance with a referral (deductible does no apply); 20% coinsurance after $600 deductible without a referral	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
CAT Scan	**Freestanding Diagnostic Facility:** $50 copay (deductible does not apply) **Hospital/Facility:** 20% coinsurance (deductible does not apply) Radiology coinsurance only applies when Facility copay does not **PCP Office:** Not Covered **All Other In-Network Providers:** 20% coinsurance with a referral (deductible does no apply); 20% coinsurance after $600 deductible without a referral	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*

ALL OTHER SERVICES PROVIDED OUTSIDE OF THE MEDICAL HOME		
	IN-NETWORK	**OUT-OF-NETWORK**
MRI	**Freestanding Diagnostic Facility:** $75 copay (deductible does not apply) **Hospital/Facility:** 20% coinsurance (deductible does not apply) Radiology coinsurance only applies when Facility copay does not **PCP Office:** Not Covered **All Other In-Network Providers:** 20% coinsurance with a referral (deductible does no apply); 20% coinsurance after $600 deductible without a referral	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
PET Scan	**Freestanding Diagnostic Facility:** $200 copay (deductible does not apply) **Hospital/Facility:** 20% coinsurance (deductible does not apply) Radiology coinsurance only applies when Facility copay does not **PCP Office:** Not Covered **All Other In-Network Providers:** 20% coinsurance with a referral (deductible does no apply); 20% coinsurance after $600 deductible without a referral	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*

* **Eligible Medical Expenses (EME):** The Eligible Medical Expenses (EME) are the amounts of the Provider's billed charges that the Trust will consider for payment.

ADDITIONAL LINE ITEMS		
	IN-NETWORK	**OUT-OF-NETWORK**
Acupuncture	WITH OR WITHOUT REFERRAL $20 copay (deductible does not apply), Limit of 20 visits per calendar year	40% coinsurance after deductible, plus any charges over Eligible Medical Expenses*
Assistant Inpatient Surgeon	WITH OR WITHOUT REFERRAL 20% coinsurance after $600 deductible	
Assistant Outpatient Surgeon	WITH OR WITHOUT REFERRAL 20% coinsurance after $600 deductible	
Chemical Dependency Counseling, Mental Health Office Visit, Therapy	WITH OR WITHOUT REFERRAL $20 copay (deductible does not apply)	
Chemotherapy	WITH REFERRAL $20 copay (deductible does not apply) WITHOUT REFERRAL 20% coinsurance after $600 deductible	
Chiropractic	WITH OR WITHOUT REFERRAL $20 copay (deductible does not apply), Limit of 20 visits per year	
Diabetic Education	WITH REFERRAL $0 copay (deductible does not apply) WITHOUT REFERRAL 20% coinsurance (deductible does not apply)	
Dialysis	WITH OR WITHOUT REFERRAL $20 copay (deductible does not apply)	
Hearing Aids	NO REFERRAL NEEDED Plan pays $1,000 per ear, every 5 years (deductible does not apply)	
Inpatient Surgeon	NO REFERRAL NEEDED 20% coinsurance after $600 deductible	
Outpatient Surgeon	NO REFERRAL NEEDED 20% coinsurance after $600 deductible	
Inpatient Physician Visits (Specialist)	NO REFERRAL NEEDED 20% coinsurance after $600 deductible	
Laboratory Pathology/Radiology Interpretation (Inpatient)	NO REFERRAL NEEDED $0 copay (deductible does not apply)	
Physical Therapy (Only when performed in an office. PT in a hospital facility falls under the hospital section)	WITH OR WITHOUT REFERRAL $20 copay (deductible does not apply), 20 Visits Per Year	
Prosthetic, Brace, Orthotic	NO REFERRAL NEEDED 20% coinsurance (deductible does not apply)	
Radiation	WITH REFERRAL $20 copay (deductible does not apply) WITHOUT REFERRAL 20% coinsurance after $600 deductible	
Sleep Studies (In-Office)	WITH REFERRAL $75 copay (deductible does not apply) WITHOUT REFERRAL 20% coinsurance after $600 deductible	
Sleep Studies (Facility)	20% coinsurance (deductible does not apply)	
Transplant Services	$1,500 in addition to all other copayment/coinsurance	Not Covered

Performance Plus Plan Benefits, Chapter 1:

Eligibility

Contents

Employees

The following charts explain which employees are considered Eligible Employees for enrollment, what type of coverage is available, and which employees ARE NOT eligible for enrollment:

Employees Eligible for Enrollment

1. A **LICENSED EMPLOYEE** identified by the Clark County School District (CCSD), paid on the teachers' salary schedule, and eligible for representation by the Clark County Education Association (CCEA); or
2. A licensed employee of a participating **CCSD CHARTER SCHOOL** and acting in the capacity of a teacher; or
3. An employee of the **CCEA**, **CTE** or the **TEACHERS HEALTH TRUST**.

Available Coverage for Eligible Employees
(These Plan is explained in further detail later in this Plan Document.)

MEDICAL, DENTAL and VISION /(including **PRESCRIPTIONS**)

HOSPITAL SUPPLEMENT

(can only be selected if you are **not** enrolled in the **MEDICAL** Plan option)

LIFE INSURANCE

Employees NOT Eligible for Enrollment

1. Any person in active military service; and/or
2. Any employee covered under another health insurance plan sponsored by the CCSD.

Dependent Eligibility

The following charts explain which Dependents are eligible for enrollment, what type of coverage is available to them, and which Dependents **ARE NOT** eligible for enrollment:

Dependents Eligible for Enrollment

1. Your legally married **SPOUSE** (common law marriage is not recognized in the State of Nevada);

2. Your **DOMESTIC PARTNER** (also see **Domestic Partners** in this **Eligibility** chapter):

   A **DOMESTIC PARTNER** relationship exists when the domestic partners have registered with the Office of the Secretary of State of Nevada and have obtained a Certificate of Registered Domestic Partnership.

3. Your **CHILD**, who is your natural child, stepchild, legally adopted child, a child placed with you by a licensed agency for adoption, a child for whom you have legal guardianship, or a child of your **ENROLLED** domestic partner*; and

   - is not on active military duty in the armed forces; **AND**
   - is aged 25 or under.

   (Also see **Dependent Policies** in this **Eligibility** chapter.)

   * Please note that your domestic partner **must** be enrolled in a Trust plan for his/her children to be eligible for enrollment in a Trust plan.

4. A child for whom you are legally responsible to obtain medical coverage due to a **QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)**, even if the child does not live with you.

   (Also see **Dependent Policies** in this **Eligibility** chapter.)

Available Coverage for Eligible Dependents

Your may enroll your Eligible Dependents in:

MEDICAL, DENTAL and VISION

Your dependents MUST BE enrolled in medical coverage to receive dental and vision benefits.

Dependent Eligibility

Dependents NOT Eligible for Enrollment
1. A Spouse from whom you are legally separated or divorced; 2. A Spouse or Domestic Partner who is covered under another Teachers Health Trust Plan or under another health insurance plan sponsored by the CCSD; 3. A Dependent child who is covered under another Teachers Health Trust Plan or under another health insurance plan sponsored by the CCSD; 4. Parents, grandparents, foster children, and boarders; and 5. Any person in active military service.

Please continue to the **Dependent Policies** section of this **Eligibility** chapter for additional information about the Trust's policies regarding **Dependents**.

Dependent Eligibility Audits

Dependent eligibility audits are conducted by the Trust on an ongoing basis. Failure to provide any requested documents or information may result in the suspension of all benefits for you and your dependents.

Dependent Policies

Dependent Children Aged 19 Up to 26

Your dependent child aged 19 up to 26 is eligible for coverage through the Trust. Approximately one month prior to your child's 19th birthday and each birthday thereafter, the Trust will mail a Dependent Certification Form to the home address that is on file for you.

Initial Enrollment

Required Forms	Form Due Date	Coverage Start Date
1. **ENROLLMENT FORM** 2. **DEPENDENT CERTIFICATION**	No later than 31 calendar days from the initial enrollment date	Coverage will begin on the initial enrollment date

Open Enrollment

Required Forms	Form Due Date	Coverage Start Date
1. **CHANGE FORM** 2. **DEPENDENT CERTIFICATION FORM**	Within the specified Open Enrollment period	Coverage will begin on the Open Enrollment date, generally January 1st of the following year

Already Enrolled Child Turning 19

Required Forms	Form Due Date	Coverage Start Date
DEPENDENT CERTIFICATION FORM	No later than 31 calendar days following you child's 19th birthday and annually thereafter	No break in coverage

Life Event

Required Forms	Form Due Date	Coverage Start Date
1. **CHANGE FORM** 2. **DEPENDENT CERTIFICATION FORM**	No later than 31 calendar days following the date your child loses coverage through his/her employer	Coverage will begin on the first day following the termination date of the employer-sponsored health coverage

Maintaining Coverage

Required Forms	Form Due Date
DEPENDENT CERTIFICATION FORM	The forms are due by the deadline indicated in the Dependent Certification letter your receive from the Trust

Dependent Policies

Dependent Children: Frequently Asked Questions

My dependent who is 22 years old has medical coverage through her employer. Can I enroll her for coverage on my dental and vision plan?
No. However, you can enroll her in the medical, dental, vision plan regardless of whether she has enrolled in her employer's plan. The Teachers Health Trust plan would be secondary.

My dependent who is 20 years old lost his job and no longer has coverage. Can I enroll him on my plan?
Yes. You must submit a Change Form, a copy of his certified birth certificate, a copy of the Certificate of Credible Coverage, and a Dependent Certification Form to the Trust within 31 days from the date his coverage terminated. If the required documents are not received within 31 days, you must pay a $100.00 administrative fee. No request for enrollment will be considered if all required documents are not received by the Trust within 60 days of the date your dependent's coverage terminated.

My dependent is going to college in Florida. Is my dependent eligible for out-of-area urgent and emergency benefits?
Yes. When you complete the Dependent Certification Form, please include your dependent's address and the name and address of the college or educational institution your dependent is attending. If urgent or emergency services (as defined in the **Emergency Services** and **Urgent Care Services** pages in the **Medical** chapter of this Plan Document) are received, they will be processed at the appropriate level of benefits.

My dependent is 25 years old and a full-time teacher with the Clark County School District. Can I enroll her for coverage as my dependent?
No. Because your dependent is offered coverage as an employee of the CCSD, she would not be eligible for coverage as your dependent.

My daughter just got married. Can I delete her from my insurance?
No, if the reason for deleting your dependent is due to the marriage; marriage is no longer considered a life event for dependents. However, if your daughter gained coverage through her spouse, you would be able to delete her for that life event. You would have 31 days from the effective date of the other coverage to submit a Change Form and a copy of the Certificate of Credible Coverage from the other insurance carrier. Also, you may add or delete dependents during the Annual Open Enrollment each November.

Domestic Partners

Each Eligible Employee may enroll a Domestic Partner in the medical plan offered by the Trust. (Domestic Partners are not eligible for enrollment in the **Hospital Supplement Plan**.)

A **DOMESTIC PARTNER** relationship exists when the domestic partners have registered with the Office of the Secretary of State of Nevada and have obtained a Certificate of Registered Domestic Partnership.

For more information on how to register as domestic partners with the state of Nevada, please visit www.nvsos.gov and click on the Domestic Partner Registration link. To review a list of frequently asked questions related to the domestic partnership laws, please visit the Trust's website at www.teachershealthtrust.org.

Dependent Policies

Domestic Partners (cont.)

Enrollment Requirements

To enroll your Domestic Partner (and his/her children, if applicable) in the health Plan offered by the Trust, you must submit ALL of the following documentation to the Trust:

Documentation Required to Enroll a Domestic Partner
1. A **CERTIFICATE OF REGISTERED DOMESTIC PARTNERSHIP** through the state of Nevada; and
2. A completed, signed **ENROLLMENT** form (or Change form).

Documentation Required to Enroll a Child of a Domestic Partner*
1. A copy of the child's **BIRTH CERTIFICATE**
2. In addition, if the child is aged 19 up to 26, a completed **DEPENDENT CERTIFICATION FORM**.
3. A completed, signed **ENROLLMENT FORM** (or Change Form).
4. A copy of the **DIVORCE** or **COURT DECREE**.

* Your domestic partner **must** be enrolled in a Trust plan for his/her children to be eligible for enrollment in a Trust plan.

Health Plan Premiums

The cost of enrolling a Domestic Partner is the same as the cost of enrolling an additional Dependent. However, premiums for you, your Domestic Partner, and any other Eligible Dependents cannot be taken from your paycheck on a pre-tax basis through the Trust's Section 125 Premium Only Plan. (See **Premiums** in the **Enrollment** chapter of this Plan Document.)

The Trust CANNOT offer tax or legal advice; therefore, you should consult an attorney and tax advisor regarding the possible impacts of declaring a Domestic Partner as an Eligible Dependent under your Plan.

Status Changes

You may terminate domestic partner coverage in the future in one of three ways: 1) you may terminate your domestic partnership through the state and supply the Trust with a copy of the termination along with a completed change form, 2) you may terminate coverage during Open Enrollment by submitting a completed change form during the Open Enrollment Period, or 3) you may terminate coverage during a qualifying life event as detailed in later pages of this Plan Document. Please note that when your domestic partnership terminates, the children of your domestic partner are no longer eligible for coverage under a Trust plan.

It is your responsibility to notify the Trust of a change in the status of your Domestic Partner relationship. This notification must be made within 31 Calendar Days of such change. If you fail to notify the Trust within the required time period, you will forfeit all premiums paid. Additionally, you will be responsible for reimbursing the Trust for any claims that were paid on behalf of the Domestic Partner and his or her dependents while he or she was ineligible for coverage.

If your Domestic Partner relationship ends, your former Domestic Partner (and his/her children, if applicable) may be eligible to continue coverage under COBRA. For additional information, please refer to **COBRA Continuation of Health Coverage** in the **Legal Notices** chapter of this Plan Document.

Performance Plus Plan Benefits, Chapter 2:

Enrollment

Contents

Available Coverage

Employees

Once you have met the Trust's eligibility requirements, you may enroll in the following plans:

Available Coverage for Eligible Employees (The Plan is explained in further detail later in this Plan Document.)
MEDICAL, DENTAL and VISION (including **PRESCRIPTIONS**)
HOSPITAL SUPPLEMENT
(can only be selected if you are **not** enrolled in the **MEDICAL** Plan option)
LIFE INSURANCE

Dependents

Available Coverage for Eligible Dependents
MEDICAL, DENTAL and VISION

Your dependents MUST BE enrolled in medical coverage to receive dental and vision benefits.

Enrollment Periods

There are three periods during which you and your Eligible Dependents may enroll in the Trust Health Plan:

Initial Enrollment
Annual Open Enrollment
Life Events

These periods, as well as your opportunity for Late Enrollment, are explained in more detail on the following pages.

Initial Enrollment

Shortly after you are hired as a licensed employee, you must attend a New Hire Orientation. At that time you will be provided the opportunity to enroll in a Trust Health Plan.

You are eligible to begin receiving benefits on the first day of the month following your hire date. You must make your elections and complete your enrollment form at the time of your orientation. You have up to 31 Calendar Days from the date of your orientation in which to make one Plan change. All required documentation, including any Dependent documentation, must be submitted to the Trust no later than 31 Calendar Days following the date of your orientation.

If you do not attend a New Hire Orientation within 31 Calendar Days of your hire date, you (but not your Dependents) will automatically be enrolled in the PERFORMANCE PLUS PLAN and a PCMH Provider will be chosen for you unless you are covered under another District-sponsored plan or you specifically decline all coverage in writing.

If you do not submit the required Dependent documentation within 31 Calendar Days of your orientation date, you will not be able to enroll your Dependents until the next Open Enrollment period, unless you or your Dependents experience a Life Event. (See Open Enrollment, Life Events, and Late Enrollment in this Enrollment chapter.)

Waiving Coverage

If you choose to decline all coverage through the Trust, you must submit a signed and notarized **TRUST WAIVER FORM**. Waiving coverage also waives your Life Insurance policy. If you cancel your own coverage, all coverage for your Dependents will also be cancelled. You have 31 days after new hire date to waive your coverage or you may waive your coverage during the Trust annual open enrollment.

Annual Open Enrollment

The Open Enrollment period is your opportunity to make changes to your existing coverage or to enroll yourself and your Eligible Dependents if you did not previously do so.

Generally, the Open Enrollment period is held during the month of November each year. (In the event of a change in the Open Enrollment period, you will be notified of the change in writing.) You must complete all required Open Enrollment paperwork by the deadline specified in the Open Enrollment materials.

If you do not submit the appropriate Trust **CHANGE** Form, **COORDINATION OF BENEFITS** Form, and eligibility documentation by the deadline specified by the Trust, coverage for you and your Dependents will remain as it was prior to the Open Enrollment Period. You will not be able to enroll yourself or your Dependents or make changes to your existing coverage until the next Open Enrollment period unless you or your Dependents experience a Life Event. (See **Life Events** in this **Enrollment** chapter.)

Enrollment Periods

Annual Open Enrollment (cont.)

If completed paperwork intended for the Open Enrollment Period is received in the Trust office after the Open Enrollment Period and/or is signed and dated after the Open Enrollment Period, the request for enrollment will be denied unless a qualifying Life Event has occurred.

You may also cancel coverage during the Open Enrollment period. See **Termination of Coverage** later on in this **Enrollment** chapter for additional information and procedures on canceling coverage for yourself or your Dependents.

Life Events

Certain events may occur in your life that can result in your need to change your enrollment election or that of your Dependents. These events are commonly known as **Life Events** or **Qualifying Life Events**. If you or your Dependents experience one of the following Life Events, you can change your enrollment election without waiting for the next Open Enrollment Period. **(Changes you make during a Life Event are limited to enrollment only.)**

You or Your Dependent Lose Other Coverage	
Description of Event	If you were eligible but did not enroll in a Trust Plan because you had other health insurance coverage, you can enroll in a Plan if the other coverage is lost due to: • Loss of eligibility (except for failure to pay premiums) • Exhaustion of COBRA Continuation Coverage
Documentation Required	In addition to the Trust Change Form, you must submit: • Dependent eligibility documentation • A **CERTIFICATE OF GROUP HEALTH INSURANCE COVERAGE** from the other insurance carrier that provides the date the other coverage was terminated and the names of all Participants who have lost coverage
Effective Date of Coverage	Your Trust coverage will be effective on the first day following the date your other coverage was lost, provided all required documentation is received within 31 Calendar Days of the event.

You Acquire a New Spouse, Domestic Partner or Dependent Child	
Description of Event	If you gain a Dependent through marriage, Domestic Partner relationship, birth, adoption, placement for adoption, or legal guardianship, you are entitled to enroll your new Dependent in your Plan.
Documentation Required	In addition to the Trust Change form, you must submit: • A copy of the **MARRIAGE** and/or **BIRTH CERTIFICATES**; or • A **CERTIFICATE OF REGISTERED DOMESTIC PARTNERSHIP**; or • A copy of the adoption or placement papers; or • A copy of the **ORDER APPOINTING GUARDIANSHIP**. Occasionally, more than one of these documents may be required.
Effective Date of Coverage	Coverage for all newly acquired Dependents will be effective on the date of the event, provided all required documentation is received within 31 Calendar Days of the event. In the case of a Domestic Partnership, the life event date is considered to be the date of the partnership event through the state of Nevada as noted on the Certificate of Registered Domestic Partnership.

Enrollment Periods

Life Events (cont.)

The Trust Receives a Qualified Medical Child Support Order (QMCSO)	
Description of Event	If the Trust receives a QMCSO, the Dependent(s) listed on the QMCSO will be enrolled in your Trust Plan.
Documentation Required	You do not have to provide any documentation.
Effective Date of Coverage	Coverage for your Dependent(s) will be effective on the first day of the month following the date the Trust receives the QMCSO.

If you do not submit the appropriate Life Event enrollment paperwork by the deadline specified by the Trust, coverage for you and your Dependents will remain as it was prior to the Life Event.

If completed paperwork intended for the Life Event enrollment period is not received by the Trust within 31 days of the Life Event, an administrative fee of $100 will be required to make a change. **Under no circumstances will a request for Late Enrollment be granted if it is received by the Trust more than 60 days from the date of the Life Event.** See **Life Events** on the following page for more information.

You may also cancel coverage during certain Life Events. See **Termination of Coverage** later in this **Enrollment** chapter for additional information and procedures on canceling coverage for you or your Dependents.

Late Enrollment

Performance Plus Plan

The following provisions apply to requests for Late Enrollment in the PERFORMANCE PLUS PLAN.

Newly-Hired Employees

You must make your elections and complete your enrollment form at the time of your orientation. You have up to 31 Calendar Days from the date of your orientation in which to make one Plan change and to select your PCMH Provider(s). **No Late Enrollment is available to newly-hired employees.**

Dependents of Newly-Hired or Rehired Employees

You have 31 Calendar Days from the date of your orientation to submit any documentation required by the Trust to cover your Dependents. If you submit the documentation more than 31 days after your orientation date, you must pay (in the form of personal check or money order) a $100 administrative fee and all applicable premiums to activate Dependent coverage retroactively to your effective date of coverage. **In no event will a request for Late Enrollment of your Dependents be granted if the required documentation is received in the Trust office more than 60 days following the date of your enrollment.**

Life Events

You have 31 Calendar Days from the Life Event in which to enroll yourself and/or a Dependent in a Trust Health Plan. If you wish to enroll more than 31 days after the Life Event, you must submit a $100 administrative fee to the Trust along with a letter explaining why you wish to make a change after the Life Event deadline. All required documents and completed forms must accompany the check, and any applicable retroactive premiums must be self-paid in full. All payments must be made in the form of personal check or money order. **In no event will a request for Late Enrollment be granted if it is received in the Trust office more than 60 days from the date of the Life Event.**

Enrollment Periods

Late Enrollment (cont.)

Open Enrollment

Generally, Open Enrollment is held during the month of November each year. (You will be provided advance notification of the Open Enrollment period each year.) All documents must be submitted to the Trust within the Open Enrollment period. **No Late Enrollment is available during the Open Enrollment period.**

Dependent Certification

You will receive a request for dependent certification once a year in the month prior to your dependent's birth date. The request will include a specific deadline date for submitting documentation regarding your dependent's college. In order to receive the Out-of-Area Urgent Benefit, the Dependent Certification Form must be received by the Trust.

Participant Returning from a Leave of Absence

If you are returning from an approved leave of absence, you have 31 days from the date of your return to re-enroll in a Trust Health Plan. If you do not re-enroll within 31 calendar days of your return to work, you but not your Dependents will automatically be enrolled in the PERFORMANCE PLUS PLAN unless you are covered by another CCSD-sponsored plan or you decline all coverage in writing. You will not be eligible to enroll your Dependents until the next open enrollment period unless you and your Dependents experience a Life Event.

Medicare Eligibility

All Trust Participants and Dependents with a disabling condition are required to apply for Medicare and/or Medicaid within 31 Calendar Days of their potential eligibility for such programs. Once you receive a copy of your Medicare card, you must submit a copy of it to the Trust.

Approximately 60 days before you turn 65, you should enroll for Medicare, although if your eligibility for Medicare is due to your age, your Trust plan will continue to be primary for you.

Premiums

While you are an active licensed employee, the CCSD contributes monthly premium payments on your behalf. You may be required to pay additional premiums based on the plan selections you make. These premiums are paid to the Trust through payroll deductions in two equal installments on or about the 10th and 25th of each month.

Section 125 Premium-Only Plan

The Teachers Health Trust Section 125 Premium-Only Plan allows you to pay your portion of the health insurance premiums before Federal and Medicare taxes are calculated. This may result in an increase in your take-home pay as illustrated in this example:

Payroll Deductions for Health Care Coverage: Post-Tax vs. Pre-Tax

Without Premium-Only Plan (Post-Tax)		With Premium-Only Plan (Pre-Tax)	
Monthly Gross	$2,333.33	Monthly Gross	$2,333.33
Less Federal Tax (15%)	$350.00	Less Premium Amount	$220.00
Less Medicare Only (1.45%)	$33.83	Adjusted Gross after Premium Payment	$2,133.33
Net Pay after Taxes	$1,949.50	Less Federal Tax (15%)	$317.00
Less Premium Amount	$220.00	Less Medicare Only (1.45%)	$30.64
Take Home Pay after Taxes and Premium Payment	**$1,729.50**	**Take Home Pay after Taxes and Premium Payment**	**$1,765.69**

MONTHLY SAVINGS with Premium-Only Plan: $36.19
ANNUAL SAVINGS with Premium-Only Plan: $434.28

Your annual tax withholding statement (W-2) will reflect your reduced taxable income. Therefore, you are not eligible to report any health plan premiums you make to the Trust on your income tax returns.

You may change or revoke your pre-tax deductions only at the end of each Calendar Year per IRS regulations.

If you have enrolled a Domestic Partner for coverage, you are not eligible to participate in the Section 125 Premium-Only Plan. You may not separate payment of your premiums.

Self-Paid Premiums While on a Leave of Absence

Approved Family and Medical Leave

If you are on an approved leave of absence which falls under the Family and Medical Leave Act of 1993 (FMLA), you can maintain your coverage by self-paying your required "per-paycheck" premiums. You can choose to self-pay your premiums each month while you are on your FMLA or you can elect to have the premiums deducted from the first paycheck you receive after you return to work. (If there are not enough available funds in your first payment from which to deduct the entire premium due, the remaining amount due will be deducted from your next paycheck.)

Premiums

Self-Paid Premiums While on a Leave of Absence (cont.)

Other Approved Leave of Absence

If you are on any other type of approved leave of absence, you can maintain your coverage by self-paying the entire monthly cost of your coverage (in other words, you must pay both your "per paycheck" premium and the CCSD contribution for your coverage).

Due Date for Self-Paid Premiums

If you are paying your premiums monthly while you are on an approved leave of absence, the required amount must be received from you no later than the 20th of each month PRIOR TO the month of coverage. You must pay the required amount due in its entirety. **The Trust will not accept partial premium payments.**

Failure to submit your payment by the 20th of the month may result in delayed eligibility verification and/or prescriptions being denied. Please allow 48 hours for the Trust to process eligibility updates.

Returned Checks

If your check is returned by the bank due to insufficient funds and you fail to submit a premium payment to replace that check by the due date, your coverage will be terminated retroactive to the first day of the month for which the premium payment was due. You will be assessed a $25 non-sufficient funds fee by the Trust.

Replacement of your check—including the $25 fee—must be paid by money order or cashier's check. **Additionally, the Trust will not accept your personal checks for future premium payments and will require you to pay by money order or cashier's check**

You and/or your Dependent(s) will not be able to access benefits, including prescription drugs, until your premiums are current. (See Termination of Coverage later in this Enrollment chapter.)

Premiums

Forfeiture of Premiums

If you fail to notify the Trust within 31 Calendar Days of a change in Dependent eligibility status that results in the Dependent's termination of coverage, you will forfeit any premiums paid for the period of time that the Dependent was ineligible for coverage.

Additionally, you will still be responsible for reimbursing the Trust for any claims which were paid on behalf of the Dependent while he or she was ineligible for coverage.

Premium Cost for CCSD Licensed Employee who is Married to, or a Domestic Partner of, another CCSD Employee (Administrative, Support Staff or School Police)

A licensed employee who is married to or is a Domestic Partner of another CCSD employee will have a different premium rate structure because of a dual premium contribution that the Teachers Health Trust will receive from the CCSD. You will be advised of the rate structure prior to your enrollment in the Trust Health Plan.

If one of the two CCSD employees leaves the District's employment, it is his or her responsibility to **IMMEDIATELY** notify the Trust if he or she wants to continue with his or her current coverage or if coverage for one or more Dependents will be terminated. (See **Termination of Coverage** later in this **Enrollment** chapter.)

If you fail to notify the Trust within 31 days of your legal separation, divorce or termination of Domestic Partnership from another CCSD employee who is covered on your plan, you will be responsible for reimbursing the Trust for all premiums retroactive to the date of the life event.

The Trust reserves the right to verify the continued employment and/or relationship of two married or Domestic Partner CCSD employees.

Required Forms and Documents

Various forms may be required by the Trust in order to meet the eligibility requirements for yourself and/or your Dependents. **Required forms received in the Trust office after the specified deadline will not be accepted.** Most forms can be obtained online at www.teachershealthtrust.org or from the Trust. You may also request that the forms be mailed to you by e-mailing the Trust at serviceteam@teachershealthtrust.org.

Name of Form	Description
Adoption Order	Copy of the initial placement order. Within six months following initial placement, a copy of the finalized adoption order must be submitted. Both the initial placement and the finalized adoption order must include the first page with filing date stamp and the final page with judge's signature.
Certified Birth Certificate	Certified Birth Certificate, which includes at least one or both of the parents' names, issued by either the state or country of birth. The Trust will not pay for the translation. Birth Certificates issued by a hospital are **not** acceptable.
Court-Ordered Documentation of Guardianship	Court document including the first page showing the filing date stamp and the page with the judge's signature.
COBRA Election Form	Form completed by the Participant for plan selection and names of Dependent(s) who will be covered under COBRA.
Consent to Discuss/Disclose Protected Health Information (PHI)	Form completed by the Participant that allows the Trust to discuss protected health information with individuals the Participant chooses.
Coordination of Benefits (COB) Form	Form used to determine if a Participant has insurance coverage through a company other than the Trust.
Dependent Certification Form	A form to determine if your dependent resides in the service area, has other insurance and/or is attending college.
Divorce Decree	Front page of Decree showing the filing date stamp and page of Decree with the judge's signature. If child(ren) are involved, document must include pages that determine custody and if the Participant is required to carry insurance for the child(ren).
Certificate of Registered Domestic Partnership	Certificate of Registered Domestic Partnership through the state of Nevada certifies the Participant and his or her partner meet the criteria to be eligible for the Benefit.
Certified Marriage Certificate	Certificate of marriage issued by the county, state or country where ceremony was performed. Must have stamp or seal and signature showing marriage has been recorded.
Two-CCSD Employee Form	Form completed by both employees to combine plans. Participants must be either married or domestic partners in order to combine plans.
Waiver of Coverage Statement	Notarized form signed by Participant which waives all coverage offered by the Trust, including the Life Insurance Benefit.

Changing Your Personal Information: Updating Demographics

If you change your name, phone number or address, you must notify the Trust office as quickly as possible to make sure all of your records are updated with that information. (In order to change your name, you will be required to first complete the change with Social Security and the Clark County School District; then submit legal proof of the name change to the Trust.)

Notification of your change of address to the U. S. Postal Service, your location's Office Manager, or the CCSD Payroll Office **MAY NOT** update Trust records. Alternatively, a notification to the Trust will not update any other company record.

Failure to notify the Trust of a change in your address may result in your not receiving important claims information and requests for information from the Trust. If your claim for benefits is pended for additional information and you do not submit the information within the required period of time, your claim may be denied. Additionally, failure to notify the Trust of a change of address will not be considered an acceptable reason to reverse a claim or eligibility determination upon appeal.

Coverage During Leaves of Absence

If you begin a leave of absence approved by the CCSD, your current coverage will continue through the end of the month in which your leave begins, provided the appropriate contributions are received from you and/or the CCSD.

Continuation of Coverage During a Leave of Absence

You can elect to continue coverage during your leave according to the following provisions:

Approved Family and Medical Leave

If you are on an approved leave of absence which falls under the Family and Medical Leave Act of 1993 (FMLA) and are not receiving a paycheck, you will be required to continue paying only your portion of the "per-paycheck" premiums if you wish to maintain your coverage. You can either self-pay your premiums each month while you are on your FMLA or you can elect to have the premiums deducted from the first paycheck you receive after you return to work.

Other Approved Leave of Absence

If you are on any other type of approved leave of absence, you must pay the entire monthly premium to maintain your coverage. (In other words, you must pay both your "per-paycheck" premium and the CCSD contribution for your coverage).

It is your responsibility to notify the Trust that you will be starting a leave of absence. Failure to pay the required premium will result in the termination of coverage. (See **Termination of Coverage** later in this **Enrollment** chapter.)

Returning to Work Following a Leave of Absence

You must re-enroll in the Plan by completing a new enrollment form no later than 31 Calendar Days following the date you return to work from a leave of absence. In certain circumstances as illustrated below, you will also be required to attend an orientation regarding your benefits.

Length of Leave of Absence	Orientation Requirement
Less than one year, continued coverage during leave	**Not Required**
Less than one year, coverage lapsed during leave	**Required**
More than one year	**Required**

It is your responsibility to inform the Trust that you have returned from a leave of absence. If you do not re-enroll within 31 calendar days of your return to work, you but not your Dependents will automatically be enrolled in the PERFORMANCE PLUS PLAN unless you are covered by another CCSD-sponsored plan or you decline all coverage in writing. You will not be eligible to enroll your Dependents until the next Open Enrollment period unless you or your Dependents experience a Life Event.

Coverage During Leaves of Absence

Termination of Employment Following a Leave of Absence

If you terminate your employment with the CCSD instead of returning from a leave of absence, you will not be eligible to enroll in continuation coverage under COBRA unless your leave of absence was covered under the Family and Medical Leave Act of 1993 or you have maintained your coverage during your non-FMLA leave of absence. (See **COBRA Continuation of Health Coverage** in the **Legal** chapter of this Plan Document.)

Termination of Coverage

You may voluntarily terminate coverage for yourself and/or your Dependents during certain Life Events or during the Open Enrollment Period. Additionally, coverage may terminate for a variety of other reasons. Reasons for and effective dates of termination are explained in the following pages. In many instances, you may be able to continue your coverage through COBRA. Please refer to the **COBRA Continuation of Health Coverage** section in the **Legal Notices** chapter of this Plan Document for additional information regarding continuing your coverage.

Coverage Termination During a Life Event

Occasionally, certain events occur in your life that can result in your need to cancel coverage for yourself and/or your Dependents. These events are commonly known as Life Events, and, except in the case of death, coverage will be terminated at midnight on the last day of the month in which the event occurs. The following illustrates the Life Events that allow cancellation of coverage:

Event	Coverage Eligible For Cancellation	Documentation Required
Death of a Spouse, Domestic Partner, or child	Coverage for all Dependents who no longer fulfill the eligibility requirement due to death (Coverage will terminate at midnight on the date of death.)	• Change Form; and • Copy of Death Certificate
Divorce, Legal Separation, Annulment, Termination of Domestic Partner relationship	Coverage for all Dependents who no longer fulfill the eligibility requirement due to divorce, legal separation, annulment,or termination of Domestic Partner relationship	• Change Form; and • Copy of divorce decree; separation agreement; annulment; or filed, stamped copy of the termination of domestic partnership filed with the state of Nevada
Gaining eligibility for other coverage	Coverage for all individuals who have become covered under other insurance Coverage will terminate the day before your child or dependent's first effective date for health coverage through his/her employer	• Change Form; and • Written documentation from the new carrier providing names of covered Participants and date coverage began; **or** • Certificate of Creditable Coverage
Termination of a Qualified Medical Child Support Order (QMCSO)	Coverage for all Dependents listed on the termination of the QMCSO	Copy of the termination of the QMCSO
Loss of Eligibility	Coverage for all Dependents who no longer meet the definition of an Eligible Dependent under a Trust Plan	• Change Form; and • Any applicable supporting documentation

All documentation must be submitted to the Trust office no later than 31 Calendar Days following the Life Event.

Termination of Coverage

Coverage Termination During Open Enrollment

You may cancel coverage for yourself and/or your Dependents during the Annual Open Enrollment Period. With this option, your Trust coverage and premium contributions will end on December 31st of that year.

To cancel coverage for yourself, you will need to sign and have notarized a Trust Waiver form. If you cancel your own coverage, all coverage for your Dependents will also be cancelled. To cancel coverage for your Dependents during Open Enrollment, you must complete a Trust Change Form. Dependents terminated during Open Enrollment are not eligible for COBRA coverage.

Other Terminations - Employees

Your coverage will automatically be terminated at midnight on:

1. The last day of the month in which you discontinue active full-time or part-time employment with the CCSD or otherwise cease to be eligible for coverage under the Trust;
2. The last day of the month in which you begin an authorized medical leave of absence, unless you self-pay your premiums;
3. The last day of the month in which you begin active duty with the armed services of any country;
4. The last day of the month in which a notarized waiver declining insurance is received by the Trust; OR
5. The date the Plan(s) is (are) terminated by the Board of Trustees.

Failure to pay a third party lien for yourself or one of your dependents once a settlement has been paid will result in suspension of coverage for the employee and any dependents until the lien has been paid. Premiums will continue to be collected from your paycheck.

Failure to reimburse the Trust for claims paid on a dependent who is no longer eligible to be covered by the Trust will result in suspension of coverage for the employee and any dependents until the outstanding balance has been paid. Premiums will continue to be collected from your paycheck.

Other Terminations - Dependents

Coverage for your Dependents will terminate at midnight on the earliest of the following dates:

1. The date your coverage terminates.
2. The last day of the month in which your divorce, legal separation, or dissolution of domestic partnership is final.
3. The day before your Dependent child enrolls as an employee of the CCSD in his or her own coverage as an employee of the CCSD.
4. The last day of the month in which you or your Dependent enters active duty with the armed services of any country.
5. For a Dependent child for whom you have full Legal Guardianship – the last day of the month in which you no longer have Legal Guardianship of the child.
6. For a Dependent child for whom you do NOT have full Legal Guardianship – the last day of the month in which you are divorced from the child's parent or your domestic relationship with the child's parent ends; or the last day of the month in which your Spouse or Domestic Partner (the child's parent) dies.
7. The last date of the month in which your Dependent otherwise ceases to meet the definition of an Eligible Dependent under the Trust Plan.
8. The day before your child or dependent first effective date for health coverage through his/her employer.

Failure to notify the Trust within 31 Calendar Days of a change in your Dependent's eligibility status will result in the forfeiture of premiums paid on behalf of the Dependent. You will also be held financially liable for all claims paid for the Dependent after he/she was no longer eligible to be covered by the Trust. In addition, a failure to notify the Trust of a change in eligibility may result in your Dependent not being eligible to continue coverage under COBRA. (See COBRA Continuation of Health Coverage in the Legal Notices chapter of this Plan Document.)

Performance Plus Plan Benefits, Chapter 3:

Other Health Insurance

Contents

Coordination of Benefits (COB)

It is very common for Participants to be insured by more than one group insurance policy. To address multiple insurance coverage situations, most group insurance policies (including your Trust Plan) contain a Coordination of Benefits provision which allows them to share the cost of your expenses. This section explains how other health coverage you may have will affect your Trust benefits.

Gathering Other Insurance Information

During the enrollment process, you will be asked to complete a Coordination of Benefits form which will provide the Trust with information regarding any other insurance you may have so the Trust can determine the order in which your benefits will be processed.

Notify the Trust immediately if you or your dependent(s) receive other insurance. If you don't provide the information the Trust needs to coordinate your benefits, claims payments will be delayed or denied. Failure to follow your primary carrier's referrals, authorizations, provider protocols, filing period guidelines, and all other requirements may also result in a denial of benefits. (See the Appeals chapter of this Plan Document.)

Determining Which Plan Pays First

When you are covered by more than one group insurance plan, one plan is considered primary and the other is considered secondary. (Many times, there may be more than two plans.) The Trust uses the following National Association of Insurance Commissioners (NAIC) guidelines to determine which plan pays first, which plan pays second, etc.:

All Coverage

1. Any other plan will automatically be primary if:

   - It is a motor vehicle or home-owner's/business insurance policy. (See **Other Party Liability** in this chapter.)
   - It is a group health plan offered for college students or any other discernible group.
   - It does not have a COB provision.
   - It is a program required or provided by law.

2. The benefits paid by a plan covering the person as an employee, member or subscriber other than a Dependent will be determined before the benefits of a plan that covers an individual as a Dependent.

3. If your Spouse is covered under a retirement plan as a result of his/her former employment, that retirement plan is primary over the Trust Plan, except in the case where your Spouse is covered under both a retirement plan and Medicare. Then, the Trust coverage is primary over both plans' medical coverage.

Unmarried Dependent Children's Coverage

Unless otherwise listed under **Exceptions for Plan of Divorced, Separated or Never-Married Parents** in this section, the following guidelines are used to determine the order of benefits for Dependent Children:

General Guidelines
First, the plan of the parent whose birthday falls earlier in each year will be the primary plan; **But**, if the other plan follows the gender rule, the father's plan will be primary to the plan of the mother.

Coordination of Benefits (COB)

Determining Which Plan Pays First (cont.)

Exceptions for Plans of Divorced, Separated or Never-Married Parents

1. **Court Decree for One Parent to Maintain Financial Responsibility**: The following chart is used to determine which plan is primary, which plan is secondary, etc., when a court decree exists ordering one parent or the other (but not both) to maintain financial responsibility for the health care of the child:

First, the plan of the parent who has financial responsibility; **Second**, the plan of the Spouse of the parent (step-parent) with financial responsibility; **Third**, the plan of the parent without financial responsibility; **Fourth**, the plan of the Spouse of the parent (step-parent) without financial responsibility. **If a determination cannot be made following the guidelines contained in this chart, then the rules listed on the previous page under General Guidelines apply.**

2. **No Court Decree; or Court Decree for Both Parents to Share Financial Responsibility when One Parent Has Primary Custody**: The following chart is used to determine which plan is primary, which plan is secondary, etc., if one parent has been awarded primary custody of the child and a) a court order exists ordering both parents to have equal financial responsibility for the health care of the child; or b) no court order exists regarding such financial responsibility.

First, the plan of the parent who has primary custody; **Second**, the plan of the Spouse of the parent (step-parent) with primary custody; **Third**, the plan of the parent without primary custody; **Fourth**, the plan of the Spouse of the parent (step-parent) without primary custody. **If a determination cannot be made following the guidelines contained in this chart, then the rules listed on the previous page under General Guidelines apply.**

3. **Court Decree for Both Parents to Share Financial Responsibility when Joint Custody Has Been Awarded**: If a court order exists establishing that a) both parents have been awarded joint custody of the child (regardless of which parent has physical custody); and b) the parents must maintain equal financial responsibility for the health care of the child, the plans are coordinated using the **General Guidelines**.

Married Dependent Children's Coverage

General Guidelines
First, the plan covering the dependent the longest will be primary; **Second**, the plan of the parent whose birthday falls earlier in the year; The above rules shall apply until such time as the National Association of Insurance Commissioners (NAIC) establishes specific guidelines for married dependent children at which time the NAIC guidelines will be in effect.

Coordination of Benefits (COB)

How to File Claims When the Trust Coverage is Secondary

If the Trust is the secondary insurance carrier, you or your Provider should submit your claims to both your primary carrier and the Trust. After the primary carrier has processed the claim, you (or your Provider) should submit a copy of the primary carrier's Explanation of Benefits (EOB) to the Trust.

Claims must be received in the Trust office no later than twelve months following the date of service.

CLAIMS NOT RECEIVED IN THE TRUST OFFICE WITHIN TWELVE MONTHS OF THE DATE OF SERVICE WILL BE DENIED!!!

Errors in Payment

If the Trust Plan processes a claim as the primary payer and it is later discovered that another insurance carrier should have been primary, the Trust will request a refund of any benefits paid from you and/or your Provider.

Frequently Asked Questions

If my primary plan states I need a prior authorization for this service or I have to use one of their plan providers and I either do not get the prior authorization or I do not use one of their plan providers, will the Trust pay on these expenses?
No, the Trust will not consider these expenses as you did not follow the guidelines of your primary plan.

My spouse is primary, per the birthday rule, but my coverage through the Trust is better. What happens if I just give the doctor my Trust ID card?
If the Trust Plan processes your claim with the Trust as the primary payer and it is later discovered it was not the primary insurer, the Trust will request a refund of any benefits paid from you and/or your provider.

My dependent's tuition includes coverage for services at their on campus health center. Is this coverage considered to be a group plan?
No, unless you are paying for a separate policy and have a policy number for the insurance, the services at the campus health center are not considered a group medical plan.

Third Party Liability Agreement

Occasionally, you or your Dependent(s) may receive services for Injuries caused by another person or entity. *The plan will not provide benefits for expenses that are the liability of another party due to the commission of a negligent act.* As a Trust participant, you are entitled and encouraged to access the Trust provider network for medical or dental services. The Trust will process your medical or dental expenses pending settlement of any claim you may have against another person. However, before any payment can be made, you must complete and sign a Third Party Liability Agreement and submit it to the Trust office. (If applicable, a police report must also be submitted to the Trust.) If you elect not to complete and sign the Third Party Liability Agreement, your claims will not be paid by the Teachers Health Trust.

By signing the Third Party Liability Agreement, you agree to the following terms and conditions:

- You will make a claim against the other person or entity before the Trust will process your medical or dental claims.
- The Teachers Health Trust has a subrogation provision which requires that the Trust be reimbursed for benefits paid to you or for you when you have a valid and collectible claim against either the person/business responsible for your or your Dependent's Injuries whether or not that person has liability insurance, or under the uninsured/underinsured motorists provision of your own liability policy. This provision applies regardless of whether or not you have been made whole after your claim has been resolved.

Third Party Liability Agreement

- If Medical Payments Coverage (Medpay) is part of your liability insurance policy, and/or part of any insurance policy of the driver of the vehicle or a pedestrian when you were injured, the Trust will not pay benefits for injuries you sustained in an accident as a driver, passenger or pedestrian until any and all Medpay benefits from all applicable insurance policies have been exhausted and the Trust is furnished with written proof of payment by the insurance company(ies).

- Once Medical Payments Coverage (Medpay) is verified as part of your liability insurance policy, and/or part of any insurance policy of the other person or entity that caused your injuries (such as automobile, homeowners, business premises, commercial activities, etc.), the Trust will not pay benefits for injuries you sustained until any and all Medpay benefits from all applicable insurance policies have been exhausted and the Trust is furnished with written proof of payment by the insurance company(ies).

- If the award of damages or the settlement does not specify the portion applicable to medical or dental expenses, the Trust will consider the amount due from the responsible person to be applied to your medical or dental expenses first.

- You must promptly reimburse the Trust for any payments received from the responsible person or entity for medical or dental expenses after deducting allowable attorney fees and court costs. If you fail to do so, the Trust will be authorized to deduct or offset the amount not reimbursed from any future benefits to which you may be entitled under the Plan.

- The Trust may file a Notice of Lien with you and/or your attorney, as well as any liability or business insurance carrier, against any monetary recovery made in connection with another party's liability. You must agree to authorize the filing of the Notice of Lien and agree to obtain the full and complete cooperation of attorneys or representatives in connection with the Trust's efforts to obtain reimbursement under the Agreement.

- You must authorize health care Providers, insurance companies, employers, and attorneys to furnish the Trust with information regarding the treatment for all injuries.

If you do not want to enter into a Third Party Liability Agreement, Trust benefits (if any) will not be paid until after you settle any claims with the person who caused your injuries. Payments from the Trust will then be reduced by any damages and/or settlement paid or owed by that person. If the award of damages or the settlement does not specify the portion applicable to medical or dental expenses, the Trust will consider the amount received to be applied to medical or dental expenses first.

ONCE YOU HAVE RECEIVED A SETTLEMENT, YOU MUST USE THAT SETTLEMENT AMOUNT TO PAY ALL FUTURE EXPENSES RELATED TO THE INJURIES CAUSED BY THE OTHER PARTY. IF THE FUTURE EXPENSES EXCEED THE SETTLEMENT AMOUNT, AFTER PAYMENT OF ATTORNEY'S FEES AND COSTS, IF ANY, YOU MUST PROVIDE ANY DOCUMENTATION REQUESTED BY THE TRUST BEFORE FUTURE INJURY-RELATED EXPENSES WILL BE CONSIDERED FOR PAYMENT BY THE TRUST.

Workers' Compensation

Regardless of the severity or type, any claim for Injury or Illness sustained on the job should be submitted to Workers' Compensation, not the Teachers Health Trust. This includes, but is not limited to, coaching injuries, environmental illnesses, etc.

Filing a Claim

If you become ill or injured on the job, while on school premises, including entering or exiting the building, or while traveling during a school function, the Clark County School District (CCSD) and the State of Nevada require that you submit a written Notice of Injury or Occupational Disease (Form C-1) within seven (7) days of the incident.

Appeals

If your Workers' Compensation claim is denied and the denial gives the right to appeal the denial, you must appeal the Workers' Compensation denial.

Exclusions

The PERFORMANCE PLUS PLAN will not cover expenses for Illness or Injury sustained as a result of being engaged in an activity primarily for wage, profit or gain, or expenses eligible for consideration under any other plan of an employer.

The Plan **will** consider coverage of services for Illness or Injury that result or arises out of any past or present employment or occupation for compensation or profit provided:

- The Participant filed a complete and **TIMELY** claim with his or her employer or other appropriate party and the claim and all permissible appeals (including court reviews) were specifically denied as non-compensable under the Nevada Industrial Act, as amended (or other applicable statue from another state); or

- The Participant who suffers work-related injuries or illnesses is not required to have (and does not have) Workers' Compensation coverage.

For more information regarding Workers' Compensation, contact the CCSD's Risk Management office at 702-799-0060.

Frequently Asked Questions

I injured my back at work a few days ago. How long do I have to file a Workers' Compensation claim?
You must file a report on injuries and/or illness incurred at work within seven (7) days of the incident.

I am a soccer coach and was injured on a trip with the team. Do I have to file for Workers' Compensation?
Yes. If you are participating in any school activities, such as field trips or other events, during or after school and you incur an injury or illness during this time, you must file a Workers' Compensation claim within seven (7) days of the incident.

If I trip in the parking lot coming into school before work or while leaving work, should I file my claim through Workers' Compensation?
Yes. Depending upon the circumstances, Workers' Compensation may cover you from your vehicle to the building and from the building to your vehicle.

With whom do I file my Workers' Compensation claim?
Report your injury or illness to your administrator immediately and then contact the Clark County School District's Risk Management office at 702-799-0060.

Workers' Compensation

Frequently Asked Questions (cont.)

What happens if I do not file my claim within seven (7) days and my claim is denied?
The Trust will not consider claims if Workers' Compensation is denied because you failed to file the claim within a timely manner. Remember, you must report your injury or illness *immediately*.

What type of paperwork will I be expected to complete?
You will have to complete a Form C-1 at your place of employment, a Form C-4 at your treating physician's office, and a TPL or Third Party Liability form from the Teachers Health Trust.

What if I don't think a claim should be considered Workers' Compensation, or what if I prefer to use my Trust coverage instead of Workers' Compensation coverage?
It is not up to you to make that determination. If the Trust deems the injury to be work-related, the Trust will not pay for the service and you will be responsible for any and all charges related to the incident.

Performance Plus Plan Benefits, Chapter 4:

Medical

Contents

Performance Plus Plan Benefits, Chapter 4:

Medical

Contents

Introduction

Once you meet the eligibility requirements for coverage under the Teachers Health Trust, you may elect one of the following options:

Performance Plus Medical Plan*

This option is a patient-centered medical home model (PCMH). It is not a physical place; it is the way your healthcare is accessed. It is healthcare delivery model that provides primary healthcare that is coordinated and focuses on quality and safety while improving accessibility. Your chosen/assigned PCMH provider will be a primary care physician (PCP), Family Practice, Internal Medicine or Pediatric provider. Women may also choose to have an OB/GYN as her second PCMH physician, Deductibles will not apply to services obtained by your PCMH provider. You generally pay a flat copayment for PCMH office visits and 20% coinsurance for all other PCMH services.

Hospital Supplement Plan*

If you decide you DO NOT want coverage under the PERFORMANCE PLUS PLAN, you may enroll in the Hospital Supplement Plan. ***There is no medical coverage available under the Hospital Supplement Plan.*** This Plan pays $260 per day for every day of overnight Inpatient hospitalization for which room and board is charged. This Plan is explained in more detail under **Hospital Supplement Plan** at the end of this **Medical** chapter.

* *Please note, Calendar Year Maximums, Copayment/Coinsurance Maximums, and Copayments are applied on a per person up to a family maximum under the PERFORMANCE PLUS PLAN..*

Frequently Asked Questions

What expenses will the PERFORMANCE PLUS PLAN cover?
The plan provides benefits for Inpatient and Outpatient medical care, including (but not limited to) hospitalizations and surgery, medical office visits, Preventive/Routine Care, physical therapy, Durable Medical Equipment, and prescription drugs.

I just enrolled in the Plan, but I have been treated for a heart condition for the last three years. Will the Plan cover my pre-existing condition?
Yes, the Plan will allow benefits for Covered medical services, regardless of when your medical condition began.

Do I have to see certain doctors for my medical care?
The Performance Plus Plan option is a patient-centered medical home (PCMH) model. You choose a primary care physician (PCP), Family Practice, Internal Medicine or Pediatric provider. Women may also choose to have an OB/GYN as their second PCMH physician, You may also use the services of a provider who is not in the network - but you will pay more out of your own pocket for those services. For more information, please refer to Out-of-Network Services in this medical section.

I know you may not pay for my Cosmetic Surgery or Bariatric Surgery, but will you pay for any complications that may occur?
No. The plan will not cover expenses incurred for complications that result from non-covered treatment or procedures.

I have more questions about my benefits. Where can I get the answers?
Most of your questions will be answered in this Plan Document. (You may wish to search the **Index** at the back of this book for the topic of your question.) However, you are always welcome to contact the Trust's service staff. The Service Team is available by telephone at 702-794-0272 or 800-432-5859 or via e-mail at **serviceteam@teachershealthtrust.org**.

Definitions

The PERFORMANCE PLUS PLAN has common terminology that is explained below and on the following pages to help you understand how your benefits are processed.

Coinsurance

Coinsurance is the *percentage* of the Eligible Medical Expenses (EME) that you pay for a particular service. For example, your coinsurance under the PERFORMANCE PLUS PLAN might look like this:

Type of Service	Eligible Medical Expenses	Your Coinsurance (amount you pay)	Balance Paid by the Trust
Ambulance	$500	20% (or $100)	80% (or $400)

* This amount is hypothetical and may or may not represent an actual EME for ambulance service.

Copayment + Coinsurance

At a PCMH Provider, a copayment is the fixed amount that you pay for a particular service you received and the coinsurance is the percentage you pay of the remaining Eligible Medical Expense (EME). For example, a copayment with coinsurance under the PERFORMANCE PLUS PLAN might look like this:

Type of Service	Eligible Medical Expenses	Copayment	Coinsurance	Balance Paid by the Trust
In-Network Office Visit	$200	$10	$0	$190
Office Surgery	$300	$0	$60	$240

* This amount is hypothetical and may or may not represent an actual EME for a physician office visit.

Definitions

The PERFORMANCE PLUS PLAN has common terminology that is explained below and on the following page to help you understand how your benefits are processed.

Deductible

The deductible is the amount of money a Participant may have to pay before the Trust will pay. Wherever a Plan Benefit lists that the deductible does not apply, the service does not require the participant to pay this amount prior to the Trust paying.

Eligible Medical Expenses (EME)

The Eligible Medical Expenses (EME) are the amounts of the Provider's billed charges that the Trust will consider for payment. The following is the basis for the EME under the PERFORMANCE PLUS PLAN*:

Type of Provider	Eligible Medical Expenses
All In-Network Providers	The contracted amount agreed upon by, or on behalf of, the In-Network Provider and the Plan.
Out-of-Network Providers located within the Service Area	The Plan-selected fee schedule for the level of service or type of equipment provided.
Out-of-Network Providers located outside the Service Area	
• Hospitals/Facility Fees	• The Plan-selected In-Network contract for the level of service provided
• Durable Medical Equipment, Medical Supplies, Drugs, Chiropractic and Acupuncture Services, Physical Therapy, Home Health Care, Home Infusion, Hyperbaric Therapy, Anesthesiology, Pathology and Laboratory.	• The Plan-selected fee schedule for the level of service or type of equipment provided
• All Other Providers	• 50th percentile of the 2012 Medical Data Research (MDR) fee schedule for the area in which the Physician is located

* For retirees who reside outside of the service area, refer to the Retiree Out-of-Area section.

In-Network Provider

An In-Network Provider is a Provider within the Trust's approved list of Providers. Generally, the In-Network Provider maintains a contract with the Trust or WellHealth Quality Care to provide Participants with negotiated fees for medical services.

Using an In-Network Provider for your health care services will help keep your personal expense down. For a comprehensive, frequently updated list of In-Network Providers, access the Trust's website at **www.teachershealthtrust.org**.

In-Network Providers may change at any time without notice. Prior to making an appointment, check the website or contact the Trust. **It is your responsibility to verify services are obtained from an In-Network Provider.**

Out-of-Network Provider

An Out-of-Network Provider is ***not*** on the Trust's approved list of Providers. Since the Trust does not have negotiated fees with Out-of-Network Providers, your personal expense for Out-of-Network services may be much greater than your expense for In-Network services. You will be responsible for deductible, coinsurance and any amount in excess of the Eligible Medical Expense (EME).

Definitions

The PERFORMANCE PLUS PLAN has common terminology that is explained below to help you understand how your benefits are processed.

Service Area

Generally, the Service Area is the area in which the Trust or WellHealth Quality Care maintains contracts with In-Network Providers. The Service Area includes the following locations and their immediate surroundings:

- Clark County, Nevada (including Henderson, Las Vegas, Boulder City, Laughlin, Logandale, Mesquite and Overton)
- Bullhead City, Arizona
- Cedar City, Utah
- St. George, Utah

Locations may be added or deleted from the Service Area, depending upon the availability of In-Network Providers. To confirm a Provider's In-Network status, log on to the Trust's website at **www.teachershealthtrust.org**.

When you obtain services from an Out-of-Network Provider, you will have to pay any amount the Provider charges over the EME.

Benefits Limitations/Maximums

The following maximums apply to the PERFORMANCE PLUS PLAN, regardless of whether the services are performed by In-Network or Out-of-Network Providers. All Medical, Dental, and Vision Maximums carry over to new coverage in all instances, including, for example, if you were a Dependent and are now the Insured or if there was a break in coverage and you re-enrolled.

Type of Benefit	Maximum Benefit Payable
Breast Pump	1 per pregnancy
Compression Garments	4 per limb per calendar year
Foot Orthotics	1 per foot per calendar year
Health Improvement Benefit (available only to licensed employees)	$50 per calendar year
Hearing Aids, including repair and replacement	$1,000 per ear every five years from the date of purchase
100 Days Maximum Services Inpatient Skilled Nursing, Inpatient Acute Rehabilitation, Outpatient, Comprehensive Day or Half-Day Rehabilitation; Inpatient Long Term Acute Care; Mental Health Inpatient Care, Partial Hospitalization and Residential Treatment; Chemical Dependency, Inpatient Care, Partial Hospitalization and/or Residential Treatment	100 days combined maximum per calendar year
Mastectomy Supplies • Bras • Breast Prosthesis • Prosthesis as part of bra	 • 2 per calendar year • 1 per breast every two calendar years • 2 per calendar year
Nutritional Consultants by a registered dietician	6 visits per calendar year
Supplies such as, but not limited to, diabetic and ileostomy.	60 days supply per order
Ultrasounds During Pregnancy	4 per pregnancy unless performed by a perinatologist
Wig or hairpiece	1 wig or hairpiece (up to $300 benefit) following chemotherapy or radiation course of treatment

Copayments/Coinsurance Maximums

In order to help you contain your health care costs, the Trust limits the amount each individual must pay in **copayments** and **coinsurance** during a Calendar Year. These limits are explained in the following charts:

Your Maximum Copayment and/or Coinsurance at In-Network Providers		
Type of Service	**Individual**	**Family**
All Covered In-Network Services (including prescriptions obtained from in-network retail or mail-order pharmacies)	$6,850 per Calendar Year*	$13,700 per Calendar Year*

* After you have met the Maximum Copayment/Coinsurance, the Trust will pay 100 percent of the Eligible Medical Expenses (EME) for Covered In-Network services that you incur during the remainder of the Calendar Year.

Your Maximum Copayment and/or Coinsurance at Out-of-Network Providers		
Type of Service	**Individual**	**Family**
All Out-of-Network Services	No Maximum	No Maximum

Case Management

The Trust provides an RN Case Manager to help you and your family members access services from the health care system. This assistance is called **Case Management** and is provided at no charge to the participant.

It is strongly recommended that you contact the Trust's RN Case Manager if you and/or one of your covered Dependents have difficulties accessing the health care system, if you have been referred to an Out-of-Network Provider for your surgical procedure or surgical approach, or if you have been diagnosed with (or have been receiving treatment related to) the following:

- Cancer
- Cardiac/Cardiovascular Disease
- Diabetes
- High Risk Pregnancy (Also see **Maternity/Pregnancy Services** in this **Medical** chapter)
- Immunodeficiency Diseases/AIDS
- Kidney Dialysis
- Lupus
- Multiple trauma/accidents
- Respiratory/Lung Diseases
- Transplant Services

The Case Management Department is available to assist with exploring your options and accessing the health care system.

MEDICARE/MEDICAID Eligibility

All Trust Participants and Dependents with a disabling condition are required to apply for Medicare and/or Medicaid within 31 Calendar Days of notification by the Trust of their potential eligibility for such programs. Once you receive a copy of your Medicare card, you must submit a copy of it to the Trust.

Contact the Case Management Department via telephone at 866-585-CARE (2273) or via e-mail at **casemanager@teachershealthtrust.org**.

For Transplant Services, failure to contact the Case Management Department will result in NO benefits being paid by the Trust. (See Prior Authorizations in this Medical chapter.)

For Extended Network Benefit Services, failure to contact the Case Management Department will result in Out-of-Network Benefits being paid by the Trust. (See Prior Authorizations in this Medical chapter.)

Prior Authorizations

Certain procedures and services require **Prior Authorization** to evaluate the medical necessity and appropriateness of the service. Accredited medical and behavioral health organizations conduct these reviews for the Trust.

Regardless of what the reviewing organization recommends, it is always up to you and your doctor to decide what, if any, care you receive. In the event you and/or your Physician do not agree with the authorization decision that you receive, your Physician may appeal the decision to the reviewing organization by providing (in writing) additional information to support the initial request for authorization.

You should advise your Physician to obtain **Prior Authorization** on your behalf if the services require it. If **Prior Authorization** is not obtained, benefits for the service may be greatly reduced or not paid at all.

Prior Authorization does not guarantee payment of benefits or determine what level of Plan benefits will apply. To verify eligibility and to determine benefit coverage, contact the Trust:

E-mail: authorizations@wellhealthqc.com
Phone: 702-832-4658 or 844-586-2244

Mental Health and Chemical Dependency Services	
Services Requiring Prior Authorization	• Counselor Visits (after 24 sessions) • Detoxification Medications • Group Therapy Visits (after 24 sessions) • Inpatient Care • Mental Health Nurse Practitioners and Physicians Assistants Visits • Partial Hospitalization • Psychiatric Visits • Psychosocial Rehabilitation and Autism Services • Residential Treatment • Therapist Visits (after 24 sessions) • MD Visits
Who to Contact	Human Behavior Institute (HBI): 702-248-8866 or 800-441-4483
When to Call	At least 48 hours prior to the service. In an emergency, contact HBI as soon as possible following the emergency.

Failure to obtain Prior Authorization for Mental Health and Chemical Dependency Services will result in NO benefits being paid for those services!

Transplant Services/Extended Network Benefit Services	
Services Requiring Prior Authorization	**ALL** Transplant Services and Extended Network Benefit Services
Who to Contact	Teachers Health Trust RN Case Manager 866-585-CARE (2273) or casemanager@teachershealthtrust.org
When to Call for Transplant Services	As soon as your Physician discusses the possibility of a transplant with you or you think you may need follow-up services from a previous transplant.
When to Call for Extended Network Benefit Services	As soon as you are considering accessing services at the Extended Network Benefit level (see the Extended Network Benefit section of this chapter for details).

Failure to coordinate transplant services and follow-up transplant services through the Trust's RN Case Manager will result in NO benefits being paid by the Trust! Please see the Transplant Services section for more information. Failure to contact the Case Management Department in regard to Extended Network Benefits will result in out-of-network benefits being paid for those services! Please see the Extended Network Benefit section for more information.

Prior Authorizations

All Other Services Requiring Prior Authorization	
Services Requiring Prior Authorizations	• Air Ambulance • Blepharoplasty • Botox • Breast Surgery • Continuous Glucose Monitoring Devices • Cosmetic Surgery • CT Scans • Dialysis • Durable Medical Equipment (over $500) • Endoscopy • Extended Network Benefit • Genetic Testing • Hernia Repair • Home Health Care • Hospice Care • Hyperbaric Oxygen Therapy • Inpatient Admissions • IV Infusions • MRI and MRA • Nerve Conduction Studies/ EMG • Oral Appliance for Sleep Apnea • Out-of-Network Laboratory • Outpatient Perinatology • Pain Management (Nerve Blocks) • PET Scans • Sclerotherapy • Skilled Nursing Facility • SPECT Cardiolyte • Testosterone Pellets Insertion • Transplant and Follow-up Transplant Services • Virtual Testing
Who to Contact	Obtain prior authorization from WellHealth Quality Care/TriStar Managed Care as follows: Phone: (702) 832-4658 or Toll Free at (844) 586-2244 Fax: (702) 847-7690 Email: authorizations@wellhealthqc.com
When to Call	**Urgent/Emergency Care:** Within one (1) day of the service or admission to a Hospital. **Non-Urgent/Non-Emergency Care:** As soon as possible prior to the service.

Failure to obtain Prior Authorization through WellHealth Quality Care/TriStar Managed Care for the above-listed services may result in benefits being greatly reduced or not paid at all.

The reviewing organizations are available by telephone or fax 24 hours a day, seven days a week, to accept requests for Prior Authorization.

Filing a Medical Claim

TriStar processes all medical claims for PERFORMANCE PLUS PLAN Participants. Most Providers will file your claim for you and you will not need to provide them with a claim form. If your Provider does require a claim form—and/or if you must file the claim yourself—you may obtain one at the Trust offices or online from the Trust's website at **www.teachershealthtrust.org**.

Your claim for benefits must include the following:

- ID number of the Participant employee (not the Dependent);
- Name and birth date of patient;
- Diagnosis code;
- Date of service;
- Procedure codes/NDC codes; and
- Provider's signature.

Generally, your claim for benefits must be submitted directly to the Trust. If the Trust is the secondary insurance carrier, you or your Provider should submit your claims to both your primary carrier and the Trust. After the primary carrier has processed the claim, you (or your Provider) should submit a copy of the primary carrier's Explanation of Benefits (EOB) to the Trust.

Claims must be received in the Trust office no later than twelve months following the date of service.

CLAIMS NOT RECEIVED IN THE TRUST OFFICE WITHIN TWELVE MONTHS OF THE DATE OF SERVICE WILL BE DENIED!!!

Completed claim forms and attachments must be mailed to:

Teachers Health Trust
P.O. Box 96238
Las Vegas, NV 89193-6238

If claims and/or attachments require foreign language translation, payment of the fee for that service is the responsibility of the Participant.

Extended Network Benefit

All Extended Network Benefit Services Require Prior Authorization!

The **Extended Network Benefit** is applicable to all **Out-of-Network** services that cannot be performed within the Trust's Network, including the UCLA Medical Center Network. The benefit is only applied if pre-authorized by Case Management prior to services being performed and billed to the Trust.

Participants must contact the Trust's RN Case Manager to review their request for benefits at the **Extended Network Benefit** and to schedule an appointment to sign the **Extended Network Benefit** protocol and the Case Management Consent Form. Failure to sign the protocol prior to services being performed or billed will result in NO **Extended Network Benefits** being applied to services!

You may contact the Trust's RN Case Manager via telephone at 866-585-CARE (2273) or via e-mail at **casemanager@teachershealthtrust.org**. (See **Prior Authorizations** at the beginning of this **Medical** chapter.)

Extended Network Benefit

All Extended Network Benefit Services Require Prior Authorization! (cont.)

The **Extended Network Benefit** is available to PERFORMANCE PLUS PLAN Participants. Details are summarized as follows:

Extended Network Benefit	
	Performance Plus Plan
Prior Authorization	Required
Amount You Pay	$2,500 (Out-of-Network Deductible); all professional charges and other services above the Eligible Medical Expenses (EME); and any non-Covered charges

- The Plan will consider medically necessary inpatient and outpatient facility services at an allowance of two (2) times the Trust's In-Network eligible medical expense (EME) amount.
- The Plan will consider medically necessary professional charges and other services at an allowance of 100 percent of the Trust's EME. This rate will be paid at 100 percent after the **Out-of-Network** Calendar Year Deductible has been satisfied.
- Ambulance Services will be limited to the Trust's In-Network EME for transportation to the closest In-Network tertiary-level facility, not to exceed a maximum distance of 300 miles. A tertiary-level facility is a specialty hospital dedicated to specific sub-specialty care where major operations, consultations with sub-specialists, sophisticated intensive care, and advanced diagnostic procedures are performed.
- All services will be subject to the Out-of-Network Calendar Year Deductible and the EME as established by the Teachers Health Trust. The Participant will be responsible for all charges above the Trust's EME, for any non-Covered services, and the Out-of-Network Calendar Year Deductible.

Surgical Approach Out-of-Area

If a surgical approach cannot be performed within the Service Area, you must first contact the Trust's Case Management Department. If the service is approved to be performed Out-of-Area, your hospital charges will be allowed at two (2) times the In-Network Rate. All other services will be the average rate for the area in which the physician is located as determined by 2012 Medical Data Research (MDR). After the deductible has been met, the Eligible Medical Expenses (EME) will be paid at 100 percent. You will be responsible for the deductible and any charges over the EME.

Mandatory Steps Required to Initiate the Extended Network Benefit

1. The Plan Participant must contact the Teachers Health Trust's RN Case Manager at **casemanager@teachershealthtrust.org** or 866-585-CARE (2273).
2. The Plan Participant must have been evaluated by two **In-Network Providers** in different practices within the Teachers Health Trust network. The evaluations must be performed by a specialist in the disease for which services are being requested.
3. Both physicians must document, in writing, that he/she physically examined the participant and is unable to provide appropriate treatment.
4. The plan participant must have the relevant medical records for a medical review by the Trust to determine if the requested Surgical/Medical services noted above can be provided within the Teachers Health Trust or UCLA Medical Center Network.
5. The Trust RN Case Manager will initiate case management, and the Participant will sign the Case Management Consent Form and the **Extended Network Benefit** protocol.

Extended Network Benefit

Mandatory Steps Required to Initiate the Extended Network Benefit (cont,)

6. The Trust's RN Case Manager will review the **Extended Network Benefit** in this Plan Document (PD) with the Participant and the Participant will acknowledge receipt in writing.

7. If the Medical Review states that **In-Network Providers** can perform the requested services, the Plan Participant must agree to receive services through Trust **In-Network** centers or be subject to the **Out-of-Network** Benefits described in this Plan Document.

Exclusions

The following services are not Covered under the PERFORMANCE PLUS PLAN:

- Expenses for experimental or investigational equipment OR services or supplies which have not been approved by the appropriate U.S. government agency or the Teachers Health Trust
- All charges for procedures which require authorization that has not been authorized by WellHealth Quality Care
- All charges for services if the Plan Participant is not eligible under the Teachers Health Trust plan
- Travel and lodging expenses
- Any additional medical/surgical services not noted in the protocol
- Any non-covered services

Limitations

Covered E.N.B. services are limited to a 90-day period beginning on the date that the first E.N.B. services are rendered. Any covered services that are rendered 90 days after the initial date of service will be processed under the out-of-network benefit provisions.

Acupuncture Services

Benefits are available for the services of a licensed acupuncturist, limited to 20 per calendar year, as outlined below:

Acupuncture Services (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Your Selected PCP (No referral required)	Not Required	$10 copayment (deductible does not apply)
Specialist (with or without referral)	Not Required	$20 copayment (deductible does not apply)

Allergy Services

The following charts should help you understand your financial responsibility for Covered Allergy Services:

Allergy Services (In-Network Providers)		
Office Visits	**Prior Authorization**	**Plan Benefit**
Your Selected PCP (No referral required)	Not Required	$10 copayment (deductible does not apply)
Specialist (with referral)	Not Required	$20 copayment (deductible does not apply)
Specialist (without referral)	Not Required	20% coinsurance after $600 deductible
Testing, Injections and Antigens*	**Prior Authorization**	**Plan Benefit**
Your Selected PCP (No referral required)	Not Required	20% coinsurance
Specialist (with referral)	Not Required	20% coinsurance
Specialist (without referral)	Not Required	20% coinsurance after $600 deductible

* Allergy testing is a covered expense only when conducted on a participant. The testing of any allergen source (animal feces, dander, plants, etc.) is not covered under the Trust plan. See the Non-Covered Expenses section of this Medical Chapter for more information.

Ambulance Services

Covered Expenses

The Performance Plus Plan will cover Emergency professional local ground or air Ambulance Services to a facility equipped to treat your Illness or Injury.

Limitations

The Plan will not cover Ambulance Service for non-emergency transportation unless the service is approved in advance.

Additionally, Ambulance Services will be limited to the Plan's In-Network Eligible Medical Expenses (EME) for transportation to the closest In-Network tertiary-level facility, not to exceed a maximum distance of 300 miles. This excludes approved transplant-associated Ambulance Services. A tertiary-level facility is a specialty hospital dedicated to specific sub-specialty care where major operations, consultations with sub-specialists, sophisticated intensive care, and advanced diagnostic procedures are performed.

Ambulance Services (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Ambulance	Not Required	20% coinsurance (deductible does not apply)
Air Ambulance	Required	20% coinsurance (deductible does not apply)

Anesthesia Services

SOME ANESTHESIA SERVICES REQUIRE PRIOR AUTHORIZATION! Always make sure your Physician contacts WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244, prior to your service! Prior Authorization services will be conducted by TRISTAR Managed Care. (See Prior Authorizations at the beginning of this Medical chapter.)

ANESTHESIA SERVICES (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Inpatient/Outpatient Surgery*	See Prior Authorizations	20% coinsurance after $600 deductible

* Be careful! Your surgeon may not always refer you to an In-Network anesthesiologist. This will greatly increase your personal expense! (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.)

Frequently Asked Questions

What happens if my doctor uses an Out-of-Network anesthesiologist during my surgery?
If you normally reside within the Service Area and had **Emergency** surgery, you will be responsible for the In-Network benefits listed in this **Anesthesia Services** section. You will also be responsible for paying any amount the Provider charges over the Trust's Eligible Medical Expenses (EME).

If your surgery was **pre-planned**, or if you normally reside outside the Service Area, you will be responsible for paying the Out-of-Network Deductible and Coinsurance listed in the **Out-of-Network Services** section of this **Medical** chapter **PLUS** any amount the Provider charges above the Trust's EME.

Please refer to the **Out-of-Network Services** section of this **Medical** chapter for additional information.

How can I make sure my doctor uses In-Network Providers during my surgery?
Using these three simple steps may reduce your personal expense for your surgical procedure:

- ***FIRST***, ask your doctor in advance what other Providers he will be using for the surgery (including Hospital, Hospitalist, anesthesiologist, and assistant surgeon).
- ***THEN***, go to **www.teachershealthtrust.org** and search the Provider directory to see if the Provider is in the Trust's network.
- ***FINALLY***, if one or more of the Providers is not in the Network, print the names of the In-Network Providers and ask your doctor to refer you to one of them.

Chemical Dependency Services

SOME CHEMICAL DEPENDENCY SERVICES REQUIRE PRIOR AUTHORIZATION! Always make sure your Physician contacts WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244, prior to your service! Prior Authorization services will be conducted by TRISTAR Managed Care. (See Prior Authorizations at the beginning of this Medical chapter.)

Individual and Group Therapy Sessions (In-Network Providers)		
Inpatient/Outpatient Visits	**Prior Authorization**	**Plan Benefit**
Psychiatrists, Mental Health Nurse Practitioners and Physician Assistants	Required	$20 copayment (deductible does not apply)
Therapists, Counselors and Group Therapy	Required after the 24th visit	$20 copayment (deductible does not apply)

Exclusions

The following services are **not Covered**:

- Administrative services, such as expert testimony; medical records review and maintenance; preparation of reports regarding civil or legal matters, or ability to stand trial; or consultations with attorneys or other representatives of social services.
- Consultation with a professional for adjudication of marital, child support and custody cases.
- Private duty nursing.
- Custodial and institutional care which is for the primary purpose of controlling or changing the Participant's environment.

Chemical Dependency Services (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Inpatient Care Facility	Required	$400 per day; maximum $800 per admission (Deductible does not apply)
Partial Hospitalization and Residential Treatment Facility	Required	$150 per day; maximum $900 per admission (Deductible does not apply)
Maximum Benefit Payable by the Plan	N/A	100 days combined maximum*

* See Benefit Limitations/Maximums

Drug Detox Protocol: Medications used to aid in detoxification of drugs and alcohol are covered under the prescription drug plan only when prior authorization is obtained through Human Behavior Institute (HBI).

If your physician prescribes a detoxification medication, you will need to make an appointment with HBI for an assessment. If HBI approves your medication, the Trust will be notified. You must fax a legible copy of the prescription, which includes the drug name, strength, patient name and patient date of birth to the Trust at 702-794-2093. The Trust will need to establish coverage for the specific time frame, medication and strength prescribed before you will be able to obtain the medication from the pharmacy.

Watch out! If Chemical Dependency Services are performed by an Out-of-Network Provider, it will greatly increase your personal expense! (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.)

Chemotherapy and Radiation Services

If Chemotherapy and/or Radiation Services are performed on an Outpatient basis or at an Outpatient facility while you are Inpatient at another facility, you will be responsible for the following:

Chemotherapy and Radiation Services (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Chemotherapy/Radiation Services (with referral)	Not Required	$20 copay (deductible does not apply)
Chemotherapy/Radiation Services (without referral)	Not Required	20% coinsurance after $600 deductible

Watch out! If Chemotherapy and/or Radiation Services are performed by an Out-of-Network Provider, it will greatly increase your personal expense! (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.)

Chiropractic Services

Chiropractic services are limited to a maximum benefit of 20 visits per calendar year. Benefits are available for the services of a licensed chiropractor as outlined below:

Chiropractic Services (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Specialist (with or without referral)	Not Required	$20 copay (deductible does not apply)

Watch out! If Chiropractic Services are performed by an Out-of-Network Provider, it will greatly increase your personal expense! (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.)

Chronic Care Programs

The Teachers Health Trust, in partnership with WellHealth, will be providing several Chronic Care Programs; covering conditions that include Diabetes, Asthma/COPD, Congestive Heart Failure and Hypertension as well as High Risk Pregnancy. Members enrolled in these programs will receive the following benefits when visiting specialists specifically identified for their illness:

PCMH Chronic Care Programs (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Medical Home Identified Chronic Condition Patients (Primary Care of Specialist Physician Office Visit – Diabetes, High-Risk Pregnancy, Cardiovascular, COPD and Asthma)	Not Required	$0 copay for office visit (deductible does not apply); 20% coinsurance for all other services (deductible does not apply)

Please note: Only one identified provider (Endocrinologist, Cardiologist, Pulmonologist and Perinatologist) may be included in the PCMH per chronic illness, per patient, in addition to your chosen PCP, Pediatrician, and/or OB/GYN. Additional conditions arising from the above mentioned chronic illnesses may not be included. For example: If you are a diabetic patient who also sees a podiatrist for complications arising from or related to diabetes, you will still be subject to all applicable specialist copays when visiting your podiatrist.

Further information and details about the Chronic Care Programs will be dispersed to members directly. For questions or concerns, please contact the Healthcare Advocate team at (855) 404-9355 or at advocates@wellhealthqc.com.

Concierge Care

Concierge Care (also known as Boutique Medicine) is a term used to describe a relationship with a physician in which the patient pays an annual fee or retainer. In exchange for the retainer, a physician agrees to provide enhanced care, such as a comprehensive annual physical and 24-hour access to the physician via phone. This fee does not usually cover the cost of other services provided by the physician during the year.

The concierge care fee and any services included in the fee are **not covered** by the PERFORMANCE PLUS PLAN. Any physician who charges a concierge care fee will be terminated from his/her in-network provider status with the Trust, and all covered services he/she provides will be paid at the out-of-network benefit level.

CONCIERGE CARE (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Annual Fee and services included in the annual fee	Not Required	Not Covered
Other Covered Services not included in the fee, such as office visits	Not Required	Covered at the Out-of-Network Benefit

My annual concierge care fee included a well care physical exam or other covered service. Can I be reimbursed for a portion of my concierge fee?

No. Regardless of whether a typically covered service is provided as part of your concierge care, any fee for services that are included in the concierge care fee will not be considered a covered expense and will not be reimbursed

Cosmetic Services

The Plan will not cover any expenses related to Cosmetic Surgery, including gender reassignment and breast reconstruction surgery, unless:

- It is Cosmetic Surgery for repair of damage sustained in an accident and the charges are incurred no later than one year following the date of the accident;
- It is Cosmetic Surgery to reconstruct the breast following a mastectomy (see **Women's Health and Cancer Rights Act of 1998** under the **Legal Notices** chapter of this Plan Document); or
- It is Cosmetic Surgery to correct a congenital anomaly that improves function.

The Plan will also not cover expenses in connection with surgical or invasive procedures—or the reversal of such procedures—for treatment of obesity (bariatric surgery), regardless of associated medical or psychological conditions. The Plan does not cover expenses for the treatment of the complications resulting from bariatric surgery.

Additional non-Covered expenses include, but are not limited to:

- Cosmetic drugs (including Minoxidil) or any other drug used to treat alopecia
- Anorexiant agents (weight reducing drugs)
- Hair transplants and related services
- Injections to remove wrinkles from the skin
- Liposuction and related services

The Trust reserves the right to determine whether additional services or supplies not listed here will be considered cosmetic in nature and not Covered under the Plan.

Diabetic and Nutritional Education

Diabetic Education Classes

Participants on the Performance Plus Plan are entitled to Diabetic Education through any In-Network Diabetic Educator. Contact the Trust for a list of Diabetic Educators within the Trust Network. No prior authorization is required.

Diabetic Education Classes (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
In-Network Classes (with referral)	Not Required	$0 copay (deductible does not apply)
In-Network Classes (without referral)	Not Required	20% coinsurance (deductible does not apply)

Nutritional Consultations

Participants on the Performance Plus Plan are entitled to six (6) outpatient visits per Calendar Year for Nutritional Consultations with an In-Network Registered Dietician. No prior authorization is required.

Nutritional Consultations (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Registered Dietician (with referral)	Not Required	$20 office visit copay (deductible does not apply); 20% coinsurance for all other services
Registered Dietician (without referral)	Not Required	20% coinsurance after $600 deductible

Watch out! If you use an Out-of-Network Dietician or Diabetic Educator, you are subject to the Out-of-Network deductible and payment will be limited to the In-Network rates. Nutritional counseling is a covered benefit under the plan only when a registered dietician provides the services. Services provided by a nutritionist are not a covered benefit under the plan.

Diagnostic Testing

SOME DIAGNOSTIC TESTS SERVICES REQUIRE PRIOR AUTHORIZATION! Always make sure your Physician contacts WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244, prior to your service! Prior Authorization services will be conducted by TRISTAR Managed Care. (See Prior Authorizations at the beginning of this Medical chapter.)

Diagnostic Testing (In-Network Providers)		
Radiology	**Prior Authorization**	**Plan Benefit**
Freestanding Diagnostic Facility	Not Required	$0 copay (deductible does not apply)
Hospital Facility*	Not Required	20% coinsurance (deductible does not apply)
PCP Office (X-rays of chest, spine. pelvis and extremities, abdomen; ultrasound of abdomen, dexa bone density)	Not Required	20% coinsurance (deductible does not apply); All other radiology services in a PCP office are not covered
All Other In-Network Providers (with referral)	Not Required	20% coinsurance (deductible does not apply)
All Other In-Network Providers (without referral)	Not Required	20% coinsurance after $600 deductible
CT Scan	**Prior Authorization**	**Plan Benefit**
Freestanding Diagnostic Facility	Required	$50 copay (deductible does not apply)
Hospital Facility*	Required	20% coinsurance (deductible does not apply)
PCP Office	N/A	Not Covered
All Other In-Network Providers (with referral)	Required	20% coinsurance (deductible does not apply)
All Other In-Network Providers (without referral)	Required	20% coinsurance after $600 deductible
MRI	**Prior Authorization**	**Plan Benefit**
Freestanding Diagnostic Facility	Required	$75 copay (deductible does not apply)
Hospital Facility*	Required	20% coinsurance (deductible does not apply)
PCP Office	N/A	Not Covered
All Other In-Network Providers (with referral)	Required	20% coinsurance (deductible does not apply)
All Other In-Network Providers (without referral)	Required	20% coinsurance after $600 deductible
PET	**Prior Authorization**	**Plan Benefit**
Freestanding Diagnostic Facility	Required	$200 copay (deductible does not apply)
Hospital Facility*	Required	20% coinsurance (deductible does not apply)
PCP Office	N/A	Not Covered
All Other In-Network Providers (with referral)	Required	20% coinsurance (deductible does not apply)
All Other In-Network Providers (without referral)	Required	20% coinsurance after $600 deductible
Cardiology Nuclear Diagnostic Procedures	**Prior Authorization**	**Plan Benefit**
Outpatient Hospital Facility	Required	20% coinsurance (deductible does not apply)
Cardiology Providers (with referral)	Required	20% coinsurance (deductible does not apply)
Cardiology Providers (without referral)	Required	20% coinsurance after $600 deductible

* When there is no facility copay; applicable copay and or coinsurance will apply.

Diagnostic Testing

SOME DIAGNOSTIC TESTS SERVICES REQUIRE PRIOR AUTHORIZATION! Always make sure your Physician contacts WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244, prior to your service! Prior Authorization services will be conducted by TRISTAR Managed Care. (See Prior Authorizations at the beginning of this Medical chapter.)

Diagnostic Testing (In-Network Providers)		
Virtual Colonoscopies, Capsule Endoscopies	**Prior Authorization**	**Plan Benefit**
Outpatient Hospital Facility	Required	20% coinsurance (deductible does not apply)
PCP Office	N/A	Not Covered
All Other In-Network Providers (with referral)	Required	20% coinsurance (deductible does not apply)
All Other In-Network Providers (without referral)	Required	20% coinsurance after $600 deductible
Surgeon Charges	Required	20% coinsurance after $600 deductible
Genetic Testing*	**Prior Authorization**	**Plan Benefit**
In-Network Providers (with referral)	Required	20% coinsurance (deductible does not apply)
In-Network Providers (without referral)	Required	20% coinsurance after $600 deductible
In-Network Standalone Lab (with referral)	Required	$0 copay per test
In-Network Standalone Lab (without referral)	Required	$0 copay per test
Out-of-Network Testing Other Than Specialty Lab	Required	See Out-of-Network Benefits

* For more information, see genetic testing.

Laboratory/Pathology (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Hospital Facility - Inpatient	Not Required	Included in hospital copay
Hospital Facility - Outpatient*	Not Required	20% coinsurance (deductible does not apply)
Performed by Quest Diagnostics or an In-Network Dialysis Lab	Not Required	$0 copay (deductible does not apply)
PCP	Not Required	20% coinsurance (deductible does not apply)
Physician's Office (with referral)	Not Required	20% coinsurance (deductible does not apply)
Physician's Office (without referral)	Not Required	20% coinsurance after $600 deductible
Specialty Lab/Pathology**	Required	20% of Eligible Medical Expenses
Performed by an Out-of-Network Provider and Services Do Not Meet Definition of Specialty Laboratory/Pathology**	Required	See Out-of-Network Benefits

* When there is no facility copay; applicable copay and or coinsurance will apply.

** By definition, Specialty Laboratory/Pathology Testing is any Laboratory and Pathology Testing requested by an In-Network Provider that cannot be performed In-Network and for which no alternative test that provides comparable clinical information is available In-Network. If your In-Network physician requests these tests for you, please have the physician's office contact WellHealth prior to having the tests completed to determine if the same or alternative test can be performed in-network. If the same or alternative test could be performed in-network but you choose to use an out of network lab, the out of network benefit will apply if authorization for the test was obtained through the utilization review company prior to completion of the test.

Watch out! If Non-Emergency Diagnostic Testing is performed by an Out-of-Network Provider, it will greatly increase your personal expense! (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.) Be careful! Your Physician may not always refer you to an In-Network Diagnostic Testing Provider.

Dialysis and Related Services

SOME DIALYSIS SERVICES SERVICES REQUIRE PRIOR AUTHORIZATION! Always make sure your Physician contacts WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244, prior to your service! Prior Authorization services will be conducted by TRISTAR Managed Care. (See Prior Authorizations at the beginning of this Medical chapter.)

If Dialysis is performed on an outpatient basis, you will be responsible for the following:

Dialysis and Related Services (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Physician/Nephrologist (with referral)	Not Required	$20 copay for office visit (deductible does not apply); 20% coinsurance for all other services (deductible does not apply)
Physician/Nephrologist (without referral)	Not Required	20% coinsurance after $600 deductible
Facility (with or without referral)	Required	$20 copay (deductible does not apply)
CAPD, CCPD, Home Dialysis including training, physician evaluation, ultrafiltration and supplies (with or without referral)	Required	$20 copay (deductible does not apply)

If you (or one of your Eligible Dependents) are diagnosed with a disabling condition, you are required to apply for Medicare within 31 Calendar Days of notification of your potential eligibility for such programs. **Watch out!** If Dialysis Services are performed by an Out-of-Network Provider, it will greatly increase your personal expense! (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.)

Durable Medical Equipment and Supplies

Prior Authorization is required for Durable Medical Equipment (DME) valued at $500 or greater and also for all repairs and/or replacement of DME. To obtain authorization, your Provider must contact WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244, prior to obtaining the DME. Prior Authorization services will be conducted by TRISTAR Managed Care. (See Prior Authorizations at the beginning of this Medical chapter.)

Durable Medical Equipment and Supplies (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
DME Valued at Under $500 (with or without referral)	Not Required	20% coinsurance (deductible does not apply)
DME Valued at Over $500 (with or without referral)	Required	20% coinsurance (deductible does not apply)

Definition

Durable Medical Equipment, commonly known as DME, is medical equipment recognized as such by Medicare Part B that meets all of the following criteria:

- It can stand repeated use and is not disposable;
- It is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience;
- It is usually not useful to a person in the absence of sickness or Injury;
- It is appropriate for home use;
- It is related to the patient's physical disorder; and
- It is certified and prescribed by a Physician as being Medically Necessary.

Durable Medical Equipment and Supplies

Definition (cont.)

DME includes, but is not limited to, crutches; Hospital-type beds; portable commodes; shower seats; oxygen equipment and related supplies; walkers; wheelchairs and oral appliances for sleep apnea. For information related to artificial limbs or eyes, braces or orthotics, please refer to **Prosthetics, Braces and Orthotics** in this **Medical** chapter.

Limitations

General

The Trust will not provide benefits for the rental or purchase of equipment such as air conditioners, dehumidifiers, heating pads, elevators, chairlifts, other modifications of stairs or vehicles, hot water bottles, water beds, swimming pools, hot tubs and any other clothing or equipment which could be used in the absence of an illness, injury, or as equipment for vacation or travel.

Rental vs. Purchase

The Plan will pay for the rental Eligible Medical Expenses (EME) of Covered DME but only up to the amount of the purchase price. Therefore, you and your Physician should first determine how long you are going to need the equipment. If the cost of renting the item is more than the purchase price, the Trust reserves the right to allow benefits for the purchase of the Covered item instead of the rental price.

Repair/Replacement

The Trust will not allow benefits for any expenses to replace or repair lost, stolen, mistreated, abused or not medically necessary DME. If your DME does require repair or replacement, contact WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244.

Insulin pump replacement will be Covered only after a four-year period of time following the initial purchase of the insulin pump provided it meets medical necessity guidelines. Any replacement insulin pump purchased prior to the end of the four-year period of time will be the responsibility of the Participant, unless the patient's medical condition changes in accordance with Medicare guidelines.

Breast Pump

The Trust will provide one breast pump per pregnancy, from the delivery date to six months following the birth of a child, at no charge to the participant, at the Trust office. Contact the Trust to confirm eligibility and schedule pick up. One Breast Pump per pregnancy is provided to the participant as part the DME covered benefits. Breast pumps are covered under the PERFORMANCE PLUS PLAN. These benefits are limited to the pump. Supplies not directly related to the breast pump are not covered.

Watch out! If your Durable Medical Equipment is provided by an Out-of-Network Provider, it will greatly increase your personal expense! (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.) Be careful! Your Physician may not always refer you to an In-Network DME Provider.

Durable Medical Equipment and Supplies

Frequently Asked Questions

My doctor prescribed medical equipment that can only be obtained from an Out-of-Network Provider. How will my claim be paid?
The DME will be paid at the Out-of-Network level of benefits. You will be responsible for any portion of the Out-of-Network Calendar Year Deductible that you have not yet met as well as 40% of the Trust's Eligible Medical Expenses (EME). You will also be required to pay any amount that the Provider charges over the Trust's EME.

What can I do to make sure my DME is obtained from an In-Network Provider?
While there may be times when you will be unable to find an In-Network Provider who can provide you with the prescribed DME, using these three simple steps may help reduce your personal expense:

- ***FIRST***, ask your doctor in advance what Providers he or she recommends for the DME.
- ***THEN***, go to **www.teachershealthtrust.org** and search the Provider directory to see if the DME Provider is in the Trust's network.
- ***FINALLY***, if the Provider is not in the network, print the names of the In-Network Providers and ask your doctor to refer you to one of them.

What steps can I take to try to save money on my DME equipment?
Get your doctor involved!

Of course, whenever possible you should try to use In-Network Providers for your DME. If he or she has prescribed DME that only an Out-of-Network Provider can supply, ask if there is an alternative piece of equipment that may be appropriate for your condition that can be provided by an In-Network Provider.

Finally, DME has many options with varying prices. You pay a percentage of the EME, so you should ask your Physician to prescribe a brand that is appropriate for your needs as well as for your personal budget.

Emergency Services

Emergency Services are **Medically Necessary Services** received from an In- or Out-of-Network* Provider in connection with an *unforeseen* Injury or Illness requiring surgical or medical attention within 24 hours after the onset, and from which, in the absence of such care, the Participant could reasonably be expected to suffer serious physical impairment or death.

True Emergencies, as determined by the Trust, include, but are not limited to, the following:

- Cardiovascular accidents (CVA)
- Emergency admissions
- Fractures
- Heart attacks
- Hemorrhaging
- Inpatient hospitalizations
- Loss of consciousness

If a Participant visits the emergency room for any non-urgent reason (such as a common cold, chronic pain, or minor cuts), there will be a different copay responsibility as indicated under "Non-Emergency Services."

EMERGENCY SERVICES* (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Ambulance	Not Required	20% coinsurance (deductible does not apply)
Emergency Room Services (True Emergency)	Not Required	$250 (deductible does not apply)
Emergency Room Services (Non-Emergency)	Not Required	$400 (deductible does not apply)
Inpatient Hospital	Required	$400 per day, $800 max per stay (deductible does not apply)
Physician Services (Including, but not limited to; Emergency Room Physician, Surgeon, Assistant Surgeon, Anesthesiologist, Hospitalist, Specialist Physician and PCP other than your selected PCP.	See Prior Authorizations	20% coinsurance after $600 deductible

* Out-of-Network Deductibles are waived for Out-of-Network Emergency Services. However, you will still be responsible for the Copayment (or Coinsurance) listed above. See the **Out-of-Network Services** section of this **Medical** chapter for additional expenses you may have.

If You (and/or Your Dependent) Normally Live Within the Service Area*

If you and/or your Dependent(s) normally reside within the Service Area and are visiting outside of the Service Area, the Out-of-Network Deductible is waived for Urgent Care Services you receive from an Out-of-Network Provider. However, all other Out-of-Network benefits will apply to the Urgent Care Services incurred.

* To reside within the Service Area means you and your Dependents live or work in the Service Area at least nine months of each Calendar Year and you and your Dependents have not moved out of the Service Area prior to receiving services.

EMERGENCY ROOMS ARE FOR EMERGENCIES! **Using the Emergency Room for non-Emergency care increases your personal expense. See your In-Network family Physician for non-Emergency care and your expense will be much lower.**

Emergency Services

Frequently Asked Questions

Is Prior Authorization required for Emergency Services?
Prior Authorization is always required for certain services. In an Emergency, the authorization should be obtained within 24 hours of the service. To view a list of services that require Prior Authorization, please refer to the **Prior Authorizations** section of this **Medical** chapter.

I live in Las Vegas, Nevada, but I was injured while on vacation in Florida and I had to visit an Emergency Room. Will my Out-of-Network Expenses be covered?
If you normally reside within the Service Area and had Emergency Services in the emergency room outside the Service Area, you will be responsible for the In-Network Copayments and Coinsurance listed in this **Emergency Services** section.

My family and I live outside of the Service Area. How will our Emergency Services be covered?
If you normally reside outside of the Service Area and you receive Emergency Services for a True Emergency from an Out-of-Network Provider, you will be responsible for the Emergency Room copay. No deductible will apply.

My daughter is a Student currently attending college and living outside of the Service Area. How will her Emergency Services be covered?
Covered Emergency Services will be processed according to the Emergency Room benefit. No deductible will apply.

While in California, I went to the Emergency Room for treatment of a cold. Will that be covered by my Plan?
This would be considered Out-of-Network. You will be responsible for 40% coinsurance after out-of-network deductible is met, plus any charges over EME.

I was taken by ambulance to an Out-of-Network facility/provider in the Service Area. Will my visit be covered?
The Trust will waive the Out-of-Network Deductible and apply the In-Network Copayments and Coinsurance listed in this **Emergency Services** section. You will also be responsible for all charges above the In-Network EME.

Essential Health Benefits (Preventive/Routine Care)

One of the keys to maintaining good health is through regular preventive and routine care. The Essential Health Benefits are provided to assist participants with this care.

All Essential Health Benefits must be received only at your selected PCP unless services can not be performed; in which case another in-network provider may be used.. No office visit copay will apply for Essential Health Benefits provided when an in-network provider is utilized. The Essential Health Benefits include, but are not limited to, preventive services and screenings found in this section.

Coverage for Pre-Existing Conditions

The Teachers Health Trust does not have any pre-existing conditions in its medical plan. An insurer cannot reject you, charge you more,or refuse to pay for essential health benefits for any medical condition you had before your coverage started.

Emergency Services

Insurance coverage provides any benefits for emergency services in an emergency department of a hospital. The Teachers Health Trust will cover emergency services for an emergency diagnosis without regard to whether a particular health care provider is an in-network provider with respect to the services, and generally cannot impose any copayment or coinsurance that is greater than what would be imposed if services were provided in network.

Lifetime and Annual Maximums

The Teachers Health Trust imposes no annual or lifetime dollar limits on the Essential Health Benefits you receive.

- Out-of-pocket maximum: This is the total amount you will have to pay no matter how much covered care you get in a plan year from an in-network provider. **Example:** If your plan has a $6,850 for individual and a $13,700 out-of-pocket maximum for your family, once you pay $6,850 for yourself or $13,700 for your family in coinsurance and copayments, the plan pays for any in-network covered care for the rest of the year.

- No annual or lifetime limits: The Trust does not put dollar limits on how much we will spend each year or over your lifetime to cover essential health benefits.

The Trust may impose an annual dollar limit and a lifetime dollar limit on spending for health care services that are not considered essential health benefits.

Pregnancy, Maternity and Newborn Care (Pre and Post Delivery)

The Teachers Health Trust covers a set of preventive services and screening tests at no cost to you, provided an in-network provider is utilized. For detailed information, see the Essential Health Benefits listing later in this section.

Breastfeeding Benefits

The Trust will provide one breast pump per pregnancy, from the delivery date to six months following the birth of a child, at no charge to the participant at the Trust office. Contact the Trust's Service Department to confirm eligibility and schedule pick up. One Breast Pump per pregnancy is provided to the participant as part the DME covered benefits. Breast pumps are covered under the PERFORMANCE PLUS PLAN. These benefits are limited to the pump. Supplies not directly related to the breast pump are not covered.

Essential Health Benefits (Preventive/Routine Care)

Birth Control Benefits

All Food and Drug Administration-approved contraceptive methods prescribed by a woman's doctor are covered, including:

- Barrier methods (used during intercourse), like diaphragms and sponges
- Hormonal methods, like birth control pills and vaginal rings
- Implanted devices, like intrauterine devices (IUDs)
- Emergency contraception, like Plan B® and ella®
- Sterilization procedures
- Patient education and counseling

Formulary and Step Therapy requirements apply.

The Trust is not required to cover:

- Drugs to induce abortions
- Services related to a man's reproductive capacity, like vasectomies

All over-the-counter contraceptives must have a prescription provided by your in-network physician.

Dental Coverage

Dental coverage for children is an essential health benefit. This means that if you are getting health coverage for someone 18 or younger, dental coverage must be available for your child as part of a health plan or as a stand-alone plan. **Note:** While dental coverage for children must be available to you, you do not have to buy it.

Dental coverage is not an essential health benefit for adults. Insurers do not have to offer adult dental coverage.

Laboratory Services

Some common laboratories tests and screenings are considered Essential Health Benefits. All laboratory services will be at no charge to you if performed by an in-network laboratory. For detailed information, see the Essential Health Benefits listing later in this section.

Mental Health and Substance Use Disorder Evaluations

These evaluations include behavioral health screenings, drug and alcohol abuse screenings and/or brief interventions in the primary care setting.

Pediatric Services

Pediatric Services for Essential Care Benefits are offered through your child's in-network pediatrician, in-network primary care provider or through the Southern Nevada Health District. This includes dental and vision screenings.

Prescription Drugs

All medication indicated under the Essential Health Benefits must be ordered by an in-network provider and be accompanied with a prescription, including all approved Essential Health Benefits over-the-counter medication.

Essential Health Benefits (Preventive/Routine Care)

Vaccinations

Vaccinations received for the purpose of domestic and/or international travel are not covered under the Essential Health Benefits and include, but are not limited to, those received for:

- The purpose of domestic and/or international travel
- Adenovirus
- Anthrax
- Bacillus Calmette-Guerin (Tuberculosis)
- Cholera
- Japanese Encephalitis
- Plague
- Rabies
- Typhoid
- Yellow fever

Vaccinations Not Covered Under Essential Health Benefits (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Your Selected PCP (No referral required)	Not Required	20% coinsurance (deductible does not apply)
Southern Nevada Health District* (with or without referral)	Not Required	20% coinsurance (deductible does not apply)
Specialist (with referral)	Not Required	20% coinsurance (deductible does not apply)
Specialist (without referral)	Not Required	20% coinsurance after $600 deductible

* Vaccinations covered under the Essential Health Benefits obtained at the Southern Nevada Health District are covered at no copayment or coinsurance to the participant.

Watch out! If Vaccinations are provided by Out-of-Network Providers, your personal expense will increase dramatically. (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.)

Essential Health Benefits (Preventive/Routine Care)

Preventive Services

The Teachers Health Trust plan covers the following list of preventive services without charging you a copayment or coinsurance. **This applies only when these services are delivered by an in-network provider.**

Service	Age Limitation	How Often	Requirements
Abdominal Aortic Aneurysm	Males age 65 to 75 who have ever smoked	Once per lifetime	Abdominal ultrasound scan
Aspirin	Male age 45-79 Female age 55-79		Present a prescription from your in-network provider to an in-network pharmacist
Bone Density	Female age 60 and older		
BRCA Testing	Genetic testing for women of higher risk		Prior authorization required.
Breast Pump	At birth – 6 months	1 per pregnancy	Available for pick-up by appointment from the Trust Service Department ONLY
Colorectal Cancer Screening (Colonoscopy)	Adults over age 50 - 75	Every 10 years	
Colorectal Cancer Screening (Sigmoidoscopy)	Adults over age 50 - 75	Every 5 years	
Fecal Occult Blood	Adults over age 50 - 75	Once per Calendar Year	
Folic Acid	Females planning pregnancy		Present a prescription from your in-network provider to in-network pharmacist
Hearing Test	Birth – Age 21	One per Calendar Year	
Herpes Zoster Vaccination (Shingles)	Age 60 and over, 50-59 with proper requirements	Once per lifetime	Prescription from in-network provider if age 50-59
HIV Testing	Ages 15 – 65 and Pregnant Women	At least One per lifetime	Testing must be done at an in-network laboratory
Influenza Vaccination (Flu)		One per Calendar Year	To be obtained at CVS pharmacy only (excluding Minute Clinic)
Iron Supplement	For anemic children		Present a prescription from your in-network provider to an in-network pharmacist
Mental Health			Screening
Mammogram	Adults age 40 and older	One per Calendar Year	
Pap Smear	Age 21 - 65	1 every 3 years	
Pneumococcal Vaccination (Pneumonia)	Age 65 and Over, unless qualified due to a condition as outlined by the CDC		

Essential Health Benefits (Preventive/Routine Care)

Preventive Services (cont.)

Service	Age Limitation	How Often	Requirements
Immunizations	Vaccine for adults – doses, recommended ages and populations as outlined by the CDC. Vaccinations include: • Hepatitis A • Hepatitis B • Herpes Zoster • Human Papillomavirus • Influenza (Flu Shot) • Measles, Mumps, Rubella • Meningococcal • Pneumococcal • Tetanus, Diphtheria, Pertussis • Varicella		Vaccinations may be received through the Southern Nevada Health District or an in-network provider. **Watch out! If a vaccination other than for Influenza (Flu) is received at CVS, your personal expense will increase dramatically.**
Smoking Cessation	For those who use tobacco products	4 Tobacco Cessation consultations per Calendar Year	FDA approved tobacco cessation Medication, including over-the-counter. Must present a prescription from your in-network provider to your in-network pharmacy
Vision Screening	For children up to age 5	One per Calendar Year	
Well-woman Visit		One per Calendar Year	Well-woman visits include a full checkup; separate from any other visit for sickness or injury. These visits focus on preventive care for women

Essential Health Benefits (Preventive/Routine Care)

Preventive Health Services and Screenings

The services listed in this section are covered under the Preventive/Routine Care Benefit when no diagnosis is present and delivered by an in-network provider. Prior authorization requirements established throughout this Plan Document apply to all Preventive/Routine Care.

Many of the screenings listed in this section are inclusive as part of a single preventive **medical** care office visit, such as comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures. It is highly recommended that you have a primary care physician to handle all of your Essential Health Benefits screenings.

Preventive Health Services and Screenings for Adults

1. **Abdominal Aortic Aneurysm one-time screening** for men of specified ages who have ever smoked
2. **Alcohol Misuse screening and counseling**
3. **Aspirin use** to prevent cardiovascular disease for men and women of certain ages; must be filled with a prescription at an in-network pharmacy
4. **Blood Pressure screening** for all adults
5. **Cholesterol screening** for adults of certain ages or at higher risk
6. **Colorectal Cancer screening** for adults over 50. Colonoscopies are limited to 1 every 10 years. Sigmoidoscopy is limited to every 5 years.
7. **Depression screening** for adults
8. **Diabetes (Type 2) screening** for adults with high blood pressure
9. **Diet counseling** for adults at higher risk for chronic disease; one consultation per calendar year
10. **Human Immunodeficiency Virus (HIV) screening** for everyone ages 15 to 65, and other ages at increased risk
11. **Immunization vaccines** for adults--doses, recommended ages, and recommended populations as outlined by the CDC:
    - Hepatitis A
    - Hepatitis B
    - Herpes Zoster
    - Human Papillomavirus
    - Influenza (Flu Shot)
    - Measles, Mumps, Rubella
    - Meningococcal
    - Pneumococcal
    - Tetanus, Diphtheria, Pertussis
    - Varicella
12. **Nutritional counseling** for all adults completed through in-network registered dieticians; one consultation per calendar year
13. **Obesity screening and consultation** for all adults; one consultation per calendar year
14. **Prostate Specific Antigen (PSA) and Digital Rectal Exam (DRE)** cancer screenings; one consultation per calendar year
15. **Sexually Transmitted Infection (STI) prevention counseling** for adults at higher risk
16. **Syphilis screening** for all adults at higher risk
17. **Tobacco Use screening** for all adults and up to four cessation consultations for tobacco users per calendar year

Essential Health Benefits (Preventive/Routine Care)

Preventive Health Services and Screenings

Preventive Health Services and Screenings for Women

1. **Anemia screening** on a routine basis for pregnant women
2. **Bacterial** urinary tract or infection screening for pregnant women
3. **Breast Cancer Genetic Test Counseling (BRCA)** for women at higher risk for breast cancer; Prior Authorization required
4. **Breast Cancer Mammography screenings** every 1 to 2 years for women over 40
5. **Breast Cancer Chemoprevention counseling** for women at higher risk
6. **Breastfeeding comprehensive support and counseling** from trained providers, and access to breastfeeding supplies, for pregnant and nursing women.
7. **Breast pumps** are available at no charge to the participant from the Teachers Health Trust Service Department. One per pregnancy will be provided. This benefit is limited to the pump and supplies directly related to the breast pump, such as tubing, pump adapter, breast pump bottle cap, breast shield, breast pump bottle and locking ring.
8. **Cervical Cancer screening** for sexually active women and 1 **Pap Smear** every 3 years
9. **Chlamydia Infection screening** for younger women and other women at higher risk
10. **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs). This does not apply to health plans sponsored by certain exempt "religious employers."
11. **Domestic and interpersonal violence screening and counseling** for all women
12. **Folic Acid** supplements for women who may become pregnant; must be filled with a prescription at an in-network pharmacy
13. **Gestational diabetes screening** for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
14. **Gonorrhea screening** for all women at higher risk
15. **Hepatitis B screening** for pregnant women at their first prenatal visit
16. **Human Immunodeficiency Virus (HIV) screening and counseling** for sexually active women
17. **Human Papillomavirus (HPV) DNA Test** every 3 years for women with normal cytology results who are 30 or older
18. **Osteoporosis screening** for women over age 60 depending on risk factors
19. **Rh Incompatibility screening** for all pregnant women and follow-up testing for women at higher risk
20. **Sexually Transmitted Infections (STI) counseling** for sexually active women
21. **Syphilis screening** for all pregnant women or other women at increased risk

Essential Health Benefits (Preventive/Routine Care)

Preventive Health Services and Screenings (cont.)

Preventive Health Services and Screenings for Women (cont.)

22. **Tobacco Use screening and up to four consultations** per calendar year or all women, and expanded counseling for pregnant tobacco users

23. **Urinary tract or other infection screening** for pregnant women

24. **Well-woman visits** to get recommended services for women under 65

Preventive Health Services and Screenings for Children

1. **Alcohol and Drug Use assessments for adolescents**

2. **Autism screening** for children at 18 and 24 months

3. **Behavioral assessments for children** at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

4. **Blood Pressure screening for children** at the following ages: 0 to 11 months, 1 to 4 years , 5 to 10 years, 11 to 14 years, 15 to 17 years.

5. **Cervical Dysplasia screening** for sexually active females

6. **Congenital Hypothyroidism screening** for all newborns

7. **Depression screening** for adolescents

8. **Developmental screening** for children under age 3

9. **Dyslipidemia screening** for children at higher risk of lipid disorders at the following ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

10. **Fluoride Chemoprevention supplements** for children without fluoride in their water source. Please note that Las Vegas does have fluoride in the water source.

11. **Gonorrhea preventive medication** for the eyes of all newborns

12. **Hearing screening** for all newborns

13. **Height, Weight and Body Mass Index measurements** for children at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

14. **Hematocrit or Hemoglobin screening** for children

15. **Hemoglobinopathies or sickle cell screening** for newborns

16. **Human Immunodeficiency Virus (HIV) screening** for adolescents at higher risk

Essential Health Benefits (Preventive/Routine Care)

Preventive Health Services and Screenings (cont.)

Preventive Health Services and Screenings for Children

17. Hypothyroidism screening for newborns

18. Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations as outlined by the CDC:

- Diptheria, Tetanus, Pertussis
- Haemophilus Influenzae Type B
- Hepatitis A
- Hepatitis B
- Human Papillomavirus
- Inactivated Poliovirus
- Influenza (Flu Shot)
- Measles
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella

19. Iron supplements for children ages 6 to 12 months at risk for anemia ; must be filled with a prescription at an in-network pharmacy

20. Lead screening for children at risk of exposure

21. Medical History for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

22. Obesity screening and consultation, one per calendar year

23. Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.

24. Phenylketonuria (PKU) screening for this genetic disorder in newborns

25. Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk

26. Tuberculin testing for children at higher risk of tuberculosis at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.

27. Vision screening for all children.

To review the complete and detailed descriptions of screening/counseling requirements, age groups and vaccine types in respect to all preventive health services as determined by the Affordable Care Act, please visit the federal website found at www.healthcare.gov.

Essential Health Benefits (Preventive/Routine Care)

Health Improvement Benefit

Benefit Overview

The Health Improvement Benefit is available **only** to **licensed employees** covered under the PERFORMANCE PLUS PLAN. **DEPENDENTS ARE NOT ELIGIBLE FOR THIS BENEFIT.**

The Plan will pay up to $50 per Calendar Year for the following health improvement programs and activities:

- Health Club Memberships
- Personal Training (The Trust may audit personal trainers to ensure appropriate and up-to-date licensing and certifications are in order for their field of expertise.)
- Tobacco Prevention Counseling and Education
- Weight Management Support Groups (for example, TOPS, Inc., Jenny Craig, Weight Watchers, etc.)

The Plan does not cover the above services outside of the Health Improvement Benefit.

How to File a Claim for this Benefit

You must submit a **HEALTH IMPROVEMENT BENEFIT REIMBURSEMENT FORM** and an **itemized** receipt to the Teachers Health Trust within **six months** of receipt date. The form will require the following information:

- Your Identification and/or Social Security Number
- Your Name and Address
- Your Telephone Number
- Your Date of Birth
- Services for which Reimbursement is requested
- Amount Paid for Services

Hand-written or non-itemized receipts will not be accepted and will not be eligible for reimbursement under this benefit. To download the Reimbursement Form, log on to the Trust's website at **www.teachershealthtrust.org**.

Exclusions

The following items are **not covered** under the Health Improvement Benefit:

- Medications and Supplements
- Any Form of Equipment
- Books, Magazines and Journals
- Videos, CDs, DVDs and other types of electronic educational devices
- Eligible program and activity charges over the $50 Calendar Year Health Improvement Benefit limit
- Entry fees for charity events
- Expenses related to seminars

Essential Health Benefits (Preventive/Routine Care)

Frequently Asked Questions

What if I had Essential Health Benefits services completed at a physicians office that was out-of-network?
The Teachers Health Trust requires you to use an **in-network** PCMH provider for Preventive care and Essential Health Benefits. If your services are completed by an out-of-network provider, you will have a much higher out-of-pocket costs because these services will not be covered by the plan.

I was treated at my in-network provider's office for an illness, but I also had preventive services completed during the same visit. What will I be charged?
The cost of your in-network office visit depends upon the primary purpose and/or treatments received in addition to preventive services during your visit. Be aware that you will be required to pay your office visit copayment/coinsurance if the preventive service(s) you received were not the primary purpose of the visit, or if your doctor bills you for the preventive services separately from the office visit. **For example:** If you visit your primary care physician for your annual physical, but discuss and receive treatment for joint pain during the visit. you may be charged an office visit. The reason is due to receiving services for non-preventive care despite initially visiting for your physical.

What constitutes a screening for the purpose of Essential Health Benefits?
The initial evaluation of an individual, intended to determine suitability for a particular treatment modality. Screenings may be questions your doctor asks you or tests that look for diseases before you have symptoms. Screening tests can find diseases early, when they are easier to treat. You can get some screenings in your doctor's office while others need special equipment, requiring you to go to a different office or clinic. In order for Essential Health Benefits screenings to be covered by the Trust, they must be completed by an in-network provider.

Are all adult vaccinations covered under Essential Health Benefits, including travel vaccinations?
No, vaccinations received for the purpose of domestic and/or international travel are not covered under the Essential Health Benefits.

What if a specific treatment I need is not on the list?
Essential Health Benefits preventive services are for screening purposes, not for treatment of an illness or condition. If you are seeking services for a specific treatment, your regular benefits will apply and you may have a copayment/coinsurance responsibility.

Is pregnancy termination covered under Essential Health Benefits?
Pregnancy termination is not a covered essential benefit. However, the Trust does cover this procedure; your regular copayments/coinsurance will be applicable if an in-network provider is utilized.

I do not like the breast pump provided to me at no charge from the Trust. Can I purchase a breast pump of my choice and get reimbursed?
No, if you do not wish to utilize the breast pump provided to you by the Teachers Health Trust, you will be responsible to pay for the pump in full.

Family Planning

Family Planning (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Injected Contraceptives	Not Required	$0 per drug billed by the physician
IUD (Device and Placement)	Not Required	$0 coinsurance (deductible does not apply)
Oral Contraceptives	Not Required	See Prescription Benefit

Watch out! If Family Planning Services are provided by an Out-of-Network Provider, it will greatly increase your personal expense! (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.)

Genetic Testing

SOME GENETIC TESTING SERVICES REQUIRE PRIOR AUTHORIZATION! Always make sure your Physician contacts WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244, prior to your service! Prior Authorization services will be conducted by TRISTAR Managed Care. (See Prior Authorizations at the beginning of this Medical chapter.)

Genetic Testing* (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Your Selected PCP (no referral required)	Required	20% coinsurance (deductible does not apply)
In-Network Providers (with referral)	Required	20% coinsurance (deductible does not apply)
In-Network Providers (without referral)	Required	20% coinsurance after $600 deductible
In-Network Standalone Lab	Required	$0 copay per test
Out-of-Network (Other than Specialty Lab)	Required	See Out-of-Network Benefits

* Genetic Testing is not covered under preventative/routine benefit.

Specialty Laboratory/Pathology* (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Specialty Lab Testing	Required	20% coinsurance (deductible does not apply)

* By definition, Specialty Laboratory/Pathology Testing is any Laboratory and Pathology Testing requested by an In-Network Provider that cannot be performed In-Network and for which no alternative test that provides comparable clinical information is available In-Network. If your In-Network physician requests these tests for you, please have the physician's office contact WellHealth prior to having the tests completed to determine if the same or alternative test can be performed in-network. If the same or alternative test could be performed in-network but you choose to use an out of network lab, the out of network benefit will apply if authorization for the test was obtained through the utilization review company prior to completion of the test.

Genetic Testing is not covered under preventive/routine benefit.

Failure to obtain Prior Authorization through WellHealth Quality Care for the above-listed services may result in benefits being greatly reduced or not paid at all.

Hearing Aids

Covered Benefit

A maximum of $1,000 per ear is payable every 5 years for Hearing Aids, Hearing Aid repairs, and Hearing Aid replacements.

Limitations

No benefits are payable for Hearing Aid batteries.

Hearing Aids (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Hearing Aid Services	Not Required	Any amount over $1,000 per ear every five (5) years from the date of purchase

* If covered Hearing Aid Services are provided by an Out-of-Network Provider, the Out-of-Network Deductible and Coinsurance will be waived. However, you will still be responsible for any amount the Provider charges in excess of the Trust's Eligible Medical Expenses (EME) as well as any amount over the Plan Maximum. (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.)

Home Health Services

SOME HOME HEALTH SERVICES REQUIRE PRIOR AUTHORIZATION! Always make sure your Physician contacts WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244, prior to your service! Prior Authorization services will be conducted by TRISTAR Managed Care. (See Prior Authorizations at the beginning of this Medical chapter.)

Definition

Home Health Care services are provided by a licensed Home Health Care Agency in your place of residence. These services must be ordered by the attending Physician as a part of a written plan of care. The Physician must review this plan of care at least once a month and he or she must certify that the treatment is Medically Necessary.

Covered Services

Home Health Care Agencies provide such Covered services as skilled nursing care, pregnancy monitoring, physical and speech therapy, occupational therapy, and miscellaneous supplies.

Home Health Services (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Home Health Services (with or without referral)	Required	20% coinsurance (deductible does not apply)

Watch out! If Home Health Services are performed by Out-of-Network Providers, you will pay 40 percent of the Trust's Eligible Medical Expenses (EME) for each service PLUS any amount the Provider charges over the EME and your out-of-network calendar year deductible. This will greatly increase your personal expense! (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.)

Be careful! Your Physician may not always refer you to an In-Network Provider!

Hospice Services

HOSPICE SERVICES REQUIRE PRIOR AUTHORIZATION! To obtain Prior Authorization, call WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244, as soon as possible prior to the start of your services.

Definition

A Hospice is a public agency or private organization that is primarily engaged in providing pain relief, symptom management and supportive services to individuals who are terminally ill. It includes both home care and Inpatient care, when needed, and a variety of services not otherwise covered under the Plan. In order to qualify for the Hospice benefit, the patient must not be receiving active medical treatment. The PERFORMANCE PLUS PLAN helps pay for Hospice care if all three of the following conditions are met:

- A doctor certifies that the patient is terminally ill and has less than six months to live;
- The patient chooses to receive care from a Hospice Provider; and
- Care is provided by a Medicare-eligible participating Hospice program.

HOSPICE SERVICES (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Hospice Services (with or without referral)	Required	20% coinsurance (deductible does not apply)

Watch out! If Hospice Services are performed by Out-of-Network Providers, it will greatly increase your personal expense! (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.) Be careful! Your Physician may not always refer you to an In-Network Provider!

Hospital Services

The following pages have been designed to help you understand what Hospital Services are covered under the PERFORMANCE PLUS PLAN and how much your expense will be for those services. In this section, you will find answers to your most frequently asked questions as well as benefit information for both Inpatient and Outpatient Hospital Services.

Definition

The PERFORMANCE PLUS PLAN provides benefits for Inpatient and Outpatient hospitalization. A Hospital is defined as an institution that:

- is licensed as a general acute care Hospital by the state in which it is located;
- is accredited by the Joint Commission on Accreditation of Health Care Organizations;
- is Medicare certified;
- engages primarily in providing medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons;
- has supervision of a staff of one or more Physicians and 24-hour-a-day nursing services by graduate RNs; and
- charges its patients for services and treatment.

A Hospital is not an institution or part of an institution that is used primarily as a clinic, rest facility, convalescent home, custodial facility or facility for the aged.

ALL INPATIENT ADMISSIONS AND MANY OUTPATIENT SERVICES REQUIRE PRIOR AUTHORIZATION! Always make sure your Physician contacts WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244, prior to your service! Prior Authorization services will be conducted by TRISTAR Managed Care. (See Prior Authorizations at the beginning of this Medical chapter.)

Inpatient

ALL INPATIENT ADMISSIONS SERVICES REQUIRE PRIOR AUTHORIZATION! Always make sure your Physician contacts WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244, prior to your service! Prior Authorization services will be conducted by TRISTAR Managed Care. (See Prior Authorizations at the beginning of this Medical chapter.)

The following charts outline your benefits while you are hospitalized at an In-Network Hospital on an Inpatient basis:

Inpatient Hospital Services (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Hospital Facility	Required	$400 per day; $800 max per stay (deductible does not apply)
Your Selected PCP (No referral required)	Not Required	$10 hospital consultation copay; 20% coinsurance for all other services (deductible does not apply)
Radiologist/Pathologist	Not Required	$0 copay (deductible does not apply)
All Other Physician Charges Not Listed Above* (Including, but not limited to; Emergency Room Physician, Surgeon, Assistant Surgeon, Anesthesiologist, Hospitalist, Specialist Physician and PCP other than your selected)	Not Required	20% coinsurance after $600 deductible

* A Specialist Physician has a 20% coinsurance after $600 deductible with or without referral when services are performed outside of the physician's office.

Outpatient Surgery with In-Patient Surgical Recovery Suite all-inclusive global rate is considered as in-patient services and requires prior authorization. Please refer to Surgical Services-Inpatient for copayments/coinsurance and prior authorization requirements. **Watch out!** If Hospital Services are performed by Out-of-Network Providers, your personal expenses can increase dramatically. (See the Out-of-Network Services section of this Medical chapter for additional information.)

Hospital Services

Outpatient

CERTAIN OUTPATIENT HOSPITAL SERVICES REQUIRE PRIOR AUTHORIZATION! Always make sure your Physician contacts WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244, prior to your service! Prior Authorization services will be conducted by TRISTAR Managed Care. (See Prior Authorizations at the beginning of this Medical chapter.)

All outpatient hospital services copayments and coinsurance rates are the same with or without a referral.

Outpatient Hospital Services (In-Network Providers)	
	Plan Benefit
Emergency Room - Hospital Charges, Emergency Services (True Emergency)	$250 (deductible does not apply)
Emergency Room - Hospital Charges, Non-Emergency Services	$400 (deductible does not apply)
Facility Charges - Outpatient, Ambulatory Surgical Center, Observation **Facility Charges Copay does not apply to all other outpatient services** (such as but not limited to; clinics, radiation, radiology services, chemotherapy, sleep studies and/or physical therapy.)	$400 per day; 800 max per stay (deductible does not apply) 20% coinsurance (deductible does not apply)
Dialysis	$20 (deductible does not apply)
Diabetic Education	$0 copay (deductible does not apply)
Your Selected PCP (No referral required)	$10 copay for hospital consult; 20% coinsurance for all other services (deductible does not apply)
Radiologist/Pathologist	$0 copay (deductible does not apply)
All Other Physician Charges Not Listed Above* (Including, but not limited to; Emergency Room Physician, Surgeon, Assistant Surgeon, Anesthesiologist, Hospitalist, Specialist Physician and PCP other than your selected)	20% coinsurance after $600 deductible

* A Specialist Physician has a 20% coinsurance after $600 deductible with or without referral when services are performed outside of the physician's office.

Hospital Services

Outpatient (cont.)

CERTAIN OUTPATIENT HOSPITAL SERVICES REQUIRE PRIOR AUTHORIZATION! Always make sure your Physician contacts WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244, prior to your service! Prior Authorization services will be conducted by TRISTAR Managed Care. (See Prior Authorizations at the beginning of this Medical chapter.)

In rare instances, an outpatient surgical facility may be medically necessary for extensive dental services (such as heart condition, asthma, cerebral palsy, etc.). A letter of medical necessity must be submitted to the Trust for review and authorization prior to services being rendered.

Outpatient Surgery with In-Patient Surgical Recovery Suite all-inclusive global rate is considered as in-patient services and requires prior authorization. Please refer to Surgical Services-Inpatient for copayments/coinsurance and prior authorization requirements.

Watch out! If Hospital Services are performed by Out-of-Network Providers, your personal expenses can increase dramatically. (See the Out-of-Network Services section of this Medical chapter for additional information.)

Frequently Asked Questions

What if I have an emergency hospitalization for an emergency diagnosis out-of area?
If you normally reside within the Service Area and have an **Emergency** hospitalization, you will be responsible for the In-Network Copayments/Coinsurance listed in this **Hospital Services** section.

If your hospitalization was **pre-planned**, you will be responsible to pay the Deductible and Coinsurance listed in the **Out-of-Network Services** section of this **Medical** chapter **PLUS** any amount the Provider charges above the Trust's EME.

Please refer to the **Out-of-Network Services** section of this **Medical** chapter for additional information.

How can I make sure my doctor uses In-Network Providers during my hospitalization?
Using these three simple steps may reduce your personal expense for your hospitalization:

- ***FIRST***, ask your doctor in advance what other Providers he will be using for the hospitalization (such as Hospital, Hospitalist, anesthesiologist, and assistant surgeon).
- ***THEN***, go to **www.teachershealthtrust.org** and search the Provider directory to see if the Provider is in the Trust's network.
- ***FINALLY***, if one or more of the Providers is not in the network, print the names of the In-Network Providers and ask your doctor to refer you to one of them.

When I was admitted to the Hospital, I was seen by a Hospitalist. What is a Hospitalist?
Hospitalists are doctors whose primary focus is the general medical care of hospitalized patients. Hospitals often assign a Hospitalist to a patient upon entering the Hospital through the Emergency room or other Hospital admission. Some Physicians hire Hospitalists to visit their hospitalized patients, which gives the Physician the opportunity to keep his or her regular office appointments.

The Hospitalist I was assigned to was an Out-of-Network Physician. Will my claim be paid at Out-of-Network levels of benefits?
If you normally reside within the Service Area and were assigned an Out-of-Network Hospitalist during an Emergency Hospital admission, you will be responsible for the In-Network Copayments/Coinsurance listed in this **Hospital Services** section. You will also be responsible to pay any amount that the Provider bills in excess of the Trust's Eligible Medical Expenses (EME). (See **Eligible Medical Expenses** at the beginning of this **Medical** chapter.)

Please refer to the **Out-of-Network Services** section of this **Medical** chapter for additional information.

Hospital Services

Frequently Asked Questions (cont.)

I was admitted as an inpatient to the Hospital from the Emergency Room. Do I have to pay an Emergency Room and Hospital Copayment/Coinsurance?
No. You are only responsible for the Inpatient Copayments/Coinsurance listed in this Medical chapter.

I seem to have so many bills from my hospitalization! Should I be getting so many bills?
That depends. You will, of course, receive a bill for your portion of the Hospital charges and Physician charges (if any). You may also get bills from a radiologist or pathologist. If you had surgery while you were in the Hospital, you may get additional bills. Surgeon, assistant surgeon, and anesthesiology billings are the most common, but it is possible you may receive bills from other Providers, too.

When you receive a bill at home, it is very important that you check online with the Trust at **www.teachershealthtrust.org** to make sure the bill has been processed as a claim under your benefit Plan.

Infusion Services (excluding Chemotherapy)

INFUSION SERVICES REQUIRE PRIOR AUTHORIZATION! Always make sure your Physician contacts WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244, prior to your service! Prior Authorization services will be conducted by TRISTAR Managed Care. (See Prior Authorizations at the beginning of this Medical chapter.)

Definition

Intravenous Infusion Services are provided by a licensed Home Health Care or Licensed Home Infusion Agency in your place of residence or at an infusion center. These services must be ordered by the attending Physician as a part of a written plan of care. The Physician must review this plan of care at least once a month and he or she must certify that the treatment is Medically Necessary.

Covered Services

Home Infusion Agencies provide such Covered services as skilled nursing care, intravenous infusion and miscellaneous supplies.

Infusion Services (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Administration Services (with or without referral)	Required	20% coinsurance (deductible does not apply)
Infusion Drugs (with or without referral)	Required	20% coinsurance (deductible does not apply)
Physician's Office and Infusion Clinic (with or without referral)	Required	20% coinsurance (deductible does not apply)

Limitations

Injectable drugs obtained from a Home Health Care Agency or Home Infusion Provider are not Covered expenses. Injectable drugs must be obtained from an in-network retail pharmacy or Mail Order Program under the prescription benefit.

Watch out! If Infusion Services are performed by Out-of-Network Providers, it will greatly increase your personal expense! Prior authorization is required for all out-of-network labs, failure to obtain prior authorization may result in denial of benefits (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.)

Be careful! Your Physician may not always refer you to an In-Network Provider!

Laboratory/Pathology Services (Excluding Genetic Testing)

Pathology services (commonly known as "lab tests") are diagnostic tests generally performed by either a laboratory or by your Physician. The following examples can help you understand the difference:

Services Performed By In-Network, In-Area, Free-Standing Laboratory

- Your doctor orders a lab test and you take the order to an in-network, in-area, free-standing laboratory; or
- Your doctor draws/takes a lab specimen from you in his office and sends the specimen to an in-network, in-area, free-standing laboratory.

Services Performed by a Physician

Your doctor draws/takes a lab specimen from you and performs the analysis in his office.

LABORATORY/PATHOLOGY* (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Your Selected PCP (No referral required)	Not Required	20% coinsurance (deductible does not apply)
Performed by Quest Diagnostics (or by an in-network dialysis laboratory)	Not Required	$0
Performed by an in-network physician's office (with referral)	Not Required	20% coinsurance (deductible does not apply)
Performed by an in-network physician's office (without referral)	Not Required	20% coinsurance after $600 deductible
Performed by an out-of-network provider and services do not meet the definition of laboratory/pathology*	Required	See Out-of-Network Benefits
Specialty Laboratory/Pathology*	Required	20% of EME + Any Amount charged over EME (deductible does not apply)

* By definition, Specialty Laboratory/Pathology Testing is any Laboratory and Pathology Testing requested by an In-Network Provider that cannot be performed In-Network and for which no alternative test that provides comparable clinical information is available In-Network. If your In-Network physician requests these tests for you, please have the physician's office contact WellHealth prior to having the tests completed to determine if the same or alternative test can be performed in-network. If the same or alternative test could be performed in-network but you choose to use an out of network lab, the out of network benefit will apply if authorization for the test was obtained through the utilization review company prior to completion of the test.

Watch out! If Laboratory/Pathology Services are performed by an Out-of-Network Provider, it will greatly increase your personal expense! Prior authorization is required for all out-of-network labs, failure to obtain prior authorization may result in denial of benefits (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.) If your physician bills your lab work, the in-network physicians copayments/coinsurance will apply. To lower your out-of-pocket costs, ask your physician to refer you to Quest Diagnostics for all lab work.

Be careful! Your Physician may not always refer you to an In-Network Provider!

Maternity/Pregnancy Services

ALL INPATIENT ADMISSIONS REQUIRE PRIOR AUTHORIZATION! Always make sure your Physician contacts WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244, prior to your service! Prior Authorization services will be conducted by TRISTAR Managed Care. (See Prior Authorizations at the beginning of this Medical chapter.)

The following charts should help you understand your financial responsibilities for prenatal, delivery and postnatal charges:

Maternity/Pregnancy Services (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Hospital Facility* (with or without referral)	Required	$400 per day; $800 max per stay (deductible does not apply)
Ambulatory Surgical Facility (with or without referral)	Not Required	$400 per day; $800 max per stay (deductible does not apply)
Your Selected Obstetrician (Total OB Care and Delivery)	Not Required	20% coinsurance (deductible does not apply)
Your Selected Obstetrician Office Visit** (If You Change PCMH OB During Pregnancy)	Not Required	Normal Pregnancy: $10 copay High Risk Pregnancy: $0 copay (deductible does not apply)
Obstetrician Other Than Your PCMH Selected (with or without referral)	Not Required	20% coinsurance after $600 deductible
Perinatologist Office Services (with referral)	Required	Normal Pregnancy: $20 copay office visit; 20% coinsurance for all other services (deductible does not apply) High Risk Pregnancy: $0 copay office visit; 20% coinsurance for all other services (deductible does not apply)
Perinatologist Office Services (without referral)	Required	20% coinsurance after $600 deductible
Perinatologist Hospitalist Services (with or without referral)	Not Required	20% coinsurance after $600 deductible
Ultrasounds*** (with or without referral)	Not Required	Freestanding Diagnostic Facility: $0 copay (deductible does not apply) PCMH Office: 20% coinsurance (deductible does not apply)
Ultrasounds* at All Other In-Network Providers** (with referral)	Not Required	20% coinsurance (deductible does not apply)
Ultrasounds* at All Other In-Network Providers** (without referral)	Not Required	20% coinsurance after $600 deductible

* Your Hospital Facility Copayment/Coinsurance is applied to the mother's and the newborn's combined charges; however, if the newborn is admitted as a medical or surgical patient and/or remains in the Hospital after the mother's discharge, a separate Copayment will apply.

** If you change obstetricians during your pregnancy, you will be responsible for paying your original obstetrician an office visit Copayment/Coinsurance for each visit you incur. You would then pay your new in-network obstetrician the Copayment/Coinsurance listed above for delivery.

*** Ultrasounds performed by providers practicing any specialty other than perinatology will be limited to four (4) ultrasounds per pregnancy.

Watch out! If Maternity/Pregnancy Services are performed by Out-of-Network Providers, it will greatly increase your personal expense! (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.)

Maternity/Pregnancy Services

Frequently Asked Questions

Do I have to pay my obstetrician every time I have an office visit during my pregnancy?
That depends on your obstetrician. Generally, he or she will charge you your copayment/coinsurance for your Prenatal Care, delivery, and post-natal care. The Trust will pay the benefit to your obstetrician after your delivery. Your obstetrician may bill you for your balance after the Trust pays, or he or she may work out a schedule with you for payments to be made throughout your pregnancy. You should discuss this with your Physician's billing department.

What happens if I change to another in-network obstetrician in the middle of my pregnancy?
If you change obstetricians during your pregnancy, you will be responsible for paying your original obstetrician the Office Visit Copayment/Coinsurance for each visit you incurred. You will also be responsible for paying your new Physician the Coinsurance listed.

Do I need to obtain Prior Authorization of the Hospital stay for my delivery?
Yes, all Inpatient hospitalizations require Prior Authorization. To obtain authorization, your obstetrician should contact WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244, prior to your hospitalization.

My daughter is pregnant. Will her maternity/pregnancy care be covered?
Yes, if your daughter is an Eligible Dependent under your coverage, your daughter's maternity/pregnancy care will be covered through her delivery and routine post-natal care. The Plan does not cover any expenses related to the newborn.

Are the services of a Nurse-Midwife covered under the Plan?
Yes, the PERFORMANCE PLUS PLAN covers the services of a certified Nurse-Midwife working under the direct supervision of an obstetrician. For coverage information, refer to **Obstetricians** in this **Maternity/Pregnancy Services** section.

Are surrogate mother services covered under the Plan?
No, expenses for surrogate mother services are not payable under the PERFORMANCE PLUS PLAN.

Will you cover expenses for egg or sperm donors?
No, the PERFORMANCE PLUS PLAN will not cover expenses related to egg or sperm donors or storage or to determine gender.

Are breast pumps covered under the Plan?
Yes, breast pumps are covered under the PERFORMANCE PLUS PLAN. These benefits are limited to the pump. Supplies not directly related to the breast pump are not covered. One breast pump per pregnancy is provided by the Trust at no charge to the participant as part the DME covered benefits. Contact the Trust via phone at 702-794-0272 or 800-432-5859 to obtain your breast pump.

My doctor says my pregnancy is High Risk. Does my Plan cover services related to High Risk pregnancies?
High Risk pregnancies, as defined by the Trust, are covered under the PERFORMANCE PLUS PLAN. Because you will likely require specialty services, you will be required to pay a separate coinsurance for those services. For example, if you require the services of a perinatologist in addition to your regular obstetrician, you will pay separate coinsurance to that specialist.

High Risk pregnancies include:

- Twins, triplets or other multiple gestations
- Pregnancies that require the services of a perinatologist
- Pregnancies determined by the obstetrician to be "high risk"
- Any pregnancy involving a Hospital admission during the pregnancy that is not connected with the routine delivery of the child
- Any pregnancy determined to include a fetal abnormality
- Any pregnancy involving excessive nausea and vomiting, resulting in weight loss

Maternity/Pregnancy Services

Frequently Asked Questions (cont.)

- Any pregnancy involving threatened or pre-term labor
- Any pregnancy that involves additional medical diagnoses, such as diabetes, blood disorders, or hypertension
- Pregnancies that result in unusual physical or mental stress
- Any pregnancy where the patient has a history of previous miscarriages
- Any pregnancy where the patient has a history of previous pre-term labor with or without pre-term deliveries.

Contact the Trust's RN Case Manager at 866-585-CARE (2273) to coordinate services during your High Risk pregnancy.

My pregnancy must be terminated. Is this a Covered expense under my medical Plan?
The PERFORMANCE PLUS PLAN provides coverage for pregnancy terminations, also known as "therapeutic abortions" or "abortions." For coverage information, please refer to **Surgical Services** in this **Medical** section.

Are prenatal vitamins covered under my medical Plan?
Prenatal vitamins are covered under the Trust's **Prescription Drug** Plan. Please refer to that section of this Plan Document for additional information.

My OB/GYN performed 10 ultrasounds during my pregnancy? Will all these expenses be covered under my medical Plan?
No. Ultrasounds performed by providers practicing any specialty other than perinatology will be limited to four (4) ultrasounds per pregnancy. The participant is responsible for all fees associated with any ultrasound(s) after the fourth test if these tests are performed by any provider other than a perinatologist.

Medical Supplies (Other than Durable Medical Equipment)

Medical Supplies (In-Network Providers)		
General	**Prior Authorization**	**Plan Benefit**
Compression Garments (with or without referral)	Not Required	20% coinsurance, four per limb per calendar year (deductible does not apply)
Diabetic Supplies	N/A	See Prescription Drugs
Feeding Pumps Supplies* (with or without referral)	Not Required	20% coinsurance (deductible does not apply)
Total Parenteral Nutrition (TPN)* (with or without referral)	Required	20% coinsurance (deductible does not apply)
Glasses** (one pair immediately following cataract surgery)	Not Required	20% of EME*** (deductible does not apply)
Ostomy Supplies (with or without referral)	Not Required	20% coinsurance (deductible does not apply)
Wigs (with or without referral)	Not Required	Maximum benefit of $300 following chemotherapy or radiation course of treatment. You pay any amount incurred in excess of the maximum benefit.
Injectable Drugs**	**Prior Authorization**	**Plan Benefit**
In-Network Pharmacy	Not Required	See Prescription Drugs
Out-of-Network Pharmacy	Not Required	See Prescription Drugs
Home Health Care Agency	Not Required	Not Covered
Masectomy Supplies	**Prior Authorization**	**Plan Benefit**
Mastectomy Bra (with or without referral)	Not Required	20% of EME, two per calendar year (deductible does not apply)
Breast Prosthesis (with or without referral)	Not Required	20% of EME one per calendar year (deductible does not apply)
Prosthesis As Part of the Bra (with or without referral)	Not Required	20% of EME, two per calendar year (deductible does not apply)

* Expenses for special formulas, food supplements and special diets are not Covered under the Plans. Enteral and parenteral nutritional therapy is covered if it is the sole source of nutrition and the nutritional replacement is only available by prescription. The nutritional supplement available over the counter would not be covered; however, all other services required to provide the non-covered nutritional supplement would be covered.

** See the Vision chapter of this Plan Document for coverage information regarding routine vision expenses.

*** Eligible Medical Expenses (EME) for glasses under this benefit is the same maximum EME under the Vision Plan.

**** If an Injectable Drug is prescribed by your Physician, the prescription must be filled through either a retail pharmacy or the prescription Plan Mail Order Program.

Watch out! If Medical Supplies are obtained from Out-of-Network Providers, your personal expenses will increase dramatically. (See the Out-of-Network Services section of this Medical chapter for additional information.)

Mental Health Services

SOME OF THE SERVICES LISTED IN THIS SECTION REQUIRE PRIOR AUTHORIZATION. Always make sure your Physician contacts HBI at 702-248-8866 or 800-441-4483 prior to obtaining the services that require authorization. Failure to obtain Prior Authorization will result in your claim being denied for coverage. (See Prior Authorizations at the beginning of this Medical chapter.)

Individual and Group Therapy Sessions (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Psychiatrists, Mental Health Nurse Practitioners and Physician Assistants (with or without referral)	Required	$20 copay per session (deductible does not apply)
Therapists, Counselors and Group Therapy (with or without referral)	Required After 24 Sessions in a Calendar Year	$20 copay per session (deductible does not apply)

Inpatient Care, Partial Hospitalization and Residential Treatment (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
100 Days Combined Maximum Benefit (See Benefit Limitations/Maximums) (with or without referral)	Required	$400 per day; 800 max per stay (deductible does not apply)

Mental Health Services (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Electroconvulsive Therapy (ECT) (with or without referral)	Required	20% coinsurance (deductible does not apply)
Psychosocial Rehabilitation/Autism Services (with or without referral)	Required	$20 per office visit; 20% coinsurance for all other services (deductible does not apply)

Exclusions

The following services are not covered under the Plan:

- Administrative services, such as expert testimony; medical records review and maintenance; preparation of reports regarding civil or legal matters, or ability to stand trial; or consultations with attorneys or other representatives of social services
- Consultation with a professional for adjudication of marital, child support and custody cases
- Private duty nursing
- Mental Health Services for mental retardation and autism, except for acute, brief interventions and short-term evaluation
- Custodial and institutional care which is for the primary purpose of controlling or changing the Participant's environment

Watch out! If Mental Health Services are performed by Out-of-Network Providers, it will greatly increase your personal expense! (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.)

Minute Clinics

CVS Pharmacy Minute Clinics are available to all Teachers Health Trust participants. Participants may visit all CVS Minute Clinics nationwide; no referral is required. The out-of-network benefit is the same as the in-network benefit.

CVS Minute Clinics (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
CVS Minute Clinics (No referral required)	Not Required	$15 copayment (deductible does not apply)

Minute Clinics are not meant to replace established care with your PCMH provider. They are meant only as bridge care; to be utilized in place of a quick care facility or emergency rooms for non-emergent or life-threatening symptoms. If you utilize a Minute Clinic, the Trust recommends that you schedule follow-up care with your selected PCMH provider.

Office Visits

Watch out! If Office Visits are performed by Out-of-Network Providers, it will greatly increase your personal expense! (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.)

Office Visits (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Your Selected PCP (No referral required)	Not Required	$10 office visit copay; 20% coinsurance for all other services (deductible does not apply)
Primary Care Physician (Other than Selected PCMH PCP)	Not Required	20% coinsurance after $600 deductible
Specialist (with referral)	Not Required	$20 office visit copay; 20% coinsurance for all other services (deductible does not apply)
Specialist (without referral)	Not Required	20% coinsurance after $600 deductible

Please refer to other applicable pages of this Medical chapter for coverage information regarding additional services (such as Diagnostic X-Rays and Laboratory Testing) that may be performed during your Physician Office Visit.

Out-of-Network Services

Although the Trust provides you with a large network of Providers to choose from for your health care, it cannot guarantee all services or surgical approaches can be done In-Network. There may be times when you receive services from an Out-of-Network Provider. The Trust provides benefits for Out-of-Network services, but they differ greatly from the In-Network benefits. You will pay more out of your own pocket for services received from Out-of-Network Providers.

Out-of-Network benefits are subject to all plan provisions as detailed in this plan document. Retirees living out of area, please refer to the Retiree Out-of-Area section. **The laws of the State of Nevada shall govern all Plan provisions.**

Generally, you will be responsible for payment of the following amounts if you use Out-of-Network Providers for health care services:

***First*, you pay any amount the Provider charges over the EME;**
***Second*, you pay an Annual Deductible; AND**
***Third*, you pay a percentage of the Eligible Medical Expenses (EME);**

The following pages explain each of the three items above and how benefits are paid for your Out-of-Network Services.

Out-of-Network Services

Eligible Medical Expenses (EME)

You have to pay any amount that the Out-of-Network Provider charges in excess of the EME. See Eligible Medical Expenses (EME) in the definitions section of this chapter.

Example

The Trust's average billed charges at an Out-of-Network Hospital are $17,782.69 per day. However, the Trust's Out-of-Network EME for acute care is only $2,075.00 per day. Therefore, the EME for your two-day hospitalization will be $4,150.00.

As you can see from the following example, the first item you will be responsible to pay is the difference between the billed amount and the EME:

Hospital Billed Charges for Two-Day Stay:	$35,000.00
Trust's EME for Two-Day Stay:	$4,150.00
Difference Between Billed Charges and EME:	**$30,850.00***

*** This is the FIRST amount you must pay if you use an Out-of-Network Provider. *You do not have to pay this amount if you use an In-Network Provider.***

Deductibles

You will have to pay a portion of the Eligible Medical Expenses (EME) called the Out-of-Network Deductible. The Plan will not begin paying benefits until you have met your Calendar Year Out-of-Network Deductible. (If you have paid your Out-of-Network Deductible for the year, you are considered to have "met" your Out-of-Network Deductible.)

This Out-of-Network Deductible is waived for Covered Out-of-Network Emergency care, Urgent Care, Ambulance, or Hearing Aid services.

Your Deductible for most Out-of-Network services is as follows:

Performance Plus Plan Out-of-Network Deductible: $2,500 per Calendar Year

Example

For example, let's say you require a two-day hospitalization and you have elected to use an Out-of-Network Hospital. Your second expense will be the Calendar Year Deductible. If you have not yet met this Out-of-Network Deductible, it will be applied to the EME as follows:

	Performance Plus Plan
Hospital Billed Charges for Two-Day Stay:	$ 4,150.00
Less Your Out-of-Network Deductible:	$ 2,500.00*
Remaining EME:	**$ 1,650.00**

*** This is the SECOND amount you must pay if you use an Out-of-Network Provider. *You do not have to meet this deductible if you use an In-Network Provider.***

Out-of-Network Services

Coinsurance

Then, after you've met your Deductible—you must pay a percentage of the Eligible Medical Expenses (EME). This percentage is known as the "Coinsurance." Your Coinsurance for Out-of-Network services listed throughout this Medical chapter is as follows:

- **0 percent** for Emergency Services provided in the emergency room by an Out-of-Network Provider (instead, you pay the Copayments and Coinsurance listed under **Emergency Services Provided by Out-of-Network Provider** in this **Medical** chapter) provided you reside within the service area;
- **0 percent** for Hearing Aid Services, up to the stated Plan Maximums;
- **20 percent** of the EME for Ambulance Services; and
- **40 percent** of the EME for all other Covered services.

Example

Continuing with our previous example, the next amount you will have to pay for your two-day hospitalization is your Coinsurance, as illustrated below:

	Performance Plus Plan
Remaining EME:	$ 1,650.00
Your Coinsurance (40% of EME):	**$ 660.00***

*** This is the <u>THIRD</u> amount you must pay if you use an Out-of-Network Provider.**
You do not have to pay this amount if you use an In-Network Provider.

Out-of-Network Services

Expenses Summary

In summary, using an Out-of-Network Provider for your medical services will generally cost you more money because:

***First*, you pay any amount the Provider charges over the EME; AND**
***Then*, you pay an annual deductible; AND**
***Finally*, you pay a percentage of the EME.**

The following chart summarizes **ALL** of the expenses you would have had to pay for your two day Out-of-Network Hospitalization and compares it to the amount you would have had to pay if you selected an In-Network Hospital for your services:

	Performance Plus Plan	
Hospital Billed Charges for Two Day Stay:	$ 35,000.00	
EME for Two Day Stay:	$ 4,150.00	
Difference Between Billed Charges and EME:	$ 30,850.00	1
EME for Two Day Stay:	$ 4,150.00	
Out-of-Network Deductible Applied:	$ 2,500.00	2
Remaining EME:	$ 1,650.00	
Your Coinsurance (40% of EME)	$ 660.00	3
TOTAL You Owe for Two Day Out-of-Network Hospitalization:	$ 34,010.00	1+2+3
Amount You Would Have Paid for In-Network Services:	**$ 1,310.00**	

Out-of-Network Services

Out-of-Network Emergency Services and Urgent Care

Emergency Services are defined as Medically Necessary services received in connection with an unforeseen Injury or Illness requiring surgical or medical attention within 24 hours after the onset. In the absence of such care, the Covered employee or Covered Dependent could reasonably be expected to suffer serious physical impairment or death.

In order for services to be covered as an emergency, the care must take place in the emergency department of a hospital. Additionally, the services must be for an emergency diagnosis. Please refer to Emergency Services section.

Urgent Care is defined as any Medically Necessary service received for an Injury or Illness of a less serious nature than Emergency Services which are required to prevent a serious deterioration in the patient's health.

Coverage for Emergency Services and/or Urgent Care obtained from an Out-of-Network Provider is determined according to the following:

If You Reside Within the Service Area

To reside within the Service Area means you and your Dependents live or work in the Service Area at least nine months of each Calendar Year and you and your dependents have not moved out of the Service Area prior to receiving services.

If you normally reside within the Service Area and require Emergency Services from an Out-of-Network Provider, the Out-of-Network Deductible will be waived.

If you normally reside within the Service Area and require Urgent Care Services from an Out-of-Network Provider while you are traveling outside the service area (for example, while you are on vacation), the Out-of-Network Deductible will be waived.

If a surgical approach cannot be performed within the service area, you must first contact the Trust's Case Management Department. Please see **Extended Network Benefit** in this **Medical** chapter for more information.

If you choose to use Out-of-Network Providers for a scheduled surgery, the Emergency Benefit will not apply to complications from that surgery.

If You or a Dependent Reside Outside of the Service Area

If you or a dependent reside outside of the Service Area and you receive Emergency Services or Urgent Care from an Out-of-Network Provider, you will be responsible for any out-of-pocket expenses in addition to any amount the Provider bills in excess of the Eligible Medical Expenses (EME) as explained in the **Out-of-Network Services** section of this **Medical** chapter. (If your Dependent Child is a college-aged student living outside the Service Area, please continue reading.)

If Your Child is a College Student Living Outside the Service Area

If your Dependent child is a college-aged student age 19 up to age 26 attending school outside of the Service Area, the Out-of-Network Deductible is waived and Covered Emergency Services will be processed according to the In-Network benefits listed throughout this Medical chapter. The Trust will attempt to negotiate a discount with certain Providers on your behalf.

If the college-aged student requires Urgent Care Services from an Out-of-Network Provider, the Out-of-Network Deductible will be waived. All other Out-of-Network benefits listed in this section will apply to the Urgent Care Services incurred. You will also be responsible to pay any amount the Provider bills in excess of the EME (as explained earlier in this **Out-of-Network Services** section).

Your child must return to the Service Area as soon as he or she is medically cleared to do so or follow-up treatments will be paid according to the benefits described earlier in this **Out-of-Network Services** section.

Out-of-Network Services

Prior Authorization for Out-of-Network Services

Failure to obtain required Prior Authorization for Out-of-Network non-Emergency Services or non-Urgent Care will result in non-payment of your claim. **It is your responsibility to obtain your medical records and submit them to the Trust with a request for a retrospective review.**

The laws of the State of Nevada shall govern all Plan provisions.

You must return to the Service Area when you are medically cleared to do so or coverage for your follow-up treatments will be determined according to the Out-of-Network benefits described earlier in this section.

If medical necessity is not established, no benefit will be payable by the Trust for the service.

Out-of-Network Benefit Maximums

Out-of-Network expenses are subject to the same Benefit Maximums as In-Network expenses. Please refer to **Benefit Maximums** at the beginning of this **Medical** chapter for a list of services subject to Benefit Maximums.

Pain Management (Nerve Blocks)

ALL PAIN MANAGEMENT/NERVE BLOCKS REQUIRE PRIOR AUTHORIZATION! Always make sure your Physician contacts WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244, prior to your service! Prior Authorization services will be conducted by TRISTAR Managed Care. (See Prior Authorizations at the beginning of this Medical chapter.)

Pain Management/Nerve Blocks (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Pain Management (with referral)	Required	$20 copays for office visit; 20% coinsurance for all other services (deductible does not apply)
Pain Management (without referral)	Required	20% coinsurance after $600 deductible

Be careful! Your surgeon may not always refer you to an In-Network Pain Management Specialist. This will greatly increase your personal expense!

Pediatric Services

The following charts illustrate your Plan benefits for the most common Pediatric Services. For all services not listed here, please refer to the specific topic in this **Medical** chapter. For example, to find out what you would pay for a Pediatric hospitalization, you could turn to either **Maternity/Pregnancy Services** or **Hospital Services** in this **Medical** Chapter.

Pediatric Services (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Routine Physical Exam and Immunizations for Children Age 0 to 6 Years (Your Selected PCMH Pediatrician)	Not Required	$0 per visit
Newborn Circumcision - Inpatient or Outpatient (Your Selected PCMH Pediatrician)	Not Required	20% coinsurance (deductible does not apply)
Physicians Office Visits Due to Illness or Injury (Your Selected PCMH Pediatrician)	Not Required	$10 office visit copay; 20% coinsurance for all other services (deductible does not apply)
Pediatric Services with Pediatrician Other Than Your Selected PCMH Pediatrician (with or without referral)	Not Required	20% coinsurance after $600 deductible

Watch out! If Non-Emergency Pediatric Services are performed by an Out-of-Network Provider, it will greatly increase your personal expense! (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.)

Physician Visits

Physician Visits (In-Network Providers)		
Your Selected PCP (No referral required)	**Prior Authorization**	**Plan Benefit**
Office Visits	Not Required	$10 copay (deductible does not apply)
Preventive Care	Not Required	$0 copay (deductible does not apply)
All Other Office Services	Not Required	20% coinsurance (deductible does not apply)
Hospital Visits	See Prior Authorizations	$10 hospital visit copay; 20% coinsurance for all other services (deductible does not apply)
Specialist Physician	**Prior Authorization**	**Plan Benefit**
Office Visit Charges (with referral)	Not Required	$20 copay (deductible does not apply)
Office Visit Charges (without referral)	Not Required	20% coinsurance after $600 deductible
Preventive Care	Not Required	Not Covered
All Other Office Services (with referral)	Not Required	20% coinsurance (deductible does not apply)
All Other Office Services (without referral)	Not Required	20% coinsurance after $600 deductible
Hospital Visits (with or without referral)	See Prior Authorizations	20% coinsurance after $600 deductible
All Other Physician Visits	**Prior Authorization**	**Plan Benefit**
Including, but not limited to; Emergency Room Physician, Surgeon, Assistant Surgeon, Anesthesiologist, Hospitalist, Specialist Physician and PCP other than your selected PCP.	See Prior Authorizations	20% coinsurance after $600 deductible

Please refer to other applicable pages of this Medical chapter for coverage information regarding additional services (such as Diagnostic X-Rays and Laboratory Testing) that may be performed during your Physician Office Visit. Physician Visits do not apply to Chemical Dependency or Mental Health Services; refer to applicable sections for in this chapter for Plan Benefit related to these services.

Prosthetics, Braces, Orthotics and Implants

The Plan will allow benefits for artificial limbs or eyes to replace natural limbs or eyes, breast prostheses, foot orthotics, orthopedic braces and implants, including cochlear, spinal cord, AICD and pacemakers, as indicated below:

Prosthetics, Braces, Orthotics and Implants (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Prosthetics, Braces, Orthotics and Implants (with or without referral)	Not Required	20% coinsurance (deductible does not apply)

Limitations

Breast Prostheses

After mastectomy, the Plan will allow one prosthesis per breast every two Calendar Years. If the prosthesis is part of a mastectomy bra, the Plan will allow two every Calendar Year.

Foot Orthotics

The Plan will allow one orthotic per foot each Calendar Year. A foot orthotic is either a modification made to existing shoes, a shoe insert, or whole shoes constructed for you. Foot orthotics are devices of rigid construction used to maintain the foot and supporting structures in a more efficient, functional state while standing or moving.

Repair/Replacement

No benefits will be allowed for any expenses incurred to replace or repair lost, stolen, mistreated or abused prosthetics, braces or orthotics.

Prosthetics and Alternative Treatment

Replacement prosthetics are not covered unless the medical needs of the participant are not being met by the current prosthetic, or it is broken and cannot be repaired. Repair/replacement of prosthetics under warranty are not covered. Prosthetics designed for a functional level above the participant's ability are not covered by the plan.

Watch out! If Prosthetics, Braces, Orthotics or Implants are provided by Out-of-Network Providers, you will pay 40% of the Trust's Eligible Medical Expenses (EME) for each service PLUS any amount the Provider charges over the EME once your calendar year deductible has been met. This will greatly increase your personal expense! (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.)

Skilled Nursing and Rehabilitation Facilities

Skilled Nursing and Rehabilitation Services provide patients with 24-hour nursing supervision in order to make sure that their medical and rehabilitation needs are met. Skilled Nursing and Rehabilitation Facilities offer a full range of care, including intravenous fluids and physical, speech or occupational therapy.

If determined Medically Necessary by the Trust's medical review organization, the Plan will cover up to 100 days per Calendar Year at an Inpatient Skilled Nursing; Inpatient Acute Rehabilitation; Outpatient, Comprehensive Day or Half-Day Rehabilitation; Inpatient Long-Term Acute Care; Mental Health Inpatient Care, Partial Hospitalization and Residential Treatment; Chemical Dependency, Inpatient Care, Partial Hospitalization and/or Residential Treatment.

ALL INPATIENT ADMISSIONS REQUIRE PRIOR AUTHORIZATION! Always make sure your Physician contacts WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244, prior to your service! Prior Authorization services will be conducted by TRISTAR Managed Care. (See Prior Authorizations at the beginning of this Medical chapter.)

The following chart outlines your benefits while you are receiving services at a Skilled Nursing Facility, or on an Inpatient, Outpatient, or Comprehensive Day or Half-day basis at a Long Term Acute Care Facility, Rehabilitation Facility, or in the Skilled Nursing or Rehabilitation Departments of an acute care Hospital:

Skilled Nursing and Rehabilitation Facilities (In-Network Facilities)		
	Prior Authorization	**Plan Benefit**
Inpatient/Residential Skilled Nursing or Rehabilitation Facility (with or without referral)	Required	$400 per day; $800 max per stay (deductible does not apply)
Outpatient Half-Day Treatment, Comprehensive Day Treatment (with or without referral)	Required	$20 per day (deductible does not apply)
Maximum Benefits Payable By the Plan	Required	100 Days Calendar Year Combined Benefit (See Benefit Limitations/Maximums)

Outpatient Half-Day and Comprehensive Day Treatment services will count as 1 full day towards the 100 day maximum. Charges incurred in excess of 100 days in a Calendar Year are not payable by the Plan and are the responsibility of the patient.

Watch out! If Skilled Nursing or Rehabilitation Facility Services are provided by Out-of-Network Providers, your personal expense will increase dramatically. (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.)

Sleep Studies

Sleep Studies (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Sleep Studies - In-Office (with or without referral)	Not Required	$75 per test (deductible does not apply)
Sleep Studies - Facility (with or without referral)	Not Required	20% coinsurance (deductible does not apply)
Durable Medical Equipment in Connection with Sleep Studies (with or without referral)	Required	20% coinsurance (deductible does not apply)

Watch out! If Sleep Studies or Durable Medical Equipment are provided by Out-of-Network Providers, you will pay 40% of the Trust's Eligible Medical Expenses (EME) for each item PLUS any amount the Provider charges over the EME once your $2,500 calendar year deductible has been met. This will greatly increase your personal expense! (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.)

Surgical Services

Inpatient

ALL INPATIENT HOSPITALIZATIONS REQUIRE PRIOR AUTHORIZATION! Always make sure your Physician contacts WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244, prior to your service! Prior Authorization services will be conducted by TRISTAR Managed Care. (See Prior Authorizations at the beginning of this Medical chapter.)

Inpatient Surgical Services (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Hospital Facility (Includes Diagnostic Testing, Including MRIs, CT Scans, EKGs, X-Rays, Labs, etc.)	Required	$400 per day; 800 max per stay (deductible does not apply)
All Other Physician Charges Not Listed Above* (Including, but not limited to; Emergency Room Physician, Surgeon, Assistant Surgeon, Anesthesiologist, Hospitalist, Specialist Physician and PCP other than your selected PCP)	Required	20% coinsurance after $600 deductible

* A Specialist Physician has a 20% coinsurance after $600 deductible with or without referral when services are performed outside of the physician's office.

Outpatient Surgery with In-Patient Surgical Recovery Suite all-inclusive global rate is considered as in-patient services and requires prior authorization. The copayments below include all services associated with the all-inclusive surgery while you remain in the recovery suite, such as surgeon, assistant surgeon, anesthesiologist, physician visits, inpatient stay and implants. Preoperative testing and/or transfers to other facilities are not included in the global rate and are covered as outlined elsewhere in this chapter.

The following chart outlines your benefits for Surgical Services while you are hospitalized at an In-Network Surgical Suite on an Inpatient basis as a Surgical patient:

Outpatient Surgery with Inpatient Surgical Recovery Suite (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Outpatient Surgery with Inpatient Surgical Recovery Suite (with or without referral)	Required	$1,400 (global copayment amount)

Watch out! If your non-Emergency Surgical Services are provided by an Out-of-Network Provider, you will pay 40% of the Trust's Eligible Medical Expenses (EME) for each item PLUS any amount the Provider charges over the EME once your $2,500 calendar year deductible has been met. This will greatly increase your personal expense! (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.)

Surgical Services

Outpatient

CERTAIN OUTPATIENT HOSPITAL SERVICES REQUIRE PRIOR AUTHORIZATION! Always make sure your Physician contacts WellHealth Quality Care at 702-832-4658 locally, or toll-free at 844-586-2244, prior to your service! Prior Authorization services will be conducted by TRISTAR Managed Care. (See Prior Authorizations at the beginning of this Medical chapter.)

Outpatient Surgical Services (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Same-Day Surgery - Facility Charges	See Prior Authorizations	$400 per day, $800 max per stay (deductible does not apply)
All Other Physician Charges Not Listed Above* (Including, but not limited to; Emergency Room Physician, Surgeon, Assistant Surgeon, Anesthesiologist, Hospitalist, Specialist Physician and PCP other than your selected)	See Prior Authorizations	20% coinsurance after $600 deductible

Frequently Asked Questions

If you normally reside within the Service Area and had Emergency surgery, you will be responsible for the In-Network Copayments/ Coinsurance listed in this **Surgical Services** section.

If your surgery was pre-planned, you will be responsible to pay the $2,500 Out-of-Network Deductible and 40% Coinsurance listed in the **Out-of-Network Services** section of this **Medical** chapter **PLUS** any amount the Provider charges above the Trust's EME.

Please refer to the **Out-of-Network Services** section of this **Medical** chapter for additional information.

How can I make sure my doctor uses In-Network Providers during my Surgery?

Using these three simple steps may reduce your personal expense for your surgical procedure:

- ***FIRST***, ask your doctor in advance what other Providers he will be using for the surgery (such as Hospital or Ambulatory Surgical Center, Hospitalist, anesthesiologist, and assistant surgeon).
- ***THEN***, go to **www.teachershealthtrust.org** and search the Provider directory to see if the Provider is in the Trust's network.
- ***FINALLY***, if one or more of the Providers is not in the network, print the names of the In-Network Providers and ask your doctor to refer you to one of them.

After surgery, I was admitted to the Hospital and I was seen by a Hospitalist. What is a Hospitalist? How do I ensure my Hospitalist is In-Network?

Hospitalists are doctors whose primary focus is the general medical care of hospitalized patients. Hospitals often assign a Hospitalist to a patient upon entering the Hospital through the Emergency room or other Hospital admission. Some Physicians hire Hospitalists to visit their hospitalized patients, which gives the Physician the opportunity to keep his or her regular office appointments.

Just as the Trust contracts with physicians and provides you with a list of In-Network Providers, the Trust also contracts with hospitalists. However, it is possible that during your stay in the hospital, you could unknowingly be seen by an Out-of-Network hospitalist, which would greatly increase your out-of-pocket expenses.

To ensure all your physicians are In-Network, advise the admissions staff that you should be seen only by Providers in the Trust Network. Question any unfamiliar doctor who enters your room, confirming that he or she is contracted with the Trust, and be sure any family member or friend speaking on your behalf knows to request In-Network Providers only.

Surgical Services

Frequently Asked Questions (cont.)

The Hospitalist I was assigned to was an Out-of-Network Physician. Will my claim be paid at Out-of-Network levels of benefits?
If you normally reside within the Service Area and were assigned an Out-of-Network Hospitalist during Emergency circumstances, you will be responsible for the In-Network Copayments/Coinsurance listed in this **Surgical Services** section. You will also be responsible to pay any amount the Provider charges over the Trust's EME.

Please refer to the **Out-of-Network Services** section of this **Medical** chapter for additional information.

I seem to have so many bills from my surgery! Should I be receiving this many bills?
That depends. You will, of course, receive a bill for your portion of the Hospital or Ambulatory Surgical Center facility charges and surgeon charges. You may also get bills from the assistant surgeon (if any), anesthesiologist, radiologist, and pathologist. While these are the most common bills, you may receive bills from other Providers as well.

When you receive a bill at home, it is very important that you check online with the Trust at **www.teachershealthtrust.org** to make sure the bill has been processed as a claim under your benefit Plan.

Telemedicine/Teletherapy

Telemedicine and Teletherapy are available 24 hours a day, 7 days a week, for medical or behavioral health needs. The service may be accessed by participants at wellhealthonline.com or by Phone Conferencing. WellHealth Online is powered by MDLIVE. Providers are able to diagnose and treat conditions, such as:

Telemedicine

- Allergies
- Asthma
- Bronchitis
- Cold & Flu
- Conjunctivitis (Pink-eye)
- Diarrhea
- Ear Infections
- Fever
- Headache
- Infections- Insect Bites
- Joint Aches
- Rashes
- Respiratory Infections
- Sinus Infections
- Skin Infections
- Strep Throat
- Urinary Tract Infections
- And More

Teletherapy

In addition, participants also have access to counselors and therapists for behavioral health needs, such as:

- Anxiety
- Coping with loss and grief
- Depression
- Financial Hardship
- Marital Problems
- Parenting Counseling
- Problems at Work
- Stresses
- Life Challenges

Telemedicine/Teletherapy (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Telemedicine/Teletherapy (No referral required)	Not Required	$0 copay (deductible does not apply)

Accessing care through Telemedicine is a secure way to see a provider. Personal medical information is only visible to the patient and the doctor during the appointment. Through their diagnosis, patients that may need antibiotics for treatment will be able to receive a prescription from their Telemedicine doctor, pending the doctor's discretion.

Although Telemedicine provides ease and convenience to see a provider at a time that works best for patients and their families, it is not meant to replace your chosen PCMH provider, therapists, or counselors, nor should it replace true emergency or crisis behavioral health needs. Telemedicine is meant to provide access to medical or behavioral health on occasions that may happen during non-traditional hours as an alternative to Urgent Care or Emergency Room visits.

Therapy Services

Covered therapy services include, but are not limited to, the following:

- Cardiac Rehabilitation
- Hyperbaric Oxygen Therapy
- Occupational Therapy*
- Physical Therapy*
- Psychosocial Rehabilitation
- Pulmonary Rehabilitation
- Speech Therapy*
- Wound Therapy

* Occupational, Physical and Speech Therapy require prior authorization after 20 sessions, each, per calendar year.

If Therapy Services are performed on an Outpatient basis, you will be responsible for the following Copayments:

THERAPY SERVICES (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Therapy Services	Not Required	$20 per visit*
Psychosocial Rehabilitation Services	Required	$20 per visit**
Hyperbaric Oxygen Therapy (with or without referral)	Required After 30 Treatments	$20 per visit

* Generally, you pay a Copayment per visit for Covered Therapy Services. If you are billed for more than one Provider visit during the same Therapy Session (for example, because you have more than one condition requiring therapy), you will be responsible to pay a Copayment for each Provider visit.

** Prior authorization for psychosocial rehabilitation must be obtained through Human Behavior Institute (HBI).

Watch out! If Therapy Services are provided by an Out-of-Network Provider, you will pay 40% of the Trust's Eligible Medical Expenses (EME) for each service PLUS any amount the Provider charges over the EME once your $2,500 calendar year deductible has been met. This will greatly increase your personal expense! (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.)

TMJ Diagnostic Testing Services

Diagnostic Testing related to temporomaxillary or temporomandibular joint (TMJ) malformation or dysfunction is covered as indicated below:

TMJ DIAGNOSTIC TESTING SERVICES (In-Network Providers)		
Freestanding Diagnostic Facility	**Prior Authorization**	**Plan Benefit**
CT Scans (with or without referral)	Required	$50 per test (deductible does not apply)
MRIs and MRAs (with or without referral)	Required	$75 per test (deductible does not apply)
All Other Diagnostic Testing, Such as X-Rays (with or without referral)	See Prior Authorizations	$0 copay (deductible does not apply)

Please see the **Dental** chapter of this Plan Document for coverage information regarding appliances used to treat TMJ malformation or dysfunction.

Watch out! If TMJ Diagnostic Testing Services are provided by an Out-of-Network Provider, you will pay 40% of the Trust's Eligible Medical Expenses (EME) for each service PLUS any amount the Provider charges over the EME once your calendar year deductible has been met. This will greatly increase your personal expense! (See the Out-of-Network Services section of this Medical chapter for additional expenses you may have.)

Transplant Services

ALL TRANSPLANT SERVICES AND FOLLOW UP TRANSPLANT SERVICES REQUIRE PRIOR AUTHORIZATION! You must contact the Trust's RN Case Manager to coordinate your Transplant Services and review and sign the Transplant Benefit Protocol. Failure to coordinate transplant services and follow up transplant services through the Trust's RN Case Manager will result in NO benefits being paid. (See Prior Authorizations at the beginning of this Medical chapter.)

You may contact the Trust's RN Case Manager via phone at 866-585-CARE (2273) or via e-mail at **casemanager@teachershealthtrust.org**.

The PERFORMANCE PLUS PLAN provides benefits for organ and bone marrow transplants as outlined below:

TRANSPLANT SERVICES (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Transplant Services	Required	$1,500 at time of transplant
All other copayments and coinsurances listed in the Medical chapter apply to covered services received in connection with a transplant.		

Transplant Follow-Up Care of Services

Transplant follow up care or services directly related to a previous transplant, not necessarily covered under a Trust-sponsored plan, including any expenses incurred as a result of any complications of the original surgery, require prior authorization. Follow up charges are considered eligible charges if the services are performed in a Trust-approved facility.

Corneal Transplants

Benefits for corneal transplants are the same as all other Surgical Services. Please refer to **Surgical Services** in this **Medical** chapter for coverage information for corneal transplants.

Transplant Donor Charges

Donor charges, not to extend beyond one year after the transplant, are considered eligible charges if the recommended course of treatment is followed. Transplant donor charges will be processed under the recipient's account. The transplant recipient must be covered under the PERFORMANCE PLUS PLAN on the date of service on which donor charges are incurred and will be responsible for applicable Copayments and/or Coinsurance as listed throughout this Medical chapter.

Watch out! Transplant Services and related follow up care not PRIOR AUTHORIZED by the Trust and not performed in a Trust-approved facility will not be paid by the Trust.

Transplant Services

Initiating Transplant Services Benefit

The following are mandatory steps required to initiate the Transplant and/or Transplant Follow Up Services Benefit:

1. Participants must contact the Teachers Health Trust's RN Case Manager via phone at 866-585-CARE (2273) or e-mail at **casemanager@teachershealthtrust.org**.

2. Participants must call Human Behavior Institute (HBI) at 702-248-8866 to schedule a mandatory counseling session prior to the transplant evaluation. Plan Participants must agree to attend supportive counseling through HBI.

3. The Teachers Health Trust's RN Case Manager will initiate case management and the Participant will sign the Case Management Consent Form.

4. Plan Participants must schedule an appointment with their attending physicians to review the Teachers Health Trust protocol and make a decision regarding evaluation and possible transplant surgery at a center contracted with the Teachers Health Trust. Plan Participants must agree to receive transplant services through Teachers Health Trust In-Network centers.

5. The plan participant must agree to receive transplant services through the Trust's approved, contracted centers. No more than two approved transplant evaluations will be covered by the Trust. Each approved center must be serviced by different Organ Procurement Organizations (OPOs). Transplant-approved, contracted providers may change at any time without notice. Prior to making an initial appointment or follow-up appointment, please contact the Case Management Department to verify that transplant-related services are obtained from an approved, contracted transplant center.

UCLA Services

ALL UCLA Referrals Require Prior Authorization

UCLA Medical Center is available for in-network services that cannot be performed within the Trust's PPO Network. The in-network benefit is only applied if pre-authorized by Case Management prior to services being performed.

Mandatory Steps required to initiate the UCLA Medical Center Referral:

1. The Plan Participant must contact the Teachers Health Trust's RN Case Manager at casemanager@teachershealthtrust.org or 866-585-CARE (2273).

2. The Trust RN Case Manager will initiate case management, and the Participant must sign the Case Management Consent Form and the UCLA Referral Protocol.

3. The Trust's RN Case Manager will review the UCLA Referral Protocol with the Participant and the Participant must acknowledge receipt in writing.

4. If it is determined by the Trust that In-Network Providers can perform the requested services, the Plan Participant must agree to receive services through Trust In-Network providers or be subject to the Out-of-Network Benefits described in this Plan Document.

5. Plan participants must have evaluations conducted by two different physicians, in different practices within the network, performed by specialists in the disease for which services are being requested.

6. Both physicians must document in writing that he/she physically examined the participant and is unable to provide appropriate treatment.

If services cannot be provided within the Trust's PPO Network or at UCLA Medical Center, the Extended Network Benefit will be applicable for specific services approved by the Trust RN Case Manager (See Extended Network Benefit in this chapter).

Watch Out! For UCLA Services, ***failure to contact the Case Management Department will result in Out-of-Network Benefits being paid by the Trust.*** (See **Prior Authorizations** in this **Medical** chapter.)

Urgent Care Services

Urgent Care Services are Medically Necessary services received in connection with an Injury or Illness which are required to prevent a serious deterioration in the Participant's health.

Urgent Care Services (In-Network Providers)		
	Prior Authorization	**Plan Benefit**
Urgent Care Facility (without referral)	Not Required	$50 copay (deductible does not apply)
Office Visit (PCP)	Not Required	$10 copay (deductible does not apply)
Office Visit Specialist (with referral)	Not Required	$20 copay (deductible does not apply)
Office Visit Specialist (without referral)	Not Required	20% coinsurance after $600 deductible
Emergency Room - Non-Emergency (without referral)	Not Required	$400 copay (deductible does not apply)
Emergency Room - Physician	Not Required	20% coinsurance after $600 deductible

Out-of-Network Services

IF YOU (and/or your Dependent) NORMALLY LIVE WITHIN THE SERVICE AREA*

If you and/or your Dependent(s) normally reside within the Service Area and are visiting outside of the Service Area, the Out-of-Network Deductible is waived for Urgent Care Services you receive from an Out-of-Network Provider.

* To reside within the Service Area means you and your Dependents live or work in the Service Area at least nine months of each Calendar Year and you and your Dependents have not moved out of the Service Area prior to receiving services.

IF YOU (and/or your Dependent) NORMALLY LIVE OUTSIDE THE SERVICE AREA

If you or a dependent reside outside of the Service Area and you receive Emergency Services or Urgent Care from an Out-of-Network Provider, you will be responsible for any out-of-pocket expenses in addition to any amount the Provider bills in excess of the Eligible Medical Expenses (EME) as explained in the "Out-of-Network Services" section of this Medical chapter. (If your Dependent Child is a student living outside the Service Area, please continue reading.)

IF YOUR CHILD IS A STUDENT LIVING OUTSIDE THE SERVICE AREA

If your Dependent child age 19 up to age 26 is a Student attending school outside of the Service Area, the Out-of-Network Deductible will be waived for Urgent Care Services received from an Out-of-Network Provider. All other Out-of-Network benefits will apply to the Urgent Care Services incurred.

Your child must return to the Service Area as soon as he or she is medically cleared to do so or follow-up treatments will be subject to the Out-of-Network benefits listed in the **Out-of-Network Services** section of this **Medical** chapter.

Urgent Care Services

Frequently Asked Questions

I live in Las Vegas, Nevada, but I became ill while on vacation in Alaska. I had to visit an Urgent Care Clinic. Will my Out-of-Network Expenses be covered?
Yes, your services would be covered. You will be responsible for a $50 copayment.

My family and I live outside of the Service Area. How will our Urgent Care Services be covered?
If you or a dependent reside outside of the Service Area and you receive Emergency Services or Urgent Care from an Out-of-Network Provider, you will be responsible for any out-of-pocket expenses in addition to any amount the Provider bills in excess of the EME as described in the **Out-of-Network Services** section of this **Medical** chapter.

My son is a Student attending college in Nebraska. He received Urgent Care Services for a sprained ankle. Now the doctor says he needs physical therapy. How will his physical therapy be covered?
If it is safe to do so, he must return to the Service Area.

My daughter, a Student attending college outside of the Service Area, went to the Emergency Room for treatment of a cold. Will that be covered by my Plan?
Based on the diagnosis, Out-of-Network benefits will apply. This means that you will be responsible for paying 40% of the EME **PLUS** any amount the Provider charges in excess of the EME. Your calendar year deductible will be waived. Keep in mind that charges from a Hospital Emergency Room will be much higher than charges from an Urgent Care clinic or Physician's office.

Non-Covered Services

The PERFORMANCE PLUS PLAN will not cover any expenses caused by, or on account of, the exclusions listed throughout this **Medical** chapter, regardless of medical necessity, appropriateness, or recommendation by a Physician. The following is a list of additional services which are not covered by this plan:

1. **Administrative Services**: Expenses for administrative services such as expert testimony, medical records review and maintenance, preparation of reports regarding civil or legal matters, evaluation of ability to stand trial, evaluation to determine level of disability, consultation with attorneys or other representatives of social services, and case management services.

2. **Allergen:** Expenses for the testing of any allergen source, such as (but not limited to) animal feces, dander, hair, plants, etc.

3. **Alternative and Complimentary Medicine:** Expenses incurred for alternative medicine interventions that are not supported by adequate evidence of safety and effectiveness by a recognized body of research (including, but not limited to, mega-vitamin therapy, hypnosis and micronutrient testing).

4. **Bariatric Surgery:** Expenses for bariatric surgery, including preoperative services, follow-up services and treatment of the complications related, but not limited to, and/or resulting from bariatric surgery, anemia, vitamin deficiency and malabsorption syndrome.

5. **Batteries, Hearing Aid:** Expenses for hearing aid batteries.

6. **Breast Pumps:** Supplies not directly related to the breast pump, including but not limited to bottles, breast pads, nursing bras, nipple shells, nipple cream and nursing pillows.

7. **Child Care:** Expenses for child care, homemaker services, or home maintenance services.

8. **Complications:** Expenses incurred for services and complications following any treatment or procedure excluded from coverage by the Trust.

9. **Concierge Fees:** Annual fee or retainer charged by a physician for providing enhanced services.

10. **Copy Fees:** Expenses for photocopying, mailing, shipping or handling.

11. **Cosmetic Services:** Expenses for cosmetic reconstructive or plastic surgery, including sex transformation and breast reconstruction surgery, except that the Trust will provide benefits if:

    - The surgery is for repair of damage sustained in an accident and the charges are incurred within one year from the date of the accident; or
    - The surgery is performed to reconstruct the breast following a mastectomy (see **The Women's Health and Cancer Rights Act of 1998** in the **Legal** chapter of this Plan Document); or
    - The surgery is performed to correct a congenital anomaly that improves function.

12. **Court-Ordered Services:** Expenses for court-ordered treatment or hospitalization unless Medically Necessary and otherwise covered under the Plan.

13. **Coverage Termination:** Expenses incurred after coverage has been terminated under the Plan or prior to the date coverage became effective.

14. **Custodial Care:** Custodial and institutional care which is for the primary purpose of controlling or changing a Plan Participant's environment; custodial care for personal comfort or convenience-related service that provides general maintenance, supportive, preventive and/or protective care, regardless of whether these services are provided in a Hospital, nursing facility, home or elsewhere.

Non-Covered Services

The PERFORMANCE PLUS PLAN will not cover any expenses caused by, or on account of, the exclusions listed throughout this **Medical** chapter, regardless of medical necessity, appropriateness, or recommendation by a Physician. The following is a list of additional services which are not covered by this Plan:

15. **Dental Expenses:** Treatment on or to the teeth, nerves within the teeth, gingivae, or alveolar processes, except to the extent necessary for repair or replacement of sound natural teeth to which damage is caused solely by accidental bodily Injury as a result of external force while a person is covered under the Plan, but only for Covered expenses initiated no later than 90 days after the date of such accident and incurred within one year of the date of the accident. The Eligible Medical Expenses (EME) for these services will be limited to the amounts set forth in the Schedule of Dental Allowances on file in the Trust office. (See the **Dental** chapter of this Plan Document for additional information.)

16. **Donor Charges, Egg or Sperm:** Expenses for egg or sperm donors or for gender selection.

17. **Donor Charges, Transplant:** Transplant donor charges incurred beyond 12 months post-transplant; expenses for transplant donor services if the transplant recipient is not eligible under the PERFORMANCE PLUS PLAN at the time the expense is incurred.

18. **Employment Exam:** Expenses for psychiatric or psychological examinations, testing or treatment for the purposes of obtaining employment or insurance, or related to judicial or administrative proceedings.

19. **Equipment, Exercise:** Expenses for the rental or purchase of exercise equipment.

20. **Equipment, Rental or Purchase:** Expenses for the rental or purchase of equipment and related supplies such as air conditioners, air purifiers, dehumidifiers, heating pads, elevators, chairlifts, wall rails, or other modifications of stairs or vehicles, hot water bottles, water beds, swimming pools, hot tubs and any other clothing or equipment which could be used in the absence of an Illness or Injury; expenses for equipment or supplies that do not meet Medicare guidelines for coverage.

21. **Equipment, Repair or Replacement:** Expenses to replace or repair equipment/prosthetics under warranty; lost, stolen, mistreated or abused Durable Medical Equipment, appliances, supplies or prosthetics.

22. **Experimental Treatment:** Expenses for experimental or investigational equipment, services or supplies which have not been approved by the appropriate U.S. government agency or the Teachers Health Trust, OR therapies that do not have general acceptance within the scientific field and whose safety and efficacy are not supported by a recognized body of research. An example of such service includes but is not limited to, orthotripsy for plantar faciitis, cold laser therapy or breast thermography scans.

23. **Food:** Expenses for special formulas, food supplements, special diets, and the cost of any formula that can be purchased without a prescription or over the counter.

24. **Free Services:** Expenses for which the Participant would not be required to pay in the absence of this coverage.

25. **Hair Transplants:** Expenses for and in connection with hair transplants.

26. **Health Improvement Benefit Services:** Expenses for health club memberships, personal training, tobacco prevention, weight management support groups for Dependents or Participants outside of the Health Improvement Benefit or Essential Health Benefits.

27. **Hearing Aid Batteries:** Expenses for hearing aid batteries are excluded from coverage.

Non-Covered Services

The PERFORMANCE PLUS PLAN will not cover any expenses caused by, or on account of, the exclusions listed throughout this **Medical** chapter, regardless of medical necessity, appropriateness, or recommendation by a Physician. The following is a list of additional services which are not covered by this Plan:

28. **Illegal Activities:** Expenses incurred for Injuries or Illness resulting from:

    - the commission or attempted commission of an act that results in conviction of a felony or misdemeanor ("misdemeanor" being limited to assault and/or battery, DUI, or reckless driving)
    - being engaged in an illegal occupation or being involved in illegal activities.

29. **Incarceration:** The Trust will not provide benefits for care or treatment provided during any period in which Participant is incarcerated.

30. **Infertility Treatment:** Expenses incurred for the treatment of infertility and expenses incurred after the initial consult or initial day of testing to diagnose infertility.

31. **Injectable Drugs Obtained from a Home Health Care Agency or Infusion Company:** Expenses for injectable drugs obtained from a Home Health Care Agency or Infusion Company.

32. **Insulin Pump Replacements:** Insulin pump replacement purchased prior to the end of four years following initial purchase, unless the patient's medical condition changes in accordance with Medicare guidelines.

33. **Intraocular Lenses:** Lenses placed during surgery to improve nearsightedness, farsightedness, and/or astigmatism, including but not limited to Toric Lenses.

34. **LASIK Eye Surgery:** Any keratorefractive surgery to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea, including but not limited to LASIK and radial keratotomy.

35. **Late Claims:** Medical claims received by the Trust more than twelve months after the date expenses were incurred.

36. **Late Information:** If a claim for benefits has been pended or denied because the Trust is awaiting your or your provider's response to an inquiry made in order to process the claim and you have failed to provide the information to the Trust within six months of the earliest date the claim was either pended or denied, the claim may not be considered a covered expense, and you may become responsible for the expense, including any late fees and/or interest charged by the provider. (See the **Claims Processing** and **Claims Appeals** chapters of this Plan Document for additional information.)

37. **Legal Consultation:** Expenses for legal or other professional consultation for adjudication of marital, child support and custody cases.

38. **Licensure/Certification:** Expenses for legal or other professional consultation for adjudication of marital, child support and custody cases.

39. **Lodging:** Lodging and other travel-related expenses.

40. **Massage Therapy:** Services provided by a massage therapist are not a covered benefit.

41. **Medical Reports:** Expenses for insurance/clerical filing; preparation of medical reports, itemized billings or claim forms; and foreign language translation of medical reports.

42. **Missed Appointments:** Expenses incurred as a result of missed appointments.

Non-Covered Services

The PERFORMANCE PLUS PLAN will not cover any expenses caused by, or on account of, the exclusions listed throughout this **Medical** chapter, regardless of medical necessity, appropriateness, or recommendation by a Physician. The following is a list of additional services which are not covered by this Plan:

43. **Negligent Acts by Another Party:** The Plan will not provide benefits for expenses that are the liability of another party due to the commission of a negligent act.

44. **Non-Medically Necessary Treatment:** Expenses relating to the treatment which is not Medically Necessary or expenses which are determined by the Trust's In-Network reviewing organizations to be for services or supplies that could have been provided in a more cost-effective manner without affecting the patient's health.

45. **Non-Prescribed Services**: Expenses for services, supplies, medication or treatment not prescribed or recommended by a licensed medical Provider or prescribed by a Provider practicing outside the scope of their license or certification.

46. **Nursing, Private Duty:** Expenses for Private Duty Nursing services, regardless of medical condition.

47. **Nutritional Supplements:** Expenses for nutritional supplementation.

48. **Nutritionist:** Services provided by a nutritionist are not a covered benefit. Nutritional counseling is covered under the plan only when provided by a registered dietician.

49. **Orthodontia:** See Dental

50. **Other Medical Services:** Expenses covered by the Teachers Health Trust Dental Plan will not be covered under the Medical Plan.

51. **Personal Comfort Items:** Expenses for personal comfort or service items such as (but not limited to) radio, television, telephone and guest meals while the Participant is confined in a medical facility.

52. **Plan Maximums:** Expenses incurred beyond the Plan's Benefit Maximums listed throughout this Plan Document.

53. **Prosthetics and Alternative Treatment:** Replacement prosthetics are not covered unless the medical needs of the participant are not being met by the current prosthetic, or it is broken and cannot be repaired. Repair/replacement of prosthetics under warranty are not covered. Prosthetics designed for a functional level above the participant's ability are not covered by the plan.

54. **Psychiatric Testing:** Expenses for psychiatric or psychological examination, testing, or treatment for purposes of obtaining employment or insurance or relating to judicial or administrative proceedings.

55. **Relatives Rendering Services:** Expenses incurred as a result of services rendered by a person who ordinarily lives in the Participant's home, or by a Spouse, child, parent or sibling of the Participant or of the Participant's Spouse.

56. **Remedial Education:** Expenses for remedial education, testing or treatment of learning and behavioral disabilities, such as dyslexia.

57. **Rest Homes:** Expenses for sanitariums, rest homes, or for custodial care, child care, homemaker services, or maintenance care.

58. **Services Performed Without Prior Authorization:** All charges for procedures not pre-approved as required by Utilization Review.

59. **Sexual Therapy Programs:** Expenses incurred for structured sexual therapy programs, or mental health programs designed to treat sexual offenders or perpetrators of sexual or physical violence.

Non-Covered Services

The PERFORMANCE PLUS PLAN will not cover any expenses caused by, or on account of, the exclusions listed throughout this **Medical** chapter, regardless of medical necessity, appropriateness, or recommendation by a Physician. The following is a list of additional services which are not covered by this Plan:

60. **Sterilization of Equipment:** Fees charged by a Provider to sterilize equipment or devices used in rendering services to a Participant.

61. **Sterilization Reversal:** Expenses incurred for the reversal of any reproductive sterilization procedure.

62. **Storage Charges:** Expenses in connection with storage, such as, but not limited to, egg, sperm or cord blood. This does not include storage of your own blood before an upcoming surgery.

63. **Surrogate Mothers:** Expenses for surrogate mothers and any services related to surrogate pregnancies and deliveries.

64. **Telephone Calls:** Expenses for telephone calls.

65. **Testing/Analysis of External Sources:** Expenses for the testing of any allergen source, such as (but not limited to) animal feces, dander, hair, plants, etc.

66. **Translation, Foreign Language:** Expenses incurred for foreign language translation of medical records.

67. **Transplant Follow-Up Services:** Follow up services directly related to transplants that were performed while the patient was insured by the Trust at a center not currently approved by the Teachers Health Trust.

68. **Transplant Surgery Related Services Performed in a Non-Approved Transplant Surgery Center:** When surgery is performed in a non-approved transplant surgery center, any follow up care or services directly related to the previous transplant, including any expenses incurred as a result of any complication of the original surgery, will not be considered covered expenses.

69. **Transportation:** Expenses for transportation, except for Medically Necessary ground and air Ambulance Services.

70. **Travel and Lodging:** Expenses for travel and lodging.

71. **Ultrasounds:** Ultrasounds performed by providers practicing any specialty other than perinatology will be limited to four (4) ultrasounds per pregnancy. The participant is responsible for all fees associated with any ultrasound(s) after the fourth test if these tests are performed by any provider other than a perinatologist.

72. **Virtual Testing:** Expenses incurred for virtual testing not covered under the Preventive/Routine Care Benefit.

73. **Vision Services:** Expenses incurred for vision therapy, orthoptics or supplies. Eye examinations for the diagnosis or treatment of a refractive error, including the fitting of eyeglasses or lenses, are not covered by the Plan, except that the Plan will cover the initial pair of eyeglasses following cataract surgery. (See the **Vision** chapter of this Plan Document for additional information.)

74. **Vocational Testing:** Expenses related to vocational testing and counseling.

75. **War:** Expenses incurred for Injuries or Illness resulting from:

- an intentional or accidental atomic explosion or other release of nuclear energy, whether in peace or war
- participation in a civil revolution or a riot
- a war or act of war which is declared or undeclared.

Non-Covered Services

The PERFORMANCE PLUS PLAN will not cover any expenses caused by, or on account of, the exclusions listed throughout this **Medical** chapter, regardless of medical necessity, appropriateness, or recommendation by a Physician. The following is a list of additional services which are not covered by this Plan:

76. Ward of the State/Court: The Trust will not provide benefits for care of treatment provided during any period in which Participant is a Ward of the State/Court.

77. Workers' Compensation: Any condition or disability sustained as a result of being engaged in activity primarily for wage, profit or gain, or expenses eligible for consideration under any other plan of an employer. If Participant's denial gives the right to appeal the denial, the Participant must appeal the Workers' Compensation denial. If the Participant does not follow all Workers' Compensation guidelines and requirements, claims will not be paid. However, the Trust will consider coverage of expenses for Injury or Illness that result or arise out of any past or present employment or occupation for compensation or profit provided that:

a. the Participant filed a complete and timely claim with their employer or other appropriate party; and
b. the claim and all permissible appeals (including court reviews) were specifically denied under the Nevada Industrial Insurance Act, as amended, as non-compensable (or other applicable statue from another state); or
c. the individual who suffers work-related injuries is not required to have Workers' Compensation for himself/herself.

Hospital Supplement Plan

If you decide that you DO NOT want coverage under the PERFORMANCE PLUS PLAN, you may enroll in the Hospital Supplement Plan. **There is no medical coverage available under the Hospital Supplement Plan.** Instead, this plan pays $260 per day for every day of overnight Inpatient hospitalization or each 24 hours of observation for which room and board is charged. This benefit is paid for up to a Lifetime Maximum of 365 days.

The Hospital Supplement Plan pays benefits directly to you and does not coordinate with any other Plan.

Your claim must be submitted no later than twelve months following the date of your Hospital discharge. The claim must be sent to:

Teachers Health Trust
P.O. Box 96238
Las Vegas, NV 89193-6238

The Hospital Supplement Plan is NOT available to Dependents!

Performance Plus Plan Benefits, Chapter 5:

Prescription Drugs

Contents

How to Use An In-Network Retail Pharmacy

Filling your prescription is easy. Present your Trust ID card to the In-Network Pharmacy and pay the appropriate Copayment per prescription. There is no claim form to complete.

If your Physician prescribes your medications as "dispense as written" when there may be a lower cost Preferred Drug or a Generic equivalent, the pharmacist may call your doctor to discuss other dispensing options. The final decision on which drug you receive is up to your doctor. Therefore, **YOU SHOULD ALWAYS REVIEW YOUR PRESCRIPTIONS WITH YOUR PHYSICIAN TO DETERMINE IF THERE IS AN ALTERNATIVE DRUG THAT MAY BE AVAILABLE AT A LOWER COST TO YOU.** A formulary list is available at www.teachershealthtrust.org.

Your benefits under the PERFORMANCE PLUS PLAN also include coverage for both Generic and Brand-Name Prescription Drugs obtained in one of three ways:

1. **At Exclusive In-Network Retail Pharmacies**
2. **At All Other In-Network Retail Pharmacies**
3. **Through CVS Caremark's Mail Order or Specialty Program**

Benefits for these services are described in more detail on the following pages. The definitions listed below will help you to understand the benefits described in this chapter.

Definitions

Generic Drugs	A drug that contains the same active ingredients as—and is equivalent in strength and dosage to—the original brand-name drug.
Preferred Drugs	Drugs that have been carefully selected based on their clinical effectiveness and cost savings to you and the Trust. The Copayments for Preferred Drugs are lower than the Copayments for Non-Preferred Drugs. A list of Preferred Drugs is sometimes known as a "Formulary."
Non-Preferred Drugs	Drugs that are not on the Preferred Drug list. The Copayments for Non-Preferred Drugs are higher than the Copayments for Preferred Drugs.
Exclusive, In-Network and Non-Preferred Retail Pharmacies	Exclusive pharmacies which are contracted include CVS, Walmart, Sam's Club, Von's, and Lin's Supermarket (Overton, NV). A complete list including Preferred and Non-Preferred Retail pharmacies is available on MedImpact's website at https://mp.medimpact.com.
Mail Order Pharmacy	A pharmacy owned and operated by CVS Caremark that is used primarily for filling maintenance medication for treatment of on-going health conditions, such as high blood pressure. All medications are delivered, postage paid, to your home.
Out-of-Network Retail Pharmacies	Independently owned pharmacies and chain pharmacies which are not contracted on behalf of the Trust.

Vacation Refills

If you will require your medication while traveling, you may fill an additional 30-day supply through a retail pharmacy one time per Calendar Year.

Prior Authorization

Certain classes of drugs (for example, growth hormones) require Prior Authorization before you can fill the prescription. To determine if your particular medication requires Prior Authorization—or to obtain the Prior Authorization—you must contact MedImpact at 844-336-2676.

Drug Detox Protocol: Medications used to aid in detoxification of drugs and alcohol are covered under the prescription drug plan only when prior authorization is obtained through Human Behavior Institute (HBI).

If your physician prescribes a detoxification medication, you will need to make an appointment with HBI for an assessment. If HBI approves your medication, the Trust will be notified. You must fax a legible copy of the prescription, which includes the drug name, strength, patient name and patient date of birth to the Trust at 702-794-2093. The Trust will need to establish coverage for the specific time frame, medication and strength prescribed before you will be able to obtain the medication from the pharmacy.

In-Network Retail Pharmacies

Early Refills

You may not obtain an early refill of your prescription unless 75 percent or more of your existing supply has been used as directed by the prescribing Provider. If the existing supply on hand is less than 75 percent used, you must pay the full cost of the refill.

Copayments

Your personal expense for drugs obtained at an In-Network Pharmacy depends upon whether you receive a Generic Drug, a Preferred Brand Name Drug, or a Non-Preferred Brand Name Drug.

Exclusive In-Network Retail Pharmacies CVS, Walmart, Sam's Club, Von's and Lin's (30-Day Supply)	
	Plan Benefit
Generic Drugs: Cost Up to $25	$5
Generic Drugs: Cost Over $25	25% of cost of prescription (Included in Out-of-Pocket Max), copayment maximum of $100 per prescription, per 30-day supply
Preferred (Formulary)	25% of cost of prescription (Included in Out-of-Pocket Max), copayment maximum of $200 per prescription, per 30-day supply
Non-Preferred Brand	40% of cost of prescription minimum $50 (Included in Out-of-Pocket Max)
Formulary Diabetic Supplies (Includes Syringes, Needles, Lancets and Test Strips; Limited to a quantity of 200 per 30-day supply.)	If enrolled in through WellHealth Diabetic Program: $0 copay; If not enrolled in WellHealth Diabetic Program: $10 copay (Included in Out-of-Pocket Max). Glucose monitors are provided, at no charge to the participant, by the Trust (Call 702-866-6192 to make an appointment).
Formulary Diabetics Insulin and Medications	25% of the cost of the prescription (Included in Out-of-Pocket Max). Participants enrolled in and compliant with the WellHealth Diabetic Program: $100 Out-of-Pocket max per prescription per 30-day supply. Participants not enrolled in and compliant with the WellHealth Diabetic Program: $200 Out-of-Pocket max per prescription per 30-day supply.

If the Dispense as Written (DAW) box on your prescription is marked by either you or your physician with a brand drug, it will automatically be filled with a brand-name drug and you will be responsible for the difference between the brand and generic cost plus the brand name copayment. Ask your physician if a generic medication is available. Generics will generally save you money.

Pharmacy Choice Fee

For prescriptions filled at in-network pharmacies other than CVS, Walmart, Sam's Club, Von's, and Lin's Supermarket (Overton, NV), the participant will pay a pharmacy choice fee (PCF) of $10 per prescription in addition to the copays listed in this chapter. A complete listing of non-preferred in-network pharmacies and formulary medications are available at https://mp.medimpact.com.

In-Network Non-Preferred Retail Pharmacies	
	Plan Benefit
Pharmacy Choice Fee	$10

Retail Prescription Reimbursement

On occasion, you may have to pay 100% for a covered prescription. It may be due to your eligibility being suspended pending your COBRA or Self-pay payment, it may be the Trust is waiting for the documents to complete the enrollment process or it could be because the prior authorization process has not been completed. If you have to pay cash for a covered prescription, you only have seven days to return to the pharmacy for a full refund less the applicable copayment. Receipts older than seven days must be submitted to MedImpact and will only be reimbursed at the contract rate less the applicable copayment if eligibility has been established and prior authorization has been approved.

MedImpact Prescription Reimbursement forms can be found on the Trust website at www.teachershealthtrust.com.

Secondary Prescription Coverage

You will be required to use the primary plan's prescription drug benefits first. If the other coverage is primary, you will have to pay your portion of the cost of the drug and submit a claim to the Trust for reimbursement. Prescription drug claims must include the following information for you to receive reimbursement:

- National Drug Code (NDC) number
- Your name and identification number (Since prescription receipts do not include identification numbers, be sure to write your number on the receipt.)
- Patient's full name
- Name and quantity of drug
- Prescription number
- Name of prescribing doctor
- Amount charged for each drug
- Purchase date of prescription
- Pharmacist's signature

Within twelve months following the date your prescription was filled, submit your original prescription receipt* with all the required information—ALONG WITH A COPY OF THE OTHER INSURANCE COMPANY'S EXPLANATION OF BENEFITS (if applicable) to:

Teachers Health Trust
P.O. Box 96238
Las Vegas, NV 89193-6238

* In lieu of an original prescription receipt, the Trust will accept a printout of your prescription history with the pharmacist's signature.

Mail Order Program

Copayments

The Trust Mail Order Program, which is provided through CVS Caremark, allows you to fill your prescriptions for maintenance medication for up to a 90-day supply at one time. Examples of maintenance drugs are birth control pills and estrogens; or medication for thyroid disease, hypertension, diabetes, glaucoma, high cholesterol, seizure disorders, heart disease or immune deficiency disease.

Your personal expense for drugs obtained through the Mail Order Program depends upon whether you receive a Generic Drug, a Preferred Brand Name Drug, or a Non-Preferred Brand Name Drug.

Specialty medications must be filled at the Specialty pharmacy and cannot be filled for more than a 30-day supply *(See Specialty Drug Orders)*.

CVS Caremark Mail Order Program (90-Day Supply)	
	Plan Benefit
Generic Drugs: Cost Up to $75	$12.50
Generic Drugs: Cost Over $75	25% of cost of prescription (Included in Out-of-Pocket Max), copayment maximum of $300 per prescription per 90-day supply
Preferred (Formulary)	25% of cost of prescription (Included in Out-of-Pocket Max), copayment maximum of $600 per prescription per 90-day supply
Non-Preferred Brand	40% of cost of prescription minimum $125 (Included in Out-of-Pocket Max)
Formulary Diabetic Supplies (Includes Syringes, Needles, Lancets and Test Strips; Limited to a quantity of 600 per 90-day supply.)	If enrolled in WellHealth Diabetic Program: $0 copay; If not enrolled in WellHealth Diabetic Program: $30 copay (Included in Out-of-Pocket Max). Glucose monitors are provided, at no charge to the participant, by the Trust (Call 702-866-6192 to make an appointment).
Formulary Diabetics Insulin and Medications	25% of the cost of the prescription. (Included in Out-of-Pocket Max) Participants enrolled in and compliant with the WellHealth Diabetic Program: $300 Out-of-Pocket max per prescription per 90-day supply. Participants not enrolled in and compliant with the WellHealth Diabetic Program: $600 Out-of-Pocket max per prescription per 90-day supply.

If the Dispense as Written (DAW) box on your prescription is marked by either you or your physician with a brand drug, it will automatically be filled with a brand-name drug and you will be responsible for the difference between the brand and generic cost plus the brand name copayment. Ask your physician if a generic medication is available. Generics will generally save you money.

Mail Order Program

How to Use the Mail Order Program

To use the Mail Order Program for a new prescription, ask your doctor to write two separate prescriptions, the first for up to a 30-day supply, and the second for a 90-day supply with refills. Then follow the below procedures:

1. Fill the 30-day prescription at a retail pharmacy. Use an In-Network Retail Pharmacy for the lowest copayment.
2. Complete a mail service order form and send it to CVS Caremark, along with your original 90-day prescription(s) and the appropriate copayment for each prescription. **Be sure to include your original prescription. Photocopies are not accepted.** You can obtain a mail order form online at www.teachershealthtrust.org.

To contact the CVS Caremark directly about the Trust Mail Order Program:

CVS Caremark
(800) 552-8159
www.caremark.com

Do not send a prescription for a 30-day supply with refills to the Mail Order Program! CVS Caremark can ONLY fill the prescription for the quantity limit written on your prescription and cannot change a prescription; therefore, you will be charged the 90-day Copayment for a 30-day supply of medicine. Your prescription must be written for a 90-day supply in order for the Mail Order Program to save you money.

Specialty Drug Orders

The specialty drug program supports patients with complex health conditions who need injectable medications, medications with strict compliance requirements and/or special storage needs. CVS/Caremark allows you to receive your specialty medications via delivery to your home, workplace, physicians' office or other designated locations.

Specialty Drugs (30-Day Supply Maximum)	
	Plan Benefit
Generic	25% of cost of prescription (Included in Out-of-Pocket Max), copayment maximum of $500 per prescription per 30-day supply
Preferred (Formulary)	25% of cost of prescription (Included in Out-of-Pocket Max), copayment maximum of $500 per prescription per 30-day supply
Non-Preferred Brand	40% of cost of prescription minimum $50 (Included in Out-of-Pocket Max)

For more information about this service, please contact CVS/Caremark at the phone number or website listed below.

CVS Caremark
(800) 237-2767
www.caremark.com

Specialty drug can only be mailed in 30-day increments. When this occurs your co-pay will be prorated. **ALWAYS ALLOW UP TO 14 CALENDAR DAYS FOR YOUR MAIL ORDER PRESCRIPTION DELIVERY.**

Out-of-Network Retail Pharmacies

There is no Out-of-Network pharmacy benefit.

Covered Expenses

To determine coverage for medication, contact MedImpact at 1-844-336-2676 or visit https://mp.medimpact.com.

Non-Covered Expenses

1. **Anabolic Steroids**
2. **Anorexiants**
3. Any medication that is **Not Covered** under the Teachers Health Trust's Formulary.
4. Any prescription filled in excess of the number specified by the Physician or **Beyond the Recommended Dosage** or any refill dispensed after one year from the Physician's original order.
5. Medication to be used for **Cosmetic Purposes**; for example, Minoxidil (propecia), and Retin-A (except for treatment of chronic acne or other skin disease).
6. Medications used to aid **Detoxification** from drugs or alcohol or in replacement of desired drug (such as methadone or Suboxone), except as covered through the drug detox protocol.
7. The following **Drug Classes** are **Not Covered**: Non-Sedating Antihistamines, Proton Pump Inhibitors, Nonsterodial Anti-inflammatory Agents (NSAIDs) and, Nasal Steroids.
8. Drugs in excess of eight pills per month for treatment of **Erectile Dysfunction.**
9. Drugs labeled, "Caution – limited by federal law to investigational use," or **Experimental Drugs**, even though a charge is made to the individual.
10. **Fertility Medications**
11. **Food Supplements**
12. Prescriptions which an eligible person is entitled to receive **Free of Charge** under any Workers' Compensation laws or any municipal, state or federal program.
13. **Irrigation Solutions**
14. Drugs prescribed for a diagnosis for which the drug is **Not Medically Indicated**; drugs requiring a prescription that have **Not Been Approved by the Federal Drug Administration (FDA)** or other governing body for the condition, dose, route and frequency for which they are prescribed (i.e., are used off-label).
15. **Naturopathic, naprapathic or homeopathic treatments/substances**
16. **Nutritional Supplements**
17. **Over-the-Counter Drugs** and products
18. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a **Patient in a Licensed Hospital**, rest home, sanitarium, extended care facility, convalescent Hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

Non-Covered Expenses

19. Replacement for lost, stolen, spilled or damaged drugs.

20. Therapeutic Devices or Appliances, including continuous glucose monitoring systems and related supplies, support garments and other non-medical substances, regardless of intended use.

21. Vitamins other than prenatal vitamins.

Frequently Asked Questions

I haven't received my card yet, but I need to fill my prescription. What do I do?
You or your pharmacist can call MedImpact at 844-336-2676. MedImpact will instruct the pharmacist on how to process your prescription claim online so that you are only charged the appropriate Copayment.

Do I need to obtain Prior Authorization for medicine?
That depends. Prior Authorization is generally NOT required for Covered Prescription Drugs. However, certain classes of drugs (e.g. growth hormones) require Prior Authorization before you can fill the prescription. To determine if your particular medication requires Prior Authorization—or to obtain the Prior Authorization—your doctor must contact MedImpact at 800-788-2949.

I have lost my prescription card. How do I get a new one?
You can request a new prescription card by calling MedImpact at **844-336-2676**.

How do I get my prescriptions filled while I'm waiting for my replacement card?
If you are an established customer at a particular pharmacy, you should not have to present your card to them because they usually have all the required information stored in their computer system. If you are using a new pharmacy, you or your pharmacist can call MedImpact at 844-336-2676. MedImpact will instruct the pharmacist on how to process your prescription claim online so that you are only charged the appropriate Copayment.

Are Generic Drugs safe and do they work as well as brand-name drugs?
The U.S. Food and Drug Administration tests new Generic Drugs to ensure their safety and effectiveness. They make sure that Generic Drugs contain the same amounts of active ingredients, that they are manufactured according to federal standards, and that they are released into the body at the same rate and in the same way as the Brand Name Drugs.

Why choose Generic Drugs?
Although not every Brand Name Drug has a Generic equivalent, you can save a significant amount of money by choosing Generic Drugs whenever available and you won't compromise on quality. Generic Drugs typically cost 30 to 60 percent less than their Brand Name counterparts because the manufacturers don't have to pay for expensive research and development or sales and advertising. Plus, your Copayment for Generic Drugs is much lower than your Copayment for Brand Name Drugs.

Can I get an early refill on my drug?
You may not obtain an early refill of your prescription unless 75 percent or more of your existing supply has been used as directed by the prescribing Provider. If the existing supply on hand is less than 75 percent used, you must pay the full cost of the refill.

Can I get coverage for a drug that is excluded from the Trust's formulary?
No, there is no benefit for medications that have been excluded from the Teachers Health Trust's formulary.

Hospital Supplement Plan

If you are covered under the Hospital Supplement Plan, you do not have Prescription Drug Coverage. See **Hospital Supplement Plan** in the **Medical** chapter for additional information.

Performance Plus Plan Benefits, Chapter 6:

Dental

Contents

Performance Plus Dental Plan

The Trust provides a Dental Plan for its Active Participants. In-Network Services are available from dentists contracted on behalf of the Trust. Out-of-Network Services are also available, but your personal expense may be much greater by using an Out-of-Network Provider. The Plan is designed to provide benefits for preventive, basic and major dental services. Coverage also includes orthodontia treatment.

Annual Deductible

There is **no Annual Deductible** to meet under the PERFORMANCE PLUS Dental Plan.

Benefit Maximums

The following chart lists the Dental Plan Maximums. You are responsible for payment of any Dental Services after the Benefit Maximum has been paid by the Trust.

Dental Benefit Maximums	Plan Benefit
Maximum Benefit - All Dental Services (except Orthodontia)	$1,500 per person per calendar year
Maximum Benefit - Orthodontia Services*	$1,000 per person per lifetime

* Orthodontia Services are available only to Dependents age eighteen (18) and under who have been enrolled in the Diamond and/or Performance Plus Plan for two current consecutive years..

Prior Authorization

The Trust **does not** require Prior Authorization of Dental Services.

Verification of Coverage

The Trust will advise your Dental Provider of the benefits available to you and/or your Eligible Dependents but will not provide individual claim payment estimates.

Eligible Dental Expenses

The Eligible Dental Expenses (EDE) are the amounts of the Provider's billed charges that the Trust will consider for payment. The following is the basis for the EDE under the PERFORMANCE PLUS PLAN.

Type of Provider	Eligible Dental Expenses
All In-Network Providers	The contracted amount agreed upon by the Provider
All Out-of-Network Providers	The Dental Fee Schedule established by the Trust and updated annually

Covered Services

Covered Services include, but are not limited to, the following:

1. **Preventive Services**
   routine oral examinations; routine prophylaxis (cleanings); bitewing, periapical, panoramic or full mouth x-rays; fluoride treatment and sealants for Participants under the age of nineteen (19)

2. **Basic Services**
   anesthesia—general; alveoplasty; apicoectomy; casts, lab studies; exams, problem focused; extractions, root recovery; gingival scaling and root planing; surgical exposure of teeth; fillings; hemisection; incision and drainage; pin retention; prophylaxis, periodontal; pulpotomy; recementation of bridges and crowns; root canals; tooth reimplantation

3. **Major Services**
   bridges; crowns; build-ups; dentures, relining and adjustment; gingivectomy, grafts, and osseous surgery; implants; inlays; onlays; posts and cores; TMJ appliances

4. **Orthodontia Services**
   Orthodontic Services (including appliances) for Dependents age eighteen (18) and under who have been enrolled in the Diamond and/or Performance Plus Plan for two current consecutive years..

In-Network Services

In-Network Dental Services	Plan Benefit
Preventive Services	$0
Basic Services	20%
Major Services	40%
Orthodontia Services	$0

You also pay any amounts billed in a Calendar Year (or Lifetime for Orthodontia Services) after the Trust has paid the Benefit Maximum for your Services.

How to Find An In-Network Provider

It is your responsibility to make sure your Provider is an In-Network Provider prior to or at the time of your appointment. To find an In-Network Provider, access the Trust's website at www.teachershealthtrust.org.

Out-of-Network Services

Out-of-Network Dentists do not have to limit their charges to the Trust's Eligible Dental Expenses (EDE). **Therefore, you will be required to pay any amount the Dentist charges over the Trust's EDE.**

In-Network VS. Out-of-Network Expenses

Let's say you've just had a crown placed by a Dentist who charged you $900 for the work. The following is an example of what you might expect to pay if that service was performed by an Out-of-Network Dentist compared to what you would pay for In-Network Services.

	Out-of-Network Provider
Billed Amount:	$ 900.00
Eligible Dental Expenses (EDE):	$ 330.72
AMOUNT YOU PAY to an Out-of-Network Provider: (difference between billed charges and EDE)	**$ 569.28**

	In-Network Provider
Billed Amount:	$ 900.00
Eligible Dental Expenses (EDE):	$ 689.00
AMOUNT YOU PAY to an In-Network Provider: (40% of EDE)	**$ 275.60**

In this example, you would have paid $293.68 MORE for Services performed by an Out-of-Network Provider!

Limitations

The following limitations apply to the combined benefits provided under the Performance Plus Plan, regardless of whether the services are performed by In-Network or Out-of-Network providers. All dental maximums and limitations carry over to new coverage in all instances, including, for example, if you were a dependent and are now the insured or if there was a break in coverage and you reenrolled.

1. Treatment to repair **Accidental Damage to the Teeth** caused by external force (for example, trauma) may be covered under your Medical Plan if initial treatment is received within 90 days of the date of the Injury and completed within one year. Otherwise, services will be considered for coverage under the Dental Plan.

2. Administration of general **Anesthesia** is covered only if surgical extractions or oral surgery is performed.

3. No more than two **Cleanings** per Calendar Year.

4. No more than two **Fluoride Treatments** per Calendar Year and coverage is only available to Participants under age nineteen (19).

5. No more than two routine **Oral Examinations** per person per Calendar Year.

6. No more than four **Periodontal Maintenance Cleanings** per Calendar Year.

7. If a dentist charges for a denture and also charges for **Rebasing or Relining the Denture** less than six months after installation, or charges for more than one denture rebasing or relining in a two-year period, the Eligible Dental Expenses (EDE) for those charges will be included as part of the EDE for the denture.

8. If a dentist charges for a bridge, denture, or partial and also charges for **Repairs to the Bridge, Denture or Partial** within one year, the EDE for those charges will be included as part of the EDE for the bridge, denture, or partial.

9. **Root Planing and Scaling** is limited to two per quadrant per person per Calendar Year.

10. **Sealant Treatments** for permanent molars will be allowed every 24 months and coverage is only available to Participants under age 19

11. If a Provider charges you for a **Temporary Crown** and also for the permanent crown, any benefit payment made by the Trust for the temporary crown will be deducted from the EDE for the permanent crown.

12. Expenses for **Temporomandibular Joint Dysfunction (TMJ)** appliances are limited to a Lifetime Benefit Maximum of $500 per person. (Also see the **TMJ Diagnostic Testing Services** section of the **Medical** chapter in this Plan Document.)

Non-Covered Services

No coverage is available for expenses related to any of the following services or supplies, regardless of medical necessity or recommendation of a dental Care Provider:

1. **Administrative Services:** Expenses for preparing dental reports, itemized bills or claim forms; expenses for telephone calls; fees for photocopying, mailing, shipping, or handling

2. **Appliances/Mouth Guards:** Athletic mouth guards, specialized appliances, precision or semi-precision attachment, treatment for fractures, or orthognathic surgery

3. **Commission of a Felony or Misdemeanor:** Expenses incurred during the commission or attempted commission of an act that results in the patient's conviction for a felony or for a misdemeanor (the latter being limited to assault and/or battery, DUI, or reckless driving)

4. **Cosmetic Services:** Any service, supply or treatment which is considered cosmetic in nature and which does not meet the standards accepted by the American Dental Association (ADA)

5. **Coverage Termination:** Charges incurred prior to the date coverage is effective under the Plan or after coverage is terminated

6. **Court-Ordered Services:** Expenses for court-ordered services unless Medically Necessary and otherwise covered by the Plan, the Trust will not provide benefits for care or treatment provided in or requested by any penal institution.

7. **Discounted or Free Services:** Expenses which a Participant is not obligated to pay and for which the Participant would not have been billed in the absence of this Dental Plan coverage

8. **Experimental Services:** Services or supplies which are primarily experimental or investigational in nature as determined by the ADA or the Plan; therapies that do not have general acceptance within the scientific field, and whose safety and efficacy are not supported by a recognized body of research

9. **Hospital or other Facility Fees:** Hospital/facility expenses

10. **Illegal Activities:** Expenses incurred for Injuries or Illness resulting from:

    - the commission or attempted commission of an act that results in conviction of a felony or misdemeanor ("misdemeanor" being limited to assault and/or battery, DUI, or reckless driving)
    - being engaged in an illegal occupation or being involved in illegal activities

11. **Late Claims:** Claims received by the Trust more than twelve months after the date the services were incurred

12. **Late Information:** If a claim for benefits has been pended or denied for more than six months because the Trust is awaiting your response to an inquiry made by the Trust in order to process the claim, the claim will not be considered a Covered expense, and you may become responsible for the expense, including any late fees and/or interest charged by the provider.

13. **Lodging/Travel:** Expenses for lodging or travel

14. **Missed Appointments:** Expenses for any appointment which the patient fails to keep

15. **Myofunctional Therapy:** Expenses in connection with myofunctional therapy

16. **Negligent Acts by Another Party:** The Plan will not provide benefits for expenses that are the liability of another party due to the commission of a negligent act.

Non-Covered Services

No coverage is available for expenses related to any of the following services or supplies, regardless of medical necessity or recommendation of a dental Care Provider:

17. **Occlusal Adjustment:** Expenses for occlusal adjustment on sound natural teeth.

18. **Oral Genetic Testing**

19. **Orthodontia Services:** Orthodontia services incurred by a Participant who does not have two current consecutive years of enrollment in the Diamond and/or Performance Plus Plan.

20. **Other Dental Services:** Expenses covered by the Teachers Health Trust Medical Plan will not be covered under the Dental Plan

21. **Plan Maximums:** Any expenses in excess of the Dental Plan Benefit Maximums or Eligible Dental Expenses (EDE)

22. **Prosthetics, Personalization of:** Expenses for services and supplies for personalization or characterization of prosthetic devices

23. **Prosthetics, Replacement of:** Expenses for the replacement of a lost, stolen, or missing prosthetic device or duplicate prosthetic devices or appliances

24. **Sterilization of Instruments:** Fees charged by an eligible dental Provider to sterilize instruments used in rendering services

25. **Third Party Liability:** Expenses for which another party is liable due to the commission of a negligent act

26. **Training/Education:** Expenses for training or educational instruction or materials relating to dietary counseling, personal oral hygiene, or dental plaque control

27. **Treatment Provided in Jail:** Care or treatment provided in any jail or other penal institution of any state or political subdivision

28. **Veneers:** Expenses for veneers

29. **War:** Expenses incurred for Injuries or Illness resulting from:

    - an intentional or accidental atomic explosion or other release of nuclear energy, whether in peace or war
    - participation in a civil revolution or a riot
    - a war or act of war which is declared or undeclared

30. **Workers' Compensation:** Any condition or disability sustained as a result of being engaged in activity primarily for wage, profit or gain, or expenses eligible for consideration under any other plan of an employer. If the Participant's denial gives the right to appeal the denial, the Participant must appeal the Workers' Compensation denial. If the Participant does not follow all Workers' Compensation guidelines and requirements, claims will not be paid. However, the Trust will consider coverage of expenses for Injury or Illness that result or arise out of any past or present employment or occupation for compensation or profit provided that:

    a. the Participant filed a complete and timely claim with their employer or other appropriate party; and
    b. the claim and all permissible appeals (including court reviews) were specifically denied under the Nevada Industrial Insurance Act, as amended, as non-compensable (or other applicable statute from another state); or
    c. the individual who suffers work-related injuries is not required to have Workers' Compensation for himself/herself.

Filing a Dental Claim

TriStar processes all dental claims for PERFORMANCE Plus Dental Plan Participants. Most Providers will file your claim for you and you will not need to provide them with a claim form. If your Provider does require a claim form—or if you must file the claim yourself—you may obtain one at the Trust offices or online from the Trust's website at **www.teachershealthtrust.org**.

Your claim for benefits must include the following:

- ID number of the Covered employee (not the Dependent)
- Name and Birth Date of the Patient
- Date of Service
- Procedure Codes and Charges
- Provider's Signature

Generally, your claim for benefits must be submitted directly to the Trust. If the Trust is the secondary insurance carrier, you or your Provider should submit your claims to both your primary carrier and the Trust. After the primary carrier has processed the claim, you (or your Provider) should submit a copy of the primary carrier's Explanation of Benefits (EOB) to the Trust.

Date of Service

For the purpose of determining Dental Plan benefits, a Covered Dental Service shall be deemed to be rendered on the date of service as illustrated in the following chart:

Dental Service	Date of Service
Dental or Partial Dentures	The date the final impression was taken
Fixed Bridges, Crowns, Inlays, Onlays	The date the teeth are first prepared
Root Canal Therapy	The date the pulp chamber is opened and canals explored to the apex
Periodontal Surgery	The date the surgery is actually performed
All Other Services	The date the service is performed

Deadline for Filing Claims

Claims must be received in the Trust office no later than twelve months following the date of service. **DENTAL CLAIMS NOT RECEIVED IN THE TRUST OFFICE WITHIN TWELVE MONTHS OF THE DATE OF SERVICE WILL BE DENIED!**

Completed claim forms and attachments must be mailed to:

Teachers Health Trust
P.O. Box 96238
Las Vegas, NV 89193-6238

If claims and/or attachments require foreign language translation, payment of the fee for that service is the responsibility of the Participant.

Performance Plus Plan Benefits, Chapter 7:

Vision

Contents

Introduction

The Trust provides one Vision Plan for all of its Participants. In-Network Services are available from Vision Service Plan (VSP). Out-of-Network Services are also available, but your personal expense may be much greater if you receive services from an Out-of-Network Provider.

All services rendered by a VSP optometrist are processed under the vision benefit.

This Plan is designed to provide benefits for routine eye examinations, eyeglasses and/or contact lenses, and Primary Eye Care (PEC) conditions treated by a VSP optometrist.

Primary Eye Care Services (other than routine eye examinations for eyeglasses or contact lenses) rendered by a physician other than an optometrist or by an optometrist that is not in the VSP network will be processed under the medical plan.

Benefit Maximums

Vision Plan Benefits	Maximum Benefit
Routine Vision Examination	One exam every calendar year
Lenses for Glasses or Contact Lenses	Either one pair of glasses or contact lenses
Frames	One frame every other calendar year

Limitations

- If you obtain contact lenses, no benefit is available for frames or eyeglass lenses for that year or the following year.
- This Plan will not cover two pairs of glasses in lieu of bifocals. However, discounts for additional pairs of glasses are available to you from VSP Providers.

In-Network Services

Locating a VSP Provider

There are VSP member doctors available in all 50 states, and it is your responsibility to make sure your Provider is an In-Network Provider prior to or at the time of your appointment. You can find a VSP doctor in one of three ways:

1. Access VSP's website at **www.vsp.com**; or
2. Call VSP at 800-877-7195; or
3. Access the Trust's website at **www.teachershealthtrust.org** and click on partner links.

Copayments

VSP provides a wide selection of materials for your vision care needs—all you pay is the Copayment for the vision examination. However, you may choose to select additional services or materials that are not covered under the Plan or that exceed VSP's allowance. If so, you will be responsible to pay any amounts not covered by the Plan or any charges in excess of VSP's EME.

BENEFIT	COPAYMENT	DESCRIPTION AND FREQUENCY
WellVision Exam	$20	Every calendar year Focuses on your eyes and overall wellness
Prescription Glasses Frame	$0	Every other calendar year $130 allowance for wide selection of frames $150 allowance for featured frame brands 20% savings on the amount over your allowance
Lenses	$0	Every calendar year Single vision, lined bifocal and lined trifocal lenses Polycarbonate lenses for dependent children
Lens Enhancements Standard Progressive Lenses Premium Progressive Lenses Custom Progressive Lenses	 $55 $95-$105 $150-$175	Every calendar year
Contacts (Instead of Glasses)	$0	Every calendar year $120 allowance for contacts and contact lens exam (fitting and evaluation) 15% savings on 20-25% on other lens exam (fitting and evaluation)
Primary Eyecare	$20	As needed; Treatment and diagnosis of eye conditions like pink eye, vision loss and monitoring of cataracts, glaucoma and diabetic retinopathy. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details

Vision benefits are provided through Vision Service Plan (VSP). All services and materials are provided at no charge to the participant if in VSP's selected covered services/materials except the examination fee.

Out-of-Network Services

Maximum Reimbursement Amount

The Vision plan also provides benefits if you choose to obtain your routine vision care services from a non-VSP doctor. You will be required to pay the In-Network Copayment for your exam. VSP will then reimburse the remaining amount of your expenses, up to the maximums listed in the following chart:

Using a Non-VSP Provider	Maximum Reimbursement Amount
Routine Vision Examination	$40
Single Vision Lenses	$30
Lined Bifocal Lenses	$50
Lined Trifocal Lenses	$65
Progressive Lenses	$65
Frames	$50
Contact Lenses	$120

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location

How to File a Claim for Out-of-Network Services

Primary Eye Care

For services performed by an out-of-network optometrist, claims must be filed with the Teachers Health Trust at P.O. Box 96238, Las Vegas, NV 89193-6238. Claims will be processed under the medical plan, and the out-of-network deductible will apply. (See Out-of-Network Services under the medical plan.)

Routine Vision Care

To file a claim for out-of-network services, you can obtain a **VSP Reimbursement Request Form** from the Trust offices or online from the Trust's website at **www.teachershealthtrust.org**. Complete, sign and mail the form—along with the paid-in-full, itemized receipts—to:

VSP
P.O. Box 997100
Sacramento, CA 95890-0001

Your claim for Out-of-Network benefits must be filed no later than twelve months following the date you receive the service or materials.

Non-Covered Services

The Plan will not cover expenses related to the following services or items. If you wish to obtain any of these items, you will be responsible for the entire cost of the item or service:

1. Services or materials in excess of Vision Plan **Benefit Maximums**
2. Progressive/blended **Bifocals**
3. **Charges in Excess** of VSP Eligible Medical Expenses (EME)
4. Any eye examination or any corrective eye wear that is required by an employer as a **Condition of Employment**
5. **Hi-Index Lenses**
6. **Intraocular Lenses** placed during surgery to improve nearsightedness, farsightedness, and/or astigmatism, including but not limited to Toric Lenses.
7. Any keratorefractive surgery to improve nearsightedness, farsightedness, and/or astigmatism by changing the shape of the cornea, including but not limited to **LASIK** and radial keratotomy.
8. **Medical or Surgical Treatment** of the eyes, except PEC services performed by a VSP in-network provider (refer to the **Medical** chapter of this Plan Document)
9. **Orthoptics** or vision training and any associated supplemental training
10. **Oversize Lenses**
11. **Photochromic or Tinted Lenses** other than Pink 1 or 2
12. **Plano Lenses** (non-prescription)
13. **Replacement of Lost, Damaged or Stolen Materials** except at the normal intervals when services are otherwise available
14. **Scratch Coating**
15. **UV Protectives**
16. Expenses incurred for **Vision Therapy**.

Frequently Asked Questions

My college student needs a vision exam. Are there VSP doctors outside of Nevada?
Yes, VSP's network extends beyond Nevada. To search for a provider, log on to the VSP website at https://www.vsp.com/signon.html and choose "Find a Provider."

I have a sty on my eyelid. Will services be covered under the Medical or Vision benefit?
It depends on the type of physician that you choose to see and whether he/she is an in-network or out-of-network provider. If services are rendered by a VSP optometrist, they are covered under the Vision Plan. If you see an ophthalmologist, that would be covered under the Medical Plan.

Performance Plus Plan Benefits, Chapter 8:

Life Insurance

Contents

Policy Information

Certificate of Insurance

The Certificate of Insurance contained in this chapter is not the entire contract of insurance. It is part of the Policy issued to the Trust and is evidence of Your insurance. The Policy can be amended by mutual consent between the Trust and Symetra Life Insurance Company. The Policy alone is the only contract under which payment will be made. Any difference between The Policy and this certificate will be settled according to the provisions of The Policy on file with The Symetra Life Insurance Company at their home office. The Policy is in the Trust's possession and may be inspected by You at any time at the Trust office during normal business hours. For a complete copy of this life insurance policy, please contact the Trust Service Team at 702-794-0272 or 800-432-5859.

This certificate replaces any other certificate previously issued to You under this Policy. This certificate is not valid unless the Schedule of Benefits is attached. It is important that You understand the coverage described in this certificate. You should read it carefully, and if You have any questions, You should contact the Trust.

Schedule of Insurance

Policy Holder: Teachers Health Trust
Policy Number: GL 01-016918-00
Policy Effective Date: January 1, 2016
Eligible Class: All individuals in the following class are eligible for insurance:
Class 1: Employees Only
Class 2: Retirees Only

CLASS 1: All Certified and Licensed Full-Time, Half-Time, or Shared Contract Teachers of Clark County School District as well as Full-Time Administrative Employees of CCEA and Teachers Health Trust, who elect to Participate in a Teachers Health Trust Medical Plan. In addition, those eligibles who are married to a Clark County Administrator covered under a Non-Teacher's Health Trust Medical Plan are eligible for Life only coverage.

WAITING PERIOD: None (for date insurance begins, refer to "Effective Dates of Coverages" section)
MINIMUM HOURS: 15 hours per week or per the employment contract.

Your Benefits
Amount of Personal Insurance: $50,000
Personal Life Insurance will terminate when you attain age 99 or retire, whichever occurs first
Additional Benefits: Accelerated Death Benefit

CLASS 2: Retiree Only. Clark County School District Retirees who are at Least 52 Years of Age and have at Least 5 Years of Service and be eligible to receive a PERS retirement benefit, Retirees less than 52 that have participated in PERS for more than 5 years and are not able to work due to disability approved by PERS, Retirees enrolled in the Trust retiree HMO plan, Retirees enrolled in the Nevada State Medical plan but not eligible for Life Insurance through Nevada State Medical plan due to not enrolling with the state plan immediately after retiring, Persons enrolled as a dependent spouse under a Trust medical plan in the case in which a spouse is retired but married to an active insured and Persons covered as a self-pay insured under a Trust active plan as long as the insured is retired from the Clark County School District and eligible to received PERS retirements benefits.

Your Benefits
Amount of Personal Insurance: $10,000
Personal Life Insurance will terminate when you attain age 99 retire, whichever occurs first

Policy Information

Amounts of Insurance

The amount of your insurance is determined by the Schedule of Insurance in the Policy. The initial amount of coverage is the amount which applies to your class on the day your coverage takes effect. You may become eligible for increases in the amount of insurance in accord with the Schedule of Insurance. Any such increase will take effect on the latest of:

(1) the first of the Insurance Month which coincides with or follows the date on which you become eligible for the increase; provided you are Actively at Work on that day;
(2) the day you resume Active Work, if you are not Actively at Work on the day the increase would otherwise take effect; or
(3) the day any required evidence of insurability is approved by the Company.

Any decrease will take effect on the day of the change; whether or not you are Actively at Work.

Definitions

ACTIVE WORK or ACTIVELY AT WORK means an employee's full-time performance of all customary duties of his or her occupation at:

(1) the EMPLOYER'S place of business; or
(2) any other business location where the employee is required to travel.

Unless disabled on the prior workday or on the day of absence, an employee will be considered Actively at Work on the following days:

(1) a Saturday, Sunday or holiday which is not a scheduled workday;
(2) a paid vacation day, or other scheduled or unscheduled non-workday; or
(3) an excused or emergency leave of absence (except a medical leave).

COMPANY means Symetra Life Insurance Company of New York; whose Group Insurance Service Office address is PO Box 1230, Enfield, CT, 06083.

DAY or DATE means at 12:01 A.M., Standard Time, at the Group Policyholder's place of business; when used with regard to eligibility dates and effective dates. It means 12:00 midnight, Standard Time, at the same place; when used with regard to termination dates.

EMPLOYER means the Group Policyholder or the Participating Employer named on the Face Page.

FULL-TIME EMPLOYEE means an employee of the EMPLOYER:

(1) whose employment with the EMPLOYER is the employee's principal occupation;
(2) who is not a temporary or seasonal employee; and
(3) who is regularly scheduled to work at such occupation at least the number of hours as shown in the Schedule of Insurance.

INSURANCE MONTH means:

(1) that period of time beginning on the Issue Date of the Policy and extending for one month; and
(2) each subsequent month beginning on the same day after that.

PERSONAL INSURANCE means the insurance provided by the Policy on Insured Persons.

Policy Information

Definitions

PHYSICIAN means a licensed practitioner of the healing arts other than the Insured Person or a relative of the Insured Person.

POLICY means the Group Insurance Policy issued by the Company to the Group Policyholder. A copy of the Policy may be examined upon request at the Group Insurance Service Office of the Group Policyholder.

Eligibility

If you are a Full-Time Employee and a member of an employee/retiree class shown in the Schedule of Insurance; then you will become eligible for the coverage provided by the Policy on the later of:

(1) the Policy's date of issue; or
(2) the day you complete the Waiting Period.

WAITING PERIOD. (See Schedule of Insurance).

Effective Dates of Coverage

Your insurance is effective on the latest of:

(1) the first day of the Insurance Month coinciding with or next following the day you become eligible for the coverage;
(2) the day you resume Active Work, if you are not Actively at Work on the day you become eligible;
(3) the day you make written application for coverage; and sign:
  (a) a payroll deduction order, if you pay any part of the premium; or
  (b) an order to pay premiums from your Section 125 Plan account, if Employer contributions are paid through a Section 125 Plan; or
(4) the day the Company approves your coverage, if evidence of insurability is required.

Evidence of insurability is required if:

(1) you apply for coverage more than 31 days after you become eligible; or
(2) you make written application to re-enroll for coverage after you have requested:
  (a) to cancel your coverage;
  (b) to stop payroll deductions for the coverage; or
  (c) to stop premium payments from your Section 125 Plan account.

EXCEPTION. If your coverage terminates due to an approved leave of absence or a military leave, any Waiting Period or evidence of insurability requirement will be waived upon your return; provided:

(1) you return within six months after the leave begins;
(2) you apply or are enrolled within 31 days after resuming Active Work; and
(3) the reinstated amount of insurance does not exceed the amount which terminated.

Policy Information

Termination of Coverage

Your coverage terminates on the earliest of:

(1) the day the Policy terminates;
(2) the last day of the Insurance Month in which you request termination;
(3) the last day of the period for which the premium for your insurance has been paid;
(4) the day you cease to be a member of an employee class shown in the Schedule of Insurance;
(5) with respect to any particular insurance benefit, the day the part of the Policy providing that benefit terminates;
(6) the day your employment with the Employer terminates; or
(7) the day you enter the armed services of any state or country on active duty; except for duty of 30 days or less for training in the Reserves or National Guard. (If you send proof of military service, the Company will refund any unearned premium.)

Ceasing Active Work terminates your eligibility. However, it may be possible to continue all or part of your insurance during a temporary layoff, leave of absence or military leave; or while you are unable to work due to sickness or injury. The conditions concerning such a continuance may be found in the Policy. See your Employer for this information.

Death Benefit

Upon receipt of satisfactory proof of your death, the Company will pay a death benefit equal to the amount of Personal Life Insurance in effect on the date of your death. The benefit will be paid in accord with the Beneficiary section. Arrangements may be made to have this death benefit paid in installments.

Beneficiary

Your Beneficiary is the person or persons named on your enrollment card. The Beneficiary may be changed in accord with the terms of the Policy. If you have not named a Beneficiary, or if no named Beneficiary is living when you die; then the death benefit will be paid to your:

(1) surviving spouse; or, if none
(2) surviving child or children in equal shares; or, if none
(3) surviving parent or parents in equal shares; or, if none
(4) surviving brothers and sisters in equal shares; or, if none
(5) estate, or in accord with the Facility of Payment section of the Policy.

Assignments

Personal Life Insurance may be assigned. The assignments allowed under the Policy are absolute assignments and funeral assignments as described below.

No assignment will be binding on the Company unless and until:

(1) it is made on a form furnished by the Company;
(2) the original is completed and filed with the Company at its Group Insurance Service Office; and
(3) it is approved by the Company.

The Company and the Employer do not assume responsibility for the validity or effect of an assignment.

Policy Information

Assignments (cont.)

ABSOLUTE ASSIGNMENTS. You may make an irrevocable assignment of your Personal Life Insurance as a gift (with no consideration), providing you have the legal capacity and the mental capacity to do so. It may be made to a trust or to one or more of your relatives, their estates, or to a trustee of a trust under which one of the relatives is a beneficiary.

The term "relatives" includes, but is not limited to, your spouse, parents, grandparents, aunts, uncles, siblings, children, adopted children, stepchildren, and grandchildren.

In some states, community property is an established form of ownership that must be considered in making an assignment. If you make an absolute assignment to two or more assignees, such assignees will be joint owners with the right of survivorship between them. You should consult with your own legal advisor before making an assignment.

Once the assignment has been recorded by the Company, you can no longer change the beneficiary and cannot apply for conversion. Only the assignee can change the beneficiary designation if the previous designation is revocable. An assignment will have no effect on a prior irrevocable beneficiary designation. Only the assignee can apply for conversion but only when the Conversion Privilege provision would have been available to you in the absence of the assignment under the Policy.

An absolute assignment cannot be used as a collateral assignment.

FUNERAL ASSIGNMENTS. Upon your death, the beneficiary may assign the Personal Life Insurance benefit to a funeral home for payment of burial expenses. After payment has been made for the burial expenses to the assigned funeral home, the remaining death benefit is then paid in accord with the Beneficiary and Settlement Options sections of the Policy.

Accelerated Death Benefit (Available for Class 1 Only)

BENEFIT. The Accelerated Death Benefit is an advance payment of part of your Personal Life Insurance. It may be paid to you, in a lump sum, once during your lifetime.

To qualify, you must:

(1) have satisfied the Active Work requirement under the Policy;
(2) have been insured under the Policy for at least 0 months; and
(3) have at least $2,000 of Personal Life Insurance under the Policy on the day before the Accelerated Death Benefit is paid.

Receiving the Accelerated Death Benefit will reduce the Remaining Life Insurance and the Death Benefit payable at death, as shown on the next page.

"Claimant," as used in this section, means the Terminal Insured Person for whom the Accelerated Death Benefit is requested.

"Terminal" means you have a medical condition which is expected to result in death within 12 months, despite appropriate medical treatment.

Policy Information

Accelerated Death Benefit (cont.)

APPLYING FOR THE BENEFIT. To withdraw the Accelerated Death Benefit, you (or your legal representative) must send the Company:

(1) written election of the Accelerated Death Benefit, on forms supplied by the Company; and
(2) satisfactory proof that the Claimant is Terminal, including a Physician's written statement.

The Company reserves the right to decide whether such proof is satisfactory.

Before paying an Accelerated Death Benefit, the Company must also receive the written consent of any irrevocable beneficiary, assignee or bankruptcy court with an interest in the benefit. (See Limitations 3, 4, and 5.)

NOTE: THIS IS NOT A LONG-TERM CARE POLICY. RECEIVING THIS ACCELERATED DEATH BENEFIT WILL REDUCE THE BENEFIT PAYABLE AT DEATH. ANY AMOUNT WITHDRAWN MAY BE TAXABLE INCOME, SO YOU SHOULD CONSULT A TAX ADVISOR BEFORE APPLYING FOR THIS BENEFIT.

AMOUNT OF THE BENEFIT. You may elect to withdraw an Accelerated Death Benefit in any $1,000 increment; subject to:

(1) a minimum of $5,000 or 10% of the Claimant's amount of Life Insurance (whichever is greater); and
(2) a maximum of $25,000 or 50% of the Claimant's amount of Life Insurance (whichever is less).

To determine the Accelerated Death Benefit, the Company will use the lesser of A or B below:

A. the Claimant's amount of Life Insurance which is in force on the day before the Accelerated Death Benefit is paid; or
B. the Claimant's amount of Life Insurance which would be in force 12 months after that date; if the coverage is scheduled to reduce, due to age, within 12 months after the Accelerated Death Benefit is paid.

ADMINISTRATIVE CHARGE: NONE

WITHDRAWAL FEE: NONE

EFFECT ON AMOUNT OF LIFE INSURANCE. "Remaining Life Insurance" means the amount of Life Insurance which remains in force on the Claimant's life after an Accelerated Death Benefit is paid. The Remaining Life Insurance will equal:

(1) the Claimant's amount of Life Insurance which was used to determine the Accelerated Death Benefit (A or B above); minus
(2) any percentage by which the Claimant's coverage is scheduled to reduce, due to age; if the reduction occurs more than 12 months after the Accelerated Death Benefit is paid, and while he or she is still living; minus
(3) the amount of the Accelerated Death Benefit withdrawn.

PREMIUM: There is no additional charge for this benefit. Continuation of the Remaining Life Insurance will be subject to timely payment of the premium for the reduced amount; unless you qualify for waiver of premium under the Policy's Extension of Death Benefit provision, if included.

CONDITIONS. If the Claimant exercises the Conversion Privilege after an Accelerated Death Benefit is paid, the amount of the conversion policy will not exceed the amount of his or her Remaining Life Insurance. If the Claimant has Accidental Death and Dismemberment benefits under the Policy, the Principal Sum will not be affected by the payment of an Accelerated Death Benefit.

Policy Information

Accelerated Death Benefit (cont.)

EFFECT ON DEATH BENEFIT. When the Claimant dies after an Accelerated Death Benefit is paid, the amount of Remaining Life Insurance in force on the date of death will be paid as a Death Benefit. Your Death Benefit will be paid in accord with the Beneficiary section of the Policy. If the Claimant dies after application for an Accelerated Death Benefit has been made, but before the Company has made payment; then the request will be void and no Accelerated Death Benefit will be paid. The amount of Life Insurance in force on the date of death will be paid in accord with Policy provisions.

EFFECT ON TAXES AND GOVERNMENT BENEFITS. Any Accelerated Death Benefit amount withdrawn may be taxable income to you. Receipt of the Accelerated Death Benefit may also affect the Claimant's eligibility for Medicaid, Supplemental Security Income and other government benefits. The Claimant should consult his or her own tax and legal advisor before applying for an Accelerated Death Benefit. The Company is not responsible for any tax owed or government benefit denied, as a result of the Accelerated Death Benefit payment.

LIMITATIONS. No Accelerated Death Benefit will be paid:

(1) if any required premium is due and unpaid;
(2) on any conversion policy purchased in accord with the Conversion Privilege;
(3) without the written approval of the bankruptcy court, if you have filed for bankruptcy;
(4) without the written consent of the beneficiary, if you have named an irrevocable beneficiary;
(5) without the written consent of the assignee, if you have assigned your rights under the Policy;
(6) if any part of the Life Insurance must be paid to your child, spouse or former spouse; pursuant to a legal separation agreement, divorce decree, child support order or other court order;
(7) if the Claimant is Terminal due to a suicide attempt, while sane or insane; or due to an intentionally self-inflicted injury;
(8) if a government agency requires you or the Claimant to use the Accelerated Death Benefit to apply for, receive or continue a government benefit or entitlement; or
(9) if an Accelerated Death Benefit has been previously paid for the Claimant under the Policy.

Conversion Privilege

If your insurance or insurance on a Dependent terminates for any reason except:

(1) termination or amendment of the Policy; or
(2) your request for:
  (a) termination of insurance; or
  (b) cancellation of your payroll deduction, an individual life policy, known as a conversion policy, may be purchased without evidence of insurability.

To purchase a conversion policy, application and payment of the first premium must be made within 31 days after the life insurance is terminated.

The conversion policy will:

(1) be in an amount not to exceed the amount of life insurance which was terminated;
(2) be on any form (except term) then issued by the Company at the age and amount for which application is made;
(3) be issued at the person's age at nearest birthday;
(4) be issued without disability or other supplemental benefits; and
(5) require premiums based on the class of risk to which the person then belongs.

Policy Information

Conversion Privilege (cont.)

A conversion policy also may be purchased if:

(1) all or part of your insurance or insurance on a Dependent terminates due to amendment or termination of the Policy; and
(2) the person applying for the conversion policy has been covered continuously under the Policy for at least 5 years.

The amount of the conversion policy may not exceed the lesser of:

(1) $50,000 for Class 1 Only; or
(2) $10,000 for Class 21 Only; or
(3) the amount of life insurance which terminates, less the amount of any group life insurance for which the person becomes eligible within 31 days after the termination.

The conversion policy will take effect on the later of:

(1) its date of issue; or
(2) 31 days after the date the insurance terminated.

If death occurs during the 31 day conversion period, the Company will pay the life insurance which could have been converted even if no one applied for the conversion policy.

When your insurance terminates, written notice of your right to convert will be given to you.

If written notice is not given to you at least 15 days before the end of the 31 day conversion period, an additional period in which to convert will be granted. Any such extension of the conversion period will expire on the earliest of:

(1) 15 days after you are given the written notice; or
(2) 60 days after the end of the 31 day conversion period, even if you are never given such notice.

No death benefit will be payable under the Policy after the 31 day conversion period has expired even though the right to convert may be extended.

Policy Information

Claims Procedure for Life or Accidental Death and Dismemberment Benefits

NOTE: The Policy may include an Extension of Death Benefit, an Accelerated Death Benefit or a Living Benefit. If so, please refer to that section for special claim procedures.

NOTICE AND PROOF OF CLAIM

Notice of Claim. Written notice of an accidental death or dismemberment claim must be given within 20 days after the loss occurs; or as soon as reasonably possible after that.* The notice must be sent to the Company's Group Insurance Service Office. It should include:

(1) your name and address; and
(2) the number of the Policy.

Claim Forms. When notice of claim is received, the Company will send claim forms for filing the required proof. If the Company does not send the forms within 15 days; then you or your Beneficiary (the claimant)may send the Company written proof of claim in a letter. It should state the nature, date and cause of the loss.

Proof of Claim. The Company must be given written proof of claim within 90 days after the date of the loss; or as soon as reasonably possible after that.* Proof of claim must be provided at the claimant's own expense. It must show the nature, date and cause of the loss. In addition to the information requested on the claim form, documentation must include:

(1) A certified copy of the death certificate, for proof of death.
(2) A copy of any police report, for proof of accidental death or dismemberment.
(3) A signed authorization for the Company to obtain more information.
(4) Any other items the Company may reasonably require in support of the claim.

* **Exception:** Failure to give notice or furnish proof of claim within the required time period will not invalidate or reduce the claim; if it is shown that it was done:

(1) as soon as reasonably possible; and
(2) in no event more than one year after it was required.
These time limits will not apply while the claimant lacks legal capacity.

EXAM OR AUTOPSY. At anytime while a claim is pending, the Company may have you examined:

(1) by a Physician of the Company's choice;
(2) as often as reasonably required.

If you fail to cooperate with an examiner or fail to take an exam, without good cause; then the Company may deny benefits, until the exam is completed. In case of death, the Company may also have an autopsy done, where it is not forbidden by law. Any such exam or autopsy will be at the Company's expense.

TIME OF PAYMENT OF CLAIMS. When the Company receives proof of claim, the claim will be approved or denied within 30 days. Benefits will be paid immediately after the Company receives complete proof and approves the claim. If payment is delayed, interest will be paid as follows.

If Life Insurance Benefits are paid more than 30 days after the death; then interest will accrue:

Policy Information

Claims Procedure for Life or Accidental Death and Dismemberment Benefits (cont.)

(1) at the current rate on death proceeds on deposit with the Company;
(2) from the date of death, until the date when the Life Insurance Benefits are paid.

If Accidental Death and Dismemberment Benefits are paid more than 30 days after claim approval; then interest will accrue:

(1) at a rate equal to the prime rate at the largest bank in Nevada, plus two percentage points;
(2) from the 30th day after claim approval, until the day such benefits are paid.

TO WHOM PAYABLE

Death. Any benefits payable for your death will be paid in accord with the Beneficiary, Facility of Payment and Settlement Options sections of the Policy. If the Policy includes Dependent Life Insurance; then any benefits payable for an insured Dependent's death will be paid to:

(1) you, if you survive that Dependent; or
(2) your Beneficiary, or in accord with the Facility of Payment section; if you do not survive that Dependent.

Dismemberment. If the Policy includes Accidental Death and Dismemberment Benefits; then any benefit, other than your death benefit, will be paid to you.

NOTICE OF CLAIM DECISION. The Company will send the claimant a written notice of its claim decision. If the Company denies any part of the claim; then the written notice will explain:

(1) the reason for the denial, under the terms of the Policy and any internal guidelines;
(2) how the claimant may request a review of the Company's decision; and
(3) whether more information is needed to support the claim.

The Company will send this notice within 15 days after resolving the claim. If reasonably possible, the Company will send it within:

(1) 90 days after receiving the first proof of a death or dismemberment claim; or
(2) 45 days after receiving the first proof of a claim for any Extension of Death Benefit, Living Benefit or Accelerated Death Benefit available under the Policy; and
(3) 30 days after receiving complete proof of either type of claim.

Delay Notice. If the Company needs more than 15 days to process a claim, in a special case; then an extension will be permitted. If needed, the Company will send the claimant a written delay notice:

(1) by the 15th day after receiving the first proof of claim; and
(2) every 30 days after that, until the claim is resolved.

The notice will explain the special circumstances which require the delay, and when a decision can be expected. In any event, the Company must send written notice of its decision within:

(1) 180 days after receiving the first proof of a death or dismemberment claim; or
(2) 105 days after receiving the first proof of a claim for any Extension of Death Benefit, Living Benefit

Policy Information

Claims Procedure for Life or Accidental Death and Dismemberment Benefits (cont.)

or Accelerated Death Benefit available under the Policy.

If the Company fails to do so; then there is a right to an immediate review, as if the claim was denied.

Exception: If the Company needs more information from the claimant to process a claim; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for claim processing.

REVIEW PROCEDURE. The claimant may request a claim review, within:

(1) 60 days after receiving a denial notice of a death or dismemberment claim; or
(2) 180 days after receiving a denial notice of a claim for any Extension of Death Benefit, Living Benefit or Accelerated Death Benefit available under the Policy.

To request a review, the claimant must send the Company a written request, and any written comments or other items to support the claim. The claimant may review certain non-privileged information relating to the request for review.

Notice of Decision. The Company will review the claim and send the claimant a written notice of its decision. The notice will explain the reasons for the Company's decision, under the terms of the Policy and any internal guidelines. If the Company upholds the denial of all or part of the claim; then the notice will also describe:

(1) any further appeal procedures available under the Policy;
(2) the right to access relevant claim information; and
(3) the right to request a state insurance department review, or to bring legal action.

For a death or dismemberment claim, the notice will be sent within 60 days after the Company receives the request for review; or within 120 days, if a special case requires more time. For a claim for any Extension of Death Benefit, Living Benefit or Accelerated Death Benefit available under the Policy, the notice will be sent within 45 days after the Company receives the request for review; or within 90 days, if a special case requires more time.

Delay Notice. If the Company needs more time to process an appeal, in a special case; then it will send the claimant a written delay notice, by the 30th day after receiving the request for review. The notice will explain:

(1) the special circumstances which require the delay;
(2) whether more information is needed to review the claim; and
(3) when a decision can be expected.

Exception: If the Company needs more information from the claimant to process an appeal; then it must be supplied within 45 days after the Company requests it. The resulting delay will not count towards the above time limits for appeal processing.

RIGHT OF RECOVERY. If benefits have been overpaid on any claim; then full reimbursement to the Company is required within 60 days. If reimbursement is not made; then the Company has the right to:

(1) reduce future benefits until full reimbursement is made; and
(2) recover such overpayments from you, or from your Beneficiary or estate.

Such reimbursement is required whether the overpayment is due to fraud, the Company's error in processing a claim, or any other reason.

Policy Information

Claims Procedure for Life or Accidental Death and Dismemberment Benefits (cont.)

LEGAL ACTIONS. No legal action to recover any benefits may be brought until 60 days after the required written proof of claim has been given. No such legal action may be brought more than three years after the date written proof of claim is required.

COMPANY'S DISCRETIONARY AUTHORITY. Except for the functions that the Policy clearly reserves to the Group Policyholder or Employer, the Company has the authority to:

(1) manage the Policy and administer claims under it; and
(2) interpret the provisions and resolve questions arising under the Policy.

The Company's authority includes (but is not limited to) the right to:

(1) establish and enforce procedures for administering the Policy and claims under it;
(2) determine your eligibility for insurance and entitlement to benefits;
(3) determine what information the Company reasonably requires to make such decisions; and
(4) resolve all matters when a claim review is requested.

Any decision the Company makes, in the exercise of its authority, shall be conclusive and binding; subject to your or your Beneficiary's rights to:

(1) request a state insurance department review; or
(2) bring legal action.

General Information Regarding the Nevada Life and Health Insurance Guaranty Association Act

Introduction

Residents of Nevada who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Nevada Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Nevada Life and Health Insurance Guaranty Association may not provide coverage for a policy. If coverage is provided, it will be subject to substantial limitations or exclusions, and require continued residency in Nevada. A person should not rely on coverage by the Nevada Life and Health Insurance Guaranty Associations in selecting an insurance policy.

Coverage is not provided for a policy or any portion of it that is not guaranteed by the insurer or for which the policyholder has assumed the risk, such as a variable contract sold by prospectus.

Insurance companies are required by law to deliver this notice to You. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association for sales, solicitation or to induce the purchase of any kind of insurance policy.

The state law that provides for this safety-net coverage is called the Nevada Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverage, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association. Anyone may obtain additional information or file a complaint with the Commissioner of Insurance at the address listed below, to allege a violation of any provision of the Nevada Life and Health Insurance Guaranty Association Act.

The Nevada Life and Health Insurance Guaranty Association
P. O. Box 3302
Reno, NV 89505

Commissioner of Insurance, State of Nevada
Department of Business and Industry, Division of Insurance
788 Fairview Drive, Suite 300
Carson City, NV 89701-5491

General Information Regarding the Nevada Life and Health Insurance Guaranty Association Act

Coverage

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in Nevada and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

Exclusions from Coverage

However, persons holding such policies or contracts are NOT protected by this Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized or licensed to do business in this state;
- Their policy was issued by a nonprofit Hospital or medical service organization (the "Blues"), a health maintenance organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does NOT provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Interest rate yields that exceed an average rate;
- Dividends;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them); and
- Unallocated annuity contracts (which give rights to group contract holders, not individuals)

General Information Regarding the Nevada Life and Health Insurance Guaranty Association Act

Limits on Amount of Coverage

The Act also limits the amount that the Association is obligated to pay. The Association cannot pay more than what the amount the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $300,000 regardless of how many policies and contracts there were with the same company, even if they provide different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $100,000 in cash surrender values, $100,000 in present value of annuities, or $100,000 in life insurance Death Benefits.

With respect to health insurance for any one natural person, the Association will not pay more than:

1. $100,000 for coverage other than disability insurance, basic hospital, medical and surgical insurance or major medical insurance, including any net cash for surrender or withdrawal;
2. $300,000 for disability insurance; or
3. $500,000 for basic hospital, medical and surgical insurance or major medical insurance

With respect to each payee of a structured settlement annuity, or Beneficiary or beneficiaries of the payee if deceased, the Association will not pay more than $100,000 in present value of benefits from the annuity in the aggregate, including any net cash for surrender or withdrawal.

With respect to any one life or person, in no event will the Association be obligated to cover more than:

1. an aggregate of $300,000 in benefits, excluding benefits for basic hospital, medical and surgical insurance or major medical insurance, or
2. an aggregate of $500,000 in benefits, including benefits for basic hospital, medical and surgical insurance or major medical insurance.

With respect to one owner of several non-group policies of life insurance, whether the owner is a natural person or an organization and whether the persons insured are officers, managers, employees or other persons, the Association will not pay more than $5,000,000 in benefits, regardless of the number of policies and contracts held by the owner.

Performance Plus Plan Benefits, Chapter 9:

Retirees

Contents

Eligibility

The following chart explains which retirees are considered Eligible Retirees for enrollment:

Retirees Eligible for Enrollment

1. Retire from active employment with Clark County School District on or after January 1, 2009 with a minimum of 5 years of service as a licensed employee*; and
2. Be at least 52 years of age; and
3. Be eligible to receive retirement benefits under CCSD's retirement plan, Public Employees Retirement Service (PERS), at the time you cease active employment with CCSD; and
4. Be enrolled in a Teachers Health Trust Plan for a minimum of five (5) continuous years immediately prior to your retirement from the CCSD. Employees who have breaks in their service may satisfy the five (5) year continuous coverage requirement in an alternate manner. A break in service of less than five (5) years will not be counted once the employee has returned to work for a period of time equal to the break in service. For instance, an employee who has ten (10) years of service terminates to care for a family member. The employee returns to work two (2) years later. After this employee has worked for two (2) additional years the employee's break in service would be canceled and treated as though the employee had twelve (12) continuous years of service; and
5. Enroll in the Retiree Health Plan within 31 calendar days of retiring from active employment as a licensed employee with CCSD OR within the 5-year period following the date on which you retired, during which you had continuous coverage as an employee under another CCSD sponsored plan (excluding COBRA plans). During the 5-year period following your retirement date, you may only enroll in the Trust plan during an annual Open Enrollment period OR within 31 calendar days after terminating coverage under another CCSD plan.

* Only actual time worked as a licensed employee will be used to determine subsidy amount for premiums or eligibility. Years of service purchased by the employee or CCSD will not be counted.

The following charts explain what type of coverage is available and which retirees ARE NOT eligible for enrollment:

Available Coverage for Retirees
(The Plan is Explained in Further Detail in the Plan Document)

MEDICAL (including **PRESCRIPTIONS**)

DENTAL

VISION

LIFE INSURANCE

Retirees NOT Eligible for Enrollment

1. Any person in active military service; and/or
2. Any retiree covered under another health insurance plan sponsored by the CCSD
3. Any retiree who does not Enroll in the Retiree Health Plan within 31 calendar days of retiring from active employment as a licensed employee with CCSD OR within the 5-year period following the date on which you retired, during which you had continuous coverage **as an employee** under another CCSD sponsored plan (excluding COBRA plans). During the 5-year period following your retirement date, you may only enroll in the Retiree Health Plan during an annual open enrollment period OR within 31 calendar days after terminating coverage under another CCSD plan.
4. Anyone age 65 or older

Available Coverage

Once you have met the Retiree Health Plan's eligibility requirements, you may enroll in the following plan:

Available Coverage for Eligible Retirees (This Plan is Explained in Further Detail in the Plan Document)
MEDICAL, DENTAL, VISION (including **PRESCRIPTIONS**)
LIFE INSURANCE

1. Retirees under age 65 who enroll in the Retiree Health plan will receive medical, dental, vision, and life insurance.
2. Retirees over the age of 65 may be eligible to enroll in a Medicare plan. Eligible retirees over the age of 65 who enroll in a Medicare plan offered through the Trust will receive medical, dental, vision and life insurance.

Available Coverage for Eligible Dependents
If you enroll your eligible dependents, they will have:
MEDICAL, DENTAL, and VISION COVERAGE

1. Dependents under age 65 who enroll in the Retiree Health plan will receive medical, dental, vision, and life insurance.
2. Dependents over the age of 65 may be eligible to enroll in a Medicare plan. Eligible retirees over the age of 65 who enroll in a Medicare plan offered through the Trust will receive medical, dental, vision and life insurance.

Enrollment Periods

There are four periods during which you and your Eligible Dependents may enroll or change coverage with the Trust:

Enrollment Periods
INITIAL ENROLLMENT
ANNUAL OPEN ENROLLMENT
LIFE EVENTS
MEDICARE ELIGIBILITY

Initial Enrollment

You must enroll and complete all applicable enrollment forms within 31 calendar days of the termination of your active insurance coverage. For example, if your active plan coverage terminates on August 31, you and your dependents will be eligible for the retiree plan on September 1, as long as you have completed all applicable enrollment forms.

Annual and Life Events Enrollment

For Annual and Life Events Open Enrollment, refer to the Enrollment chapter of this Plan Document.

Enrollment Periods

Late Enrollment

After you reach age 65, there is no later enrollment if you do not enroll in a Medicare plan within 31 calendar days of becoming eligible for Medicare, coverage will be terminated the first day of the month of your 65th birthday.

For retirees under the age of 65, you will be required to pay a $100 administrative fee and all applicable premiums to activate coverage. **No changes will be accepted if documentation is received more that 60 days after coverage is terminated.**

Monthly Premiums

Your retiree premiums must be deducted from your monthly PERS checks. The only exception is if your PERS check will not cover the cost of the premium. If that is the case, the Trust will allow you to self-pay your premium monthly. Your payment must be received made payable to the Teachers Health Trust and received by the 20th of the month PRIOR to the month of coverage. Neither you nor your dependents will be eligible for benefits unless you are current with your premium payments. If payment is not received within 31 days from the due date, coverage will be terminated, and you and your dependents will no longer be eligible to participate in the Retiree Health Plan.

Premiums are deducted from your PERS check the month prior to the month of coverage. For example, premiums for September coverage will be deducted from your August PERS check.

Termination of Coverage

AS A RETIRED, LICENSED EMPLOYEE, YOU MAY CANCEL YOUR COVERAGE AT ANY TIME; however, if you do, you may never again enroll in a Retiree Health Plan as a retired, licensed employee. Your cancellation notice must be submitted in writing.

Coverage will be terminated on the last day of the month in which the written notice is received. Coverage for your dependents will also be terminated at that time.

If you wish to continue coverage for yourself, but cancel dependent coverage, you may do so only during Open Enrollment or because of a Life Event. You must notify the Trust to initiate any changes to dependent eligibility status.

Additionally, coverage may terminate for a variety of other reasons. Reasons for and effective dates of termination are explained in the following pages. In many instances, your dependents may be able to continue coverage through COBRA. Please refer to the **COBRA Continuation of Health Coverage** section in the **Legal Notices** chapter of this Plan Document for additional information regarding continuing coverage.

Retiree Medicare Advantage Plan

The Medicare Advantage Plan is managed through United Health Care at **877-714-0178**. All questions concerning your Medicare Advantage Plan, changes in a primary care provider, provider information or claims information will be answered by the customer service department of United Health Care.

Definitions

Eligible Medical Expenses (EME)

The Eligible Medical Expenses (EME) are the amounts of the Provider's billed charges that the Trust will consider for payment. The following is the basis for the EME under the RETIREE Plan:

Type of Provider	Eligible Medical Expenses
All In-Network Providers	The contracted amount agreed upon by, or on behalf of, the In-Network Provider and the Trust.
Out-of-Network Providers located within the Service Area	The Trust-selected fee schedule for the level of service or type of equipment provided.
Out-of-Network Providers located outside the Service Area	
▪ Hospitals/Facilities	• One and one half times the Trust-selected In-Network contract for the level of service provided.
▪ Durable Medical Equipment, Medical Supplies, Drugs, Chiropractic and Acupuncture Services, Physical Therapy, Home Health Care, Home Infusion, Hyperbaric Therapy, Anesthesiology, Pathology and Laboratory	• The Trust-selected fee schedule for the level of service of type of equipment provided.
▪ All Other Providers	• 50th percentile of the 2015 Medical Data Research (MDR) fee schedule for the area in which the Physician is located.

When you obtain services from an Out-of-Network Provider, you will have to pay any amount the Provider charges over the EME.

Deductible

For retirees living outside of the service area, the Out-of-Network Deductible is $250. For retirees living within the service area, the same standard Performance Plus Plan deductible of $2,500 applies.

Living outside of the Service Area means that you and your Dependents live or work outside of the Service Area at least nine months of each Calendar Year and you and your Dependents have not moved out of the Service Area prior to receiving Services. The Services Area is defined as the area in which the Trust maintains contracts with In-Network Providers. The Service Area includes the following locations and their immediate surroundings:

- Clark County, Nevada (including Henderson, Las Vegas, Laughlin, Logandale, Mesquite, and Overton)
- Bullhead City, Arizona
- St. George, Utah

Locations may be added or deleted from the Service Area, depending upon the availability of In-Network Providers. To confirm a Provider's In-Network status, log on to the Trust's website at www.teachershealthtrust.org.

Out-of-Network Services for Retirees Living Outside of the Service Area

Although the Retiree Health Plan provides you with a large network of Providers to choose from for your health care, it cannot guarantee all services or surgical approaches can be done In-Network. There may be times when you receive services from an Out-of-Network Provider. The Trust provides benefits for Out-of-Network services, but they differ greatly from the In-Network benefits. You will pay more out of your own pocket for services received from OUT-OF-NETWORK PROVIDERS.

The examples explained in the following pages apply only to retirees who reside outside of the service area. Retirees who reside within the service area should refer to the Out-of-Network Services section of the Medical chapter within this Plan Document. Living outside of the Service Area means that you and your Dependents live or work outside of the Service Area at least nine months of each Calendar Year and you and your Dependents have not moved out of the Service Area prior to receiving Services. The Services Area is defined as the area in which the Trust maintains contracts with In-Network Providers. The Service Area includes the following locations and their immediate surroundings:

- Clark County, Nevada (including Henderson, Las Vegas, Laughlin, Logandale, Mesquite, and Overton)
- Bullhead City, Arizona
- St. George, Utah

Locations may be added or deleted from the Service Area, depending upon the availability of In-Network Providers. To confirm a Provider's In-Network status, log on to the Trust's website at www.teachershealthtrust.org.

The laws of the State of Nevada shall govern all Plan provisions.

Generally, you will be responsible for payment of the following amounts if you use Out-of-Network Providers for your health care services:

FIRST, you pay any amount the Provider charges over the EME; AND
SECOND, you pay an Annual Deductible; AND
THIRD, you pay a percentage of the Eligible Medical Expenses (EME).

The following pages explain each of the three items above and how benefits are paid for your Out-of-Network Services.

Eligible Medical Expenses (EME)

FIRST, you have to pay any amount that the Out-of-Network Provider charges in excess of the EME. See Eligible Medical Expenses (EME) in the Definitions section of this chapter.

Example

The Trust's average billed charges at an Out-of-Network Hospital are $17,782.69 per day. Therefore, your two-day hospitalization will cost about $35,565.38. However, the Trust's Out-of-Network EME is only $3,112.50 per day (which the Trust arrives at by using the average contracted amount for In-Network Hospitals). Therefore, the EME for your two-day hospitalization will be $6,225.00.

As you can see from the following example, the first item you will be responsible to pay is the difference between the billed amount and the EME:

Hospital Billed Charges for Two-Day Stay:	$35,000.00
Trust's EME for Two-Day Stay:	$6,220.00
Difference Between Billed Charges and EME:	**$28,780.00***

*** This is the FIRST amount you must pay if you use an Out-of-Network Provider.**
You do not have to pay this amount if you use an In-Network Provider.

Out-of-Network Services for Retirees Living Outside of the Service Area

Deductibles

SECOND, you will have to pay a portion of the EME called the Deductible. The Plan will not begin paying benefits until you have met your Calendar Year Deductible. (If you have paid your Deductible for the year, you are considered to have "met" your deductible.) Once you have met your Deductible for the Calendar Year, you do not have to meet another Deductible until the next Calendar Year.

This Out-of-Network Deductible is waived for Covered Out-of-Network Ambulance Services or Hearing Aids.

Your Deductible for most Out-of-Network services is as follows:

RETIREE Plan Out-of-Network Deductible: $250.00 per Calendar Year

Example

For example, let's say you require a two-day hospitalization and you have elected to use an Out-of-Network Hospital. Your first expense will be the Calendar Year Deductible. If you have not yet met this Out-of-Network Deductible, it will be applied to the EME as follows:

	Retiree Plan
Hospital Billed Charges for Two-Day Stay:	$ 6,225.00
Less Your Out-of-Network Deductible:	$ 250.00*
Remaining EME:	**$ 5,975.00**

*** This is the SECOND amount you must pay if you use an Out-of-Network Provider.**
You do not have to meet this deductible if you use an In-Network Provider.

Out-of-Network Services for Retirees Living Outside of the Service Area

Coinsurance

FINALLY, after you've met your Deductible—you must pay a percentage of the EME. This percentage is known as the "Coinsurance." Your Coinsurance for Out-of-Network services listed throughout this **Medical** chapter is as follows:

40 percent of the EME for all covered services, including Prescription Drugs.

Your Coinsurance Maximum for most Out-of-Network services is as follows:

Retiree Plan Out-of-Network Coinsurance Maximum: $10,000
After you have met the Maximum Coinsurance, the Trust will pay 100 percent of the EME for covered Out-of-Network services that you incur during the remainder of the calendar year. You will still be responsible for any amount the provider charges in excess of the EME. This amount does not include any coinsurance applied to In-Network Providers.

Example

Continuing with our previous example, the next amount you will have to pay for your two-day hospitalization is your Coinsurance, as illustrated below:

	Retiree Plan
Remaining EME:	$ 5,975.00
Your Coinsurance (40% of EME):	**$ 2,390.00***

*** This is the FINAL amount you must pay if you use an Out-of-Network Provider. *You will not have to pay this amount if you use an In-Network Provider.***

Out-of-Network Services for Retirees Living Outside of the Service Area

Expenses Summary

IN SUMMARY, using an Out-of-Network Provider for your medical services will generally cost you more money because:

FIRST, you pay any amount the Provider charges over the EME; **AND**
THEN, you pay an Annual Deductible; **AND**
FINALLY, you pay a percentage of the EME.

The following chart summarizes **ALL** of the expenses you would have had to pay for your two-day Out-of-Network Hospitalization and compares it to the amount you would have had to pay if you selected an In-Network Hospital for your services:

	Retiree Plan
Hospital Billed Charges for Two-Day Stay:	**$ 35,000.00**
EME for Two-Day Stay:	**$ 6,225.00**
Difference between Billed Charges and EME:	**$ 28,775.00**
EME for Two-Day Stay:	**$ 6,225.00**
Out-of-Network Deductible Applied:	**$ 250.00**
Remaining EME:	**$ 5,975.00**
Your Coinsurance (40 percent of the EME):	**$ 2,390.00**
TOTAL You Owe for Two-Day Out-of-Network Hospitalization:	**$ 31,415.00**
Amount You Would Have Paid for In-Network Services:	**$ 1,725.00**

Urgent Benefit

No urgent benefit is available for retirees living outside of the service area. Urgent benefits will be processed with a $250 Out-of-Network Deductible and 40% coinsurance.

Performance Plus Plan, Chapter 10:

Appeals

Contents

Federal Rules Governing Claims and Appeals

On November 21, 2000, the Department of Labor released new Claim Procedure Regulations that replace regulations that were originally effective in 1977. Claims are now categorized as "Pre-service claims," which includes urgent care claims and pre-authorization of benefits, and "Post-service claims, which are defined as all claims that are not "Pre-service" claims. A claim is defined as "any request for a plan benefit or benefits, made by a claimant or by a representative of a claimant that complies with a plan's reasonable procedure for making benefit claims."

Adverse Benefit Determination

An "adverse benefit determination" is defined as a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment for a claim that is based on:

1. A determination of an individual's eligibility to participate in a Plan or health insurance coverage;
2. A determination that a benefit is not a covered benefit;
3. The imposition of a source-of-injury exclusion, PPO provider network exclusion, or other limitation on otherwise covered benefits; and/or
4. A determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

A denial, reduction, or failure to provide to make a payment (in whole or in part) for a benefit can include both pre-service claims (for example, a claim denial resulting from the application of any precertification or utilization review requirement), as well as post-service claims.

Failure to make a payment in whole or in part includes any instance where a Plan pays less than the total amount of expenses submitted with regard to a claim for which the claimant is financially responsible, including a denial of part of the claim due to the terms of a Plan or health insurance coverage regarding copayments, deductibles or other cost-sharing requirements.

An Adverse Benefit Determination also includes any rescission of coverage, whether or not there is an adverse effect on any particular benefit at the time coverage is rescinded. A "rescission of coverage" is defined as a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent that it is attributable to a failure to timely pay requested premiums or contributions towards the cost of coverage.

How to File an Appeal

If you wish to file an appeal, you (or your authorized representative) should contact a Trust Service Team Member at 702-794-0272 or 800-432-5859. The Service Team Member will send you an Appeal Request form to complete. Your appeal should include:

- An outline of the issue and your reason(s) for requesting the appeal; and
- Any pertinent documentation (such as medical records) that will substantiate your request.

(It is your responsibility to pay any copy fees charged for medical records.)

If you are filing an eligibility appeal to make changes to your enrollment at a time other than an Open Enrollment or Life Event enrollment period, certain additional documentation (such as birth certificates, change forms or letters from other insurance carriers) and a $100 administrative fee may be requested from you. The Service Team Member will advise you of the requirements when you call to obtain an appeal form.

Claims Appeals Procedures

Introduction

All Claims must be submitted to this Plan and all Claims review must comply with the rules and procedures set forth in this Plan. A Claim is defined as "any request for a plan benefit or benefits, made by a claimant or by a representative of a claimant that complies with a plan's reasonable procedure for making benefit claims."

Types of Claims

1. This Plan has four (4) categories of Claims:

   - Post-Service Claim;
   - Pre-Service Claim;
   - Urgent Pre-Service Claim; and
   - Concurrent Care Claim.

2. Each category of Claims has its own set of Claim and appeal requirements. The primary difference between the categories of Claims is the timeframe within which Claims must be determined.

3. For the purposes of determining which Claim and appeal procedures to follow, the Claim type is determined initially. However, if the nature of the Claim changes as it proceeds through the Claim and appeal process, the Claim can be re-characterized. For example, a Claim may initially be an Urgent Pre-Service Claim. If the urgency subsides, it may be recharacterized as a Pre-Service Claim. Once the services are rendered and submitted to this Plan for payment, it becomes a Post-Service Claim.

Workers' Compensation Claims and Appeals

If your Workers' Compensation claim is denied and the denial gives the right to appeal the denial, you must appeal the Workers' Compensation Denial. For more information, refer to the Other Health Insurance chapter of this Plan Document or contact the CCSD's Risk Management office at 702-799-6496.

Filing A Claim

Pre-Service Claims (including Urgent Pre-Service Claims):

- **Incorrectly Filed Claim.** Failure to submit a Claim to the proper place and/or in writing, if requested, may result in the Claim being treated as an incorrectly filed Claim. If a Pre-Service Claim has been filed incorrectly, this Plan will notify the Claimant as soon as possible, but no later than the timeframes stated below.
- **Pre-Service Claims (not including Urgent Pre-Service Claims).** No later than five (5) days following receipt of the incorrectly filed Claim.
- **Urgent Pre-Service Claims.** No later than twenty-four (24) hours following receipt of the incorrectly filed Claim.

How Your Claim is Processed

When a claim is submitted to the Trust by a Trust Participant or a health care Provider, it is reviewed to determine if the expense was a covered benefit, if you were eligible for coverage at the time of the service and if you complied with all the terms and conditions of the Plan. A determination of your claim will be mailed to you. This determination is known as an Explanation of Benefits (EOB).

Claim payments will be issued to the Provider of services if the claim contains an Assignment of Benefits authorizing payment to be made to the Provider.

The Plan uses various reference sources during the administration process; including CPT, HCPCS, ASA, ADA, ICD-9 and/or ICD-10 guidelines, and Medicare Correct Coding Initiatives. Payable benefits are determined in accordance with the corresponding Plan

Claims Appeals Procedures

How Your Claim is Processed (cont.)

provisions and internally established claims administration procedures. Claims paid using negotiated contract rates with providers will be based on the contract in place as of the date of service and not (in the case of an inpatient admission) based on the date of admission.

If additional information is required before the claim can be processed, you and your provider will be sent a written notice of what is needed. The information must be provided within the specified time period. If the information is not submitted within the required time, the claim will be denied. If a claim is denied in whole or in part, and/or you disagree with the benefit determination, you have the right to appeal the benefit denial.

Timeframes for Claim and Pre-Determination Decision

Note: Nothing precludes a Claimant from voluntarily agreeing to extend the timeframes specified below for this Plan to make a decision.

Timeframes: The following timeframes apply unless the Claim is incomplete, as described below.

1. **Post-Service Claims:** This Plan will determine the Claim within thirty (30) days of receipt of the Claim. If this Plan is not able to determine the Claim within this time period due to matters beyond its control, this Plan may take an additional period of up to fifteen (15) days to determine the Claim. If this additional time will be needed, this Plan will notify the Claimant in writing prior to the expiration of the initial thirty (30) day time period for determining the Claim.

2. **Pre-Service Claims:** This Plan will determine the Claim within fifteen (15) days of receipt of the Claim. If this Plan is not able to determine the Claim within the time period due to matters beyond its control, this Plan may take an additional period of up to fifteen (15) days to determine the Claim. If this additional time will be needed, the Plan will notify the Claimant in writing prior to the expiration of the initial fifteen (15) day time period for determining the Claim.

3. **Urgent Pre-Service Claims:** This Plan will determine the Claim as soon as possible but no later than seventy-two (72) hours after receipt of the Claim.

4. **Concurrent Care Claims:**

   A. For a reduction or termination of coverage for a previously approved benefit, this Plan will determine the Claim sufficiently in advance to allow the Claimant to appeal and obtain a determination on review before coverage for the previously approved benefit is reduced or terminated.

   B. Where an extension is requested by the Claimant for coverage beyond the initially approved benefit,

   i. If the request meets the definition of an Urgent Pre-Service Claim and is filed at least twenty-four (24) hours prior to the end of the treatment, this Plan will determine the Claim within twenty-four (24) hours.

   ii. If the request meets the definition of an Urgent Pre-Service Claim and is filed less than twenty-four (24) hours prior to the end of treatment, this Plan will determine the Claim within seventy-two (72) hours.

   iii. If the request does not meet the definition of an Urgent Pre-Service Claim, this Plan will determine the Claim within fifteen (15) days. If this Plan is not able to determine the Claim within this time period due to matters beyond its control, this Plan may take an additional period of up to fifteen (15) days to determine the Claim. If this additional time will be needed, this Plan will notify the Claimant in writing prior to the expiration of the initial time period for determining the Claim.

Claims Appeals Procedures

Timeframes for Claim and Pre-Determination Decision (cont.)

5. **Incomplete Claims:**

   A. Post-Service Claims and Pre-Service Claims (not including Urgent Pre-Service Claims). Incomplete Claims can be addressed through the fifteen (15) day extension of time described above. If the reason for the extension is the failure to provide necessary information and the Claimant is appropriately notified, this Plan's period of time to make a decision is suspended from the date upon which notification of the missing necessary information is sent until the date upon which the Claimant responds or should have responded.

   The notification will include a timeframe of at least forty-five (45) days in which the necessary information must be provided. Once the necessary information has been provided, this Plan will decide the Claim within the extension described above. If the requested information is not provided within the time specified, the Claim may be denied.

   B. Urgent Pre-Service Claims. This Plan will notify the Claimant of an incomplete Claim as soon as possible, but no later than twenty-four (24) hours following receipt of the incomplete Claim. The notification will describe the information necessary to complete the Claim and specify the timeframe of at least forty-eight (48) hours within which the Claim must be complete.

Notification may be made orally to the Claimant or the Healthcare Provider, unless the Claimant requests written notice.

This Plan will make a Claim determination as soon as possible but not later than the earlier of (1) twenty-four (24) hours after receipt of the specified information, or (2) the end of the period of time provided to submit the specified information.

Notification of Claim Decisions

1. **Plan Provided Notification of a Claim Determination.**

   A. Post-Service Claims and Concurrent Care Claims. Notification will be provided only if the decision is an Adverse Benefit Determination.

   B. Pre-Service Claims (including Urgent Pre-Service Claims). Notification will be provided whether the Claim or request is approved or denied.

2. **Content of Notification.**

   A. Adverse Benefit Determination. Notice of an Adverse Benefit Determination will be provided in written or electronic form. For Urgent Pre-Service Claims, notification will be provided orally to the Claimant within the timeframe described above and written or electronic notification will be furnished not later than three (3) days after the oral notification.

   The notification will include the following:

   i. The specific reason(s) for the determination;

   ii. Reference to the specific Plan provision(s) on which the determination is based;

   iii. A description of any additional material or information necessary to complete the Claim and an explanation of why such information is necessary;

   iv. A description of this Plan procedures and time limits for appeal of the Adverse Benefit Determination and the right to sue in federal court;

Claims Appeals Procedures

Notification of Claim Decision (cont.)

v. Disclosure of any internal rule, guideline, protocol or similar criterion relied on in making the Adverse Benefit Determination or a statement that such information was relied upon in making the Adverse Benefit Determination and will be provided free of charge upon request;

vi. If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of this Plan to the Claimant's medical circumstances or a statement that such explanation will be provided free of charge upon request; and

vii. Disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist Covered Individuals with the internal Claims and appeals and external review process.

B. Not Adverse Benefit Decision. For Pre-Service Claim and Urgent Pre-Service Claim determinations that are not adverse, notice that the request for Precertification has been approved will be provided.

Appeals Process

The following will apply to all types and levels of Adverse Benefit Determinations:

1. **Submission and Consideration of Comments:** The Claimant will have the opportunity to submit documents, written comments or other information in support of the appeal. The review of the Adverse Benefit Determination will take into account all information, whether or not presented or available for the initial determination. No deference will be given to the prior determination.

2. **Appeals Committee:** The Appeals Committee is comprised of three or more licensed employees and/or retirees appointed by the Trust Chairperson to serve a two-year term. Only Appeals Committee members and Trust representatives (including a manager from both the Claims and Service Departments) attend the Appeals Committee meetings. All information pertaining to Participant identity is removed and all details revealed at the meeting are strictly confidential.

   If your appeal has been scheduled to be heard by the Appeals Committee, you will be notified of the date in the Appeal Process Notification that the Trust mails to you. If you and/or your authorized representative wish to attend the Appeals Committee meeting, you must notify the Trust by calling 702-794-0272 or 800-432-5859. If you have additional information to present at the meeting, it must be submitted to the Trust in writing as soon as possible prior to the scheduled meeting.

   You will receive a review that takes into account all comments, documents, records and other claim-related information on file in the Trust office, pertinent information provided by you as part of your appeal, and provisions contained in the Trust Plan Document and the Trust Administrative Guidelines. The decision reached on appeal is based on a majority of votes by the Appeals Committee. You and/or your representative will not be present during the voting process.

   Notification of the Appeals Committee's decision shall be forwarded to you in writing within thirty (30) Calendar Days of the hearing date. In the notice, you will be provided:

   - The specific reasons for the determination;
   - A reference to specific Plan provisions on which the decision was based;
   - A statement informing you of your rights to receive, upon request and at no charge, access to and copies of all documents, records and other information relevant to the claim; and
   - A description of any additional, voluntary appeal procedures the Trust offers and of your right to obtain information about the procedures.

Claims Appeals Procedures

Appeals Process (cont.)

If additional information is required before the Appeals Committee renders its decision, you will be notified in writing as to the additional information that is required

3. **Consultation with Independent Medical Expert:** In the case of a Claim denied on the grounds of a medical judgment, a Healthcare Provider with appropriate training and experience will be consulted. The Healthcare Provider who is consulted on appeal will not be the individual who was consulted, if any, during the prior determination or a subordinate of that individual.

Filing An Appeal

If there is an Adverse Benefit Determination, the Claimant may request a review by the Trust by filing an appeal.

1. **An appeal request may be made by contacting the Trust Service Team at 702-794-0272.** A Service Team Member will send you an Appeal Request Form to complete, which must be submitted to:

   Teachers Health Trust
   Attn: Appeals
   2950 E. Rochelle Ave.
   Las Vegas, NV 89121

2. **Special rule for expedited review of Urgent Pre-Service Claims.** A Claimant may request an expedited review orally or in writing and all necessary information (including this Plan's benefit determination on review) will be transmitted by telephone, facsimile or other available expeditious method.

   A. An appeal must include the following information:

      i. The name of this Plan;

      ii. The identity of the Claimant (including name, address, and date of birth);

      iii. Information regarding the Claim or Pre-Determination request being appealed, such as:

         a. For Post-Service Claims: A copy of the Explanation of Benefits or the Claim number listed on the Explanation of Benefits.
         b. For other types of Claims: A copy of the Adverse Benefit Determination notice the Claimant received or other information to identify the Claim.
         c. For Pre-Determination requests: A copy of the denial letter.

      iv. A statement that the Claimant is requesting an appeal;

      v. An explanation of why an appeal is being requested, including the particular aspect of the Adverse Benefit Determination the Claimant is disputing; and

      vi. Supporting documentation.

   B. An appeal of an Adverse Benefit Determination must be submitted to this Plan within one hundred eighty (180) days following receipt of a notification of an Adverse Benefit Determination of a Claim. Submission to the Plan is accomplished by notifying the Teachers Health Trust. If a first level appeal is not requested within these one hundred eighty (180) days, the Claimant loses the right to appeal.

Claims Appeals Procedures

Times for Appeals

A Claimant may voluntarily agree to extend the timeframes specified below for this Plan to make a decision.

Note: Nothing precludes a Claimant from voluntarily agreeing to extend the timeframes specified below for this Plan to make a decision.

1. **Post-Service Claims.** This Plan will make a determination no later than sixty (60) days from the date the first level appeal was received.

2. **Pre-Service Claims.** This Plan will make a determination no later than thirty (30) days from the date the first level appeal was received.

3. **Urgent Pre-Service Claims.** This Plan will make a determination no later than seventy-two (72) hours from the date the first level appeal was received.

4. **Concurrent Care Claims.**

   A. For a reduction or termination of coverage for a previously approved benefit, this Plan will make a determination sufficiently in advance to allow the Claimant to file a second level appeal and obtain a determination before the benefit is reduced or terminated.

   B. Where an extension is requested by the Claimant for coverage beyond the initially approved benefit:

      i. If the request meets the definition of an Urgent Pre-Service Claim, this Plan will make a determination no later than seventy-two (72) hours from the date the first level appeal was received.

      ii. If the request does not meet the definition of an Urgent Pre-Service Claim, this Plan will make a determination no later than thirty (30) days from the date the first level appeal was received.

Notification of Appeal Decision

Written or electronic notification of this Plan's determination will be provided to the Claimant for all appeals.

1. **When Notice Will Be Provided:** Written or electronic notification of this Plan's determination will be provided to the Claimant for all appeals.

2. **Content of Notification:**

   A. Adverse Benefit Determination. The notification will include the following:

      i. The specific reason(s) for the Adverse Benefit Determination;

      ii. Reference to the specific Plan provision(s) on which the determination is based;

      iii. A statement indicating entitlement to receive, upon request, and free of charge, reasonable access to or copies of all documents, records and other information relevant to the Claimant's Claim for benefits;

      iv. A statement regarding additional levels of appeal (if any) and the right to sue in federal court;

Claims Appeals Procedures

Notification of Appeal Decision (cont.)

v. Disclosure of any internal rule, guideline, protocol or similar criterion relied on in making the Adverse Benefit Determination (or a statement that such information will be provided free of charge upon request); and

vi. If the decision involves scientific or clinical judgment, an explanation of the scientific or clinical judgment applying the terms of this Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

B. Not Adverse Benefit Decision. Notice will be provided that informs the Claimant that the decision has been reversed, and the Claim or Pre-Determination request has been approved.

Healthcare Provider Notification

The Plan may notify the Claimant, person on the Claimant's behalf, Authorized Representative and Healthcare Provider of Claims decisions even where not otherwise required under this Plan, provided such notification does not violate applicable law.

Plan Interpretation

This Plan will be administered in accordance with its terms. The Trust, Claims Administrator and/or a fiduciary acting as a fiduciary with respect to this Plan, to the extent that such individual or entity is acting in its fiduciary capacity, shall have the complete and final authority, responsibility, and control, in its sole discretion, to manage, administer and operate this Plan, to make factual findings, to construe the terms of this Plan, and to determine all questions arising in connection with the administration, interpretation, and application of this Plan, including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. All determinations and decisions will be binding on this Plan, Covered Individuals, Claimants and all interested parties.

A Covered Individual's Right to Take Legal Action

Unless there are special circumstances, the appeals process outlined above must be completed prior to initiating legal action regarding a Claim for benefits. If a Claimant intends to initiate legal action, s/he must do so within two (2) years after receipt of a notification of an Adverse Benefit Determination. If, due to special circumstances, the Claimant was not required to complete the appeals process outlined above, legal action must be brought within two (2) years of the date the Claimant's Claim for benefits was submitted to this Plan. Claimants may not bring legal action after the expiration of the two-year period.

Note: This is not the same as the period of time within which a Claim must be submitted to the Plan. A Claim must be made within 180 days of the date the expense was incurred.

Questions Regarding Claims and Appeals Procedures

If a Covered Individual has any questions regarding these procedures, the Covered Individual should contact the Teachers Health Trust at 702-794-0272 or 800-432-5859.

Federal External Review Process

Review by an accredited independent review organization ("IRO"), separate and apart from the Plan, is available for most Adverse Benefit Determinations once guidance has been implemented. The availability of this review is collectively referred to as "the federal external review process." There are two types of external review, "standard" external review and "expedited" external review.

Note: Regulatory guidance in this area is ongoing. Changes may need to be made to this process. The Covered Individual will be promptly notified of such changes.

Claims Appeals Procedures

Standard External Review

1. If a Covered Individual wants to have a Claim that was denied by the Plan reviewed externally, the Covered Individual (or someone on the Covered Individual's behalf) must file a request for an external review within four (4) months after the date of receipt of notice of an Adverse Benefit Determination. The request for an external review must be made in writing on the form made available by the Trust and submitted to the Trust.

2. Within five (5) business days following the date of receipt of the external review request, the Trust will complete a preliminary review of the request to determine whether:

   A. The Covered Individual is (or was) covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, the Covered Individual was covered under the Plan at the time the health care item or service was provided;
   B. The Adverse Benefit Determination is not based on the fact that the Covered Individual was not eligible for coverage under the Plan;
   C. The Covered Individual has exhausted the Plan's internal appeal process (unless exhaustion is not otherwise required); and
   D. The Covered Individual has provided all the information and forms required to process an external review.

   The Covered Individual (or someone on the Covered Individual's behalf) will be notified by the Trust of the results of the preliminary review of the request within one business day of the Claim Administrator's completion of the preliminary review. If the request is complete but not eligible for external review, the notice will state the reasons for the request not being eligible for external review and will provide other important information. If the request is incomplete, the notice must describe the information, materials, etc. needed to complete the request. The Covered Individual (or someone on the Covered Individual's behalf) will then be provided time to perfect the request; the longer of the initial four month period within which to request an external review or, if later, forty-eight (48) hours (or such longer period specifically identified in the notice) after the receipt of the notice.

3. With respect to a request that is eligible for external review, the Trust will assign an IRO to conduct the external review. The parameters under which the IRO will operate include the following:

   The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan. The IRO will notify the Covered Individual (or someone on the Covered Individual's behalf) in writing of the request's eligibility and acceptance for external review and that it has been assigned to conduct the external review. The Covered Individual (or someone on the Covered Individual's behalf) may submit additional information in writing to the IRO within ten (10) business days of the IRO's notification that is has been assigned the request for external review. The IRO must consider this additional information when conducting the external review.

   The Trust will timely provide to the IRO documents and any information considered in making the Adverse Benefit Determination. The IRO will review all of the information and documents timely received. To the extent additional information or documents are available and the IRO considers them appropriate, the IRO may also consider the following in reaching a decision:

   A. The Covered Individual's medical records;
   B. The attending health care professional's recommendation;
   C. Reports from appropriate health care professionals and other documents submitted by the Trust, the Covered Individual, or the Covered Individual's treating Healthcare Provider;
   D. The terms of the Covered Individual's summary plan description;
   E. Evidence-based practice guidelines;
   F. Any applicable clinical review criteria developed and used by the Trust; and
   G. The opinion of the IRO's clinical reviewer or reviewers after considering information noted above, as appropriate.

   In making its decision, the IRO is not bound by the Plan's prior determination.

Claims Appeals Procedures

Standard External Review (cont.)

4. The IRO will provide written notice of the final external review decision within forty-five (45) days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision. The notice of the final external review decision shall be provided to the Covered Individual (or someone on the Covered Individual's behalf) and the Plan. To the extent the final external review decisions reverses the Plan's decision (as was reflected in the Adverse Benefit Determination), the Plan shall follow the final external review decision of the IRO.

Expedited External Review

1. The Covered Individual (or someone on the Covered Individual's behalf) may request an expedited external review when:

   A. An Adverse Benefit Determination involves a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the Covered Individual's life, health, or ability to regain maximum function, and a request for an expedited internal appeal has been filed; or

   B. An Adverse Benefit Determination involves (i) a medical condition where the timeframe for completing an expedited internal appeal under the interim final regulations would seriously jeopardize the Covered Individual's life, health, or ability to regain maximum function, or (ii) an admission, availability of care, continued stay, or health care item or service for which the Covered Individual received emergency services, but have not been discharged from a facility.

   The request for an expedited external review must be made in writing on the form made available by the Trust and submitted to the Trust.

2. Immediately upon receipt of the request for an expedited external review, the Trust will determine whether the request meets the requirements described above for a standard external review and will notify the Covered Individual (or someone on the Covered Individual's behalf) of its eligibility for expedited determination.

3. When the Trust determines that the Covered Individual's request is eligible for external review, an IRO will be assigned as described above for a standard external review.

4. The Trust will provide all necessary documents and information considered in making the Adverse Benefit Determination to the IRO by any available expeditious method.

5. In reaching its decision, the IRO must consider the information or documents as described above for a standard external review and the IRO is not bound by the Plan's prior determination.

6. The IRO will provide notice of the final external review decision as expeditiously as the Covered Individual's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the IRO's notice of decision is not in writing, the IRO must provide written confirmation of the decision within forty-eight (48) hours to the Covered Individual (or someone on the Covered Individual's behalf) and the Plan. To the extent the final external review decision reverses the Plan's decision (as was reflected in the Adverse Benefit Determination), the Plan shall follow the final external review decision of the IRO.

Claims Appeals Procedures

Appeal Processing Timeframes

	Pre-Service Claim	Post-Service Claim	Urgent Pre-Service Claim	Concurrent Claim
Notice: Initial Claim Approval	Within 15 Days of Receipt	N/A	Within 72 Hours of Receipt	See Pre-Service or Urgent Pre-Service Claim, in accordance with concurrent care type
Notice: Initial Claim Determination	Within 15 Days of Receipt	Within 30 Days of Receipt	Within 72 Hours of Receipt	
Initial Claim Determination Extension Period	Up to 15 Days for Matters Beyond Plan's Control	Up to 15 Days for Matters Beyond Plan's Control	None	
Time to Submit Complete Claim Information to Plan	Within 45 Days of Notice	Within 45 Days of Notice	Within 48 Hours of Receipt	
Notice: Claim Filed Incorrectly	Within 5 Days of Receipt	N/A	Within 24 Hours of Receipt	
Notice: Claim Filed Incomplete	Within 5 Days of Receipt	N/A	Within 24 Hours of Receipt	
Notice: Internal Appeal Determination	Within 30 Days of Appeal Receipt	Within 60 Days of Appeal Receipt	Within 72 Hours of Receipt	Within 72 Hours for Urgent Pre-Service Claim; 30 Days for All Other Claims

Initial claim determinations are usually, though not always, supplied in your Explanation of Benefits (EOB)

Performance Plus Plan Benefits, Chapter 11:

Legal Notices

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Performance Plus Plan Benefits, Chapter 11:

Legal Notices

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Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a medical child support order that "creates or recognizes the existence of an alternative recipient's right to receive benefits for which a participant or beneficiary is eligible under a group health plan" 29 U.S.C. § 1169(a)(2)(A).

This Plan will provide Benefits to the Dependent children of an Employee if a QMCSO is issued, regardless of whether the children reside with the Employee. A QMCSO may be issued by a court of law, or issued by a state agency as a National Medical Support Notice, which is treated by Teachers Health Trust in the same manner as a QMCSO. If a QMCSO is issued, the child or children will become an alternate recipient or recipients of Benefits under this Plan. An alternate recipient will be treated as a normal beneficiary under this Plan and subject to the limitations, restrictions, provisions, and procedures as all other beneficiaries.

National Medical Support Notice

The National Medical Support Notice (NMSN) is intended to provide a standardized means of communication between State child support enforcement agencies, employers, and administrators of group health plans regarding the medical support obligations of non-custodial parents. The NMSN facilitates the process of enrolling children in the group health plans for which their non-custodial parents are eligible. For the purposes of this Summary Plan Description, a NMSN and a QMCSO will be considered one and the same.

Procedural QMCSO Requirements

When this Plan receives a medical child support order, it will notify the Employee, and each child specified in the order, whether the order is or is not a QMCSO.

To be considered a QMCSO, the medical child support order must create or recognize the right of an alternate recipient (an Employee's child who is recognized under the order as having a right to be enrolled under this Plan) or assigns to the alternate recipient the right to receive Benefits.

A QMCSO must contain:

1. The name and last known mailing address of the Employee and the name and address of each child to be covered by this Plan;
2. A reasonable description of the type of coverage to be provided by this Plan to each named child, or the manner in which the type of coverage is to be determined;
3. The time period to which the order applies; and
4. A listing of the plan or plans the Employee is required to provide.

If the order is determined by Teachers Health Trust to be a QMCSO, each named child will be covered by this Plan in the same manner as any other Dependent child covered by this Plan. Each child named in the QMCSO will be considered a Participant under this Plan. Another person, such as a custodial parent or legal guardian, may be designated to receive copies of explanations of benefits, checks, and other material that would otherwise be sent directly to the named child.

If it is determined that the medical child support order is not a QMCSO, each named child may appeal that decision by submitting a written letter of appeal to Teachers Health Trust. Teachers Health Trust will review the appeal and reply in writing within 30 days of receipt of the appeal.

Qualified Medical Child Support Order

Effective Dates for a Child Covered by a QMCSO

Coverage for a child covered under a QMCSO will begin on the latest of the following dates:

1. If the Employee is currently covered under the Plan, the child's coverage will be effective as of the date the QMCSO is received;
2. If the Employee is currently covered under the Plan, the child's coverage will be effective as of the date specified by the QMCSO;
3. If the Employee is within the Waiting Period as specified under Employee Eligibility and Termination, the child's coverage will become effective the same date the Employee's coverage is effective; or
4. If the Employee is otherwise eligible but previously waived coverage, the Employee's and the child's coverage will become effective as of the date specified in 1. or 2. above.

This Plan will not provide any type or form of benefit or any option not otherwise provided under this Plan. All other Dependent eligibility, Effective Date, and termination provisions will apply. The employer will withhold all premiums that are the Employee's responsibility from the Employee's paycheck for the coverage that the Plan provides to comply with the QMCSO.

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Health Information Privacy

This Notice is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to describe how the Teachers Health Trust (Trust) health plan will protect your health information with respect to its self-insured health benefits. "Health information" for this purpose means information that identifies you and either relates to your physical or mental health condition or relates to the payment of your health care expenses. This individually identifiable health information is known as "protected health information" (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this Notice or as otherwise permitted by federal or state PHI privacy laws.

On August 21, 1996, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted to improve portability and continuity of health insurance coverage. HIPAA protects covered Participants by:

1. Providing new rights that allow individuals to enroll for health coverage when they lose other health coverage, get married, or add a new Dependent; and
2. Prohibits discrimination in enrollment and in premiums charged to Employees and their Dependents based on health status-related factors.

This plan complies with the HIPAA regulations. The HIPAA regulations do not prevent this plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits offered, provided the limitations or restrictions do not exceed the HIPAA regulations, and all limitations or restrictions are applied on a non-discriminatory basis to all covered Participants over age 18.

Teachers Health Trust Privacy Obligations

The Trust is required by law to:

- make sure that health information that identifies you is kept private;
- give you this Notice of its legal duties and privacy practices with respect to your PHI; and
- follow the terms of the Notice that are in effect.

HIPAA Notice of Privacy Practices

Special Enrollment Through Lost Coverage or Eligibility for Premium Subsidy Under Medicaid or Children's Health Insurance Program (CHIP)

This group Plan is required to provide you with a special enrollment period if you did not enroll in the Plan at your first opportunity and subsequently lost eligibility for your other source of coverage or, based on your state of residence, you become eligible for a premium assistance subsidy under Medicaid or a Children's Health Insurance Program (CHIP) based on the Children's Health Insurance Program Reauthorization Act of 2009. You are allowed to enroll in this Plan if:

1. You have been covered under another group health plan or had an individual policy at the time this Plan offered you initial coverage;
2. You stated in writing at the time initial enrollment was offered that your other coverage was the reason for declining enrollment in the Plan, but only if the Plan required such a written statement at the time you declined initial enrollment, and provided the Employee with a notice of the requirement and consequences;
3. You lost coverage as the result of a certain event, including, but is not limited to the following:

    a. you were under COBRA and exhausted your COBRA coverage;
    b. you were not under COBRA and your other coverage was terminated as a result of you losing eligibility for that coverage (including as the result of legal separation, divorce, loss of Dependent status, death of an Employee, termination of employment, and the reduction in the number of hours worked);
    c. you moved out of an HMO service area with no other option available;
    d. you met or exceeded a Lifetime limit on all Benefits;
    e. the Plan is no longer offering benefits to a class of similarly situated individuals (e.g., the Plan terminates coverage for all part-time Employees);
    f. the benefit package option is no longer being offered and no substitute is available; and
    g. the employer contributions were terminated.

4. The Employee-requested enrollment within 30 days of termination of other coverage stated in item 3 above;
5. Your Medicaid or CHIP coverage is terminated as a result of you losing eligibility and the Employee requests enrollment within 60 days of the loss; and
6. You become eligible for a premium assistance subsidy under Medicaid or CHIP in states that adopt the subsidy program and the Employee requests enrollment within 60 days of eligibility.

If you lost the other coverage as a result of 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 lost coverage), then you do not have a special enrollment right.

You must complete an enrollment form within 30 days of the events specified in item 3 above, or within 60 days of the events specified in items 5 and 6 above, and can obtain a statement of lost group coverage form from the employer.

Effective Dates of Coverage for Special Enrollment Entrants

The Effective Date for special enrollees eligible through the events specified in items 3, 5 and 6 above will be the date of the qualifying event, provided an enrollment form is signed and completed, and the above requirements are met. If you qualify for a special enrollment you will be considered a timely entrant.

HIPAA Notice of Privacy Practices

Special Enrollment Through Marriage, Birth or Adoption

This group Plan is required to provide a special enrollment period when a new Dependent is acquired by marriage, birth, adoption, or placement for adoption. Qualifying for this special enrollment allows for the Employee, Spouse, and any otherwise eligible Dependent to enroll, provided application is made within 31 days of the event. If you seek to enroll, coverage becomes effective on the following dates:

1. Marriage - The date of marriage, or no later than the first day of the first month beginning after the date the request was completed;
2. Birth - The date of birth. The mother of the newborn may also be enrolled as a Dependent if the mother is otherwise eligible for coverage; or
3. Adoption - The date of adoption or the placement for adoption.

Teachers Health Trust may require documentation proving dependency, including birth certificates, tax records, or initiation of legal proceedings severing parental rights.

How the Trust May Use and Disclose Your PHI

The Trust may use PHI or disclose it to others for a number of different reasons. The following are the different ways that the Trust may use and disclose your PHI without your authorization:

- **For Treatment.** The Trust may disclose your PHI to a health care provider who provides, coordinates or manages health care treatment on your behalf. For example, if you are unable to provide your medical history as a result of an accident, the Trust may advise an emergency room physician about the different medications that you may have been prescribed.

- **For Payment.** The Trust may use and disclose your PHI so claims for health care treatment, services, and supplies that you receive from health care providers may be paid according to the Trust's terms. The Trust may also use your PHI for billing, reviews of health care services received, and subrogation. For example, the Trust may tell a doctor or hospital whether you are eligible for coverage or what benefit payment will be paid by the Trust for services rendered.

- **For Health Care Operations.** The Trust may use and disclose your PHI to enable it to operate more efficiently or to make certain that all of its participants receive the appropriate health benefits. For example, the Trust may use your PHI for case management, to refer individuals to disease management programs, for underwriting, premium rating, activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, to arrange for medical reviews, or to perform population-based studies designed to reduce health care costs. In addition, the Trust may use or disclose your PHI to conduct compliance reviews, audits, legal reviews, actuarial studies, and/or for fraud and abuse detection. The Trust may combine PHI about participants and disclose it to designated Trust personnel or consultants in a non-identifiable, summary fashion so that the Trust can decide, for example, what types of coverage the Trust should provide. The Trust may remove information that identifies you from PHI that is disclosed so that the PHI that is used by consultants or the Trust does not identify the specific Trust participants.

- **To the Plan Sponsor.** The Trust may disclose your PHI to designated personnel at the Trust so that they can carry out related administrative functions, including the uses and disclosures described in this Notice. Such disclosures will be made only to the individuals authorized to receive such information under the Trust. These individuals will protect the privacy of your PHI and ensure that it is used only as described in this Notice or as permitted by law. Unless authorized by you in writing, your PHI (1) may not be disclosed by the Trust to any other employee or department of the Trust; (2) will not be shared with your employer for use in any employment-related actions or decisions, or in connection with any other employee benefit plans sponsored by your employer; and (3) will not be disclosed by the Trust to any employee or department of your employer.

HIPAA Notice of Privacy Practices

How the Trust May Use and Disclose Your PHI (cont.)

- **To a Business Associate.** Certain services are provided to the Trust by third parties known as "business associates." For example, the Trust may place information about your health care treatment into an electronic prescription drug claims processing system maintained by a business associate so that your pharmacy claims may be paid. In so doing, the Trust will disclose your PHI to its business associates so that the business associates can perform their claims payment functions. However, the Trust will require its business associates, through written agreements, to appropriately safeguard your PHI.

- **For Treatment Alternatives.** The Trust may use and disclose your PHI to tell you about possible treatment options or health care alternatives that may be of interest to you.

- **For Health-Related Benefits and Services.** The Trust may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

- **To Individuals Involved in Your Care or Payment of Your Care.** Unless you object, the Trust may provide relevant portions of your PHI to a family member, friend, or other person you indicate is involved in your health care or in helping you receive payment for your health care. If you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, we will disclose PHI (as we determine) in your best interest. After the emergency, we will give you the opportunity to object to future disclosures to family and friends.

- **As Required by Law.** The Trust will disclose your PHI when required to do so by federal, state, or local law, including those laws that require the reporting of certain types of wounds, illnesses, or physical injuries.

Special Use and Disclosure Situations

The Trust may also use or disclose your PHI without your authorization under the following circumstances:

- **Lawsuits and Disputes.** If you become involved in a lawsuit or other legal action, the Trust may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other forms of lawful due process.

- **Law Enforcement.** The Trust may release your PHI if asked to do so by a law enforcement officer, for example, to report child abuse; to identify or locate a suspect, material witness, or missing person; to report a crime, the crime's location, or victims; or to report the identity, description, or location of the person who committed the crime.

- **Workers' Compensation.** The Trust may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws and other similar programs.

- **Military and Veterans.** If you are or become a member of the U.S. armed forces, the Trust may release medical information about you as deemed necessary by military command authorities.

- **To Avert Serious Threats to Health or Safety.** The Trust may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

- **Public Health Risks.** The Trust may disclose PHI about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or problems with medical products; or notifying people of recalls of products they have been using.

- **Health Oversight Activities.** The Trust may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

- **Research.** Under certain limited circumstances, the Trust may use and disclose your PHI for medical research purposes.

HIPAA Notice of Privacy Practices

Special Use and Disclosure Situations

- **National Security, Intelligence Activities, and Protective Services.** The Trust may release your PHI to authorized federal officers (1) for intelligence, counterintelligence, and other national security activities authorized by law and (2) to enable them to provide protection to the members of the U.S. government or foreign heads of state, or to conduct special investigations.

- **Organ and Tissue Donation.** If you are an organ donor, the Trust may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank to facilitate organ or tissue donation and transplantation.

- **Coroners, Medical Examiners, and Funeral Directors.** The Trust may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Trust may also release your PHI to a funeral director, as necessary, to carry out his/her responsibilities.

Your Rights Regarding Your PHI

You have the following rights regarding the PHI that the Trust maintains about you:

- **Right to Inspect and Copy Your PHI.** You have the right to inspect and copy your PHI that is maintained in a designated record set for so long as the Trust maintains your PHI. A "designated record set" includes medical information about eligibility; enrollment; and claim, appeal, medical, and billing records maintained by the Trust but does not include psychotherapy notes; information intended for use in a civil, criminal, or administrative proceeding; or information that is otherwise prohibited by law.

  To inspect and copy PHI maintained by the Trust, submit your request in writing to the Privacy Officer. The Trust may charge a fee for the cost of copying and/or mailing your request. The Trust must act upon your request for access no later than 30 days after receipt (60 days if the information is maintained off-site). A single 30-day extension is allowed if the Trust is unable to comply by the initial deadline. In limited circumstances, the Trust may deny your request to inspect and copy your PHI. Generally, if you are denied access to your PHI, you will be informed as to the reasons for the denial and of your right to request a review of the denial.

- **Right to Amend Your PHI.** If you feel that the PHI that the Trust has about you is incorrect or incomplete, you may ask the Trust to amend it. You have the right to request an amendment for so long as the Trust maintains your PHI in a designated record set.

  To request an amendment, send a detailed request in writing to the Privacy Officer. You must provide the reason(s) to support your request. The Trust may deny your request if you ask the Trust to amend your PHI that was (1) accurate and complete, (2) not created by the Trust, (3) not part of the PHI kept by or for the Trust, or (4) not information that you would be permitted to inspect and copy. The Trust has 60 days after the request is received to act on the request. A single 30-day extension is allowed if the Trust cannot comply by the initial deadline. If the request is denied, in whole or in part, the Trust will provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and, if permitted under HIPAA, have that statement included with any future disclosures of your PHI.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures" of your PHI. This is a list of disclosures of your PHI that the Trust has made to others for the six (6) year period prior to the request, except for those disclosures necessary to carry out treatment, payment, or health care operations; disclosures previously made to you; disclosures that occurred prior to the date on which the accounting is requested; or in certain other situations described under HIPAA.

HIPAA Notice of Privacy Practices

Your Rights Regarding Your PHI (cont.)

To request an accounting of disclosures, submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six (6) years prior to the date the accounting was requested. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the Trust provides you with a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Trust will charge a reasonable, cost-based fee for each subsequent accounting.

- **Right to Request Restrictions.** You have the right to request a restriction on the PHI that the Trust uses or discloses about you for treatment, payment, or health care operations. You also have the right to request that the Trust limit the individuals (for example, family members) to whom the Trust discloses PHI about you. For example, you could ask that the Trust not use or disclose information about a surgical procedure that you had. While the Trust will consider your request, it is not required to agree to it, except in those situations where (1) the requested restriction relates to the disclosure to the Plan for purposes of carrying out payment or health care operations (and not for treatment) and (2) the PHI pertains solely to a health care item or service that was paid for out-of-pocket in full. If the Trust agrees to the restriction, it will comply with your request until such time as the Trust provides written notice to you of its intent to no longer agree to such restriction, or unless such disclosure is required by law.

  To request a restriction or limitation, make your request in writing to the Privacy Officer. In your request, you must state (1) what information you want to limit; (2) whether you want to limit the Trust's use, disclosure, or both; and (3) to whom you want the limit(s) to apply. Note: the Trust is not required to agree to your request.

- **Right to Request Confidential Communications.** You have the right to request that the Trust communicate with you about health matters using alternative means or at alternative locations. For example, you can ask that the Trust send your explanation of benefits (EOB) forms about your benefit claims to a specified address. To request confidential communications, make your request in writing to the Privacy Officer. The Trust will make every attempt to accommodate all reasonable requests. Your request must specify how or where you want to be contacted.

- **State Privacy Rights.** You may have additional privacy rights under state laws, including rights in connection with mental health and psychotherapy reports, pregnancy, HIV/AIDS-related illnesses, and the health treatment of minors.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice upon request. This right applies even if you have previously agreed to accept this Notice electronically. You may write to the Privacy Officer to request a written copy of this Notice at any time.

Other Uses and Disclosures of PHI

Other uses and disclosures of PHI not covered by this Notice or by the laws that apply to the Trust will be made only with your written authorization. If you authorize the Trust to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Trust will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the Trust will not reverse any uses or disclosures already made in reliance on your prior authorization. The Plan will notify you in the event that there is a breach involving unsecured PHI.

Changes to This Privacy Notice

The Trust reserves the right to change this Notice at any time and from time to time, and to make the revised or changed Notice effective for PHI that the Trust already has about you, as well as any information that the Trust may receive in the future. The revised Notice will be provided to you in the same manner as this Notice, or electronically if you have consented to receive the Notice electronically.

HIPAA Notice of Privacy Practices

Complaints

If you believe that your PHI privacy rights as described under this Notice have been violated, you may file a written complaint with the Trust by contacting the person listed at the address under "Contact Information." You may also file a written complaint directly with the regional office of the U.S. Department of Health and Human Services, Office for Civil Rights. The complaint should generally be filed within 180 days of when the act or omission complained of occurred. Note: You will not be penalized or retaliated against for filing a complaint.

Questions Concerning Your HIPAA Rights

If you have questions concerning your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration toll-free at 866-444-3272. For free HIPAA publications, you should ask for publications concerning changes in health care laws. Participants may also contact the CMS publications hotline at 800-633-4227 and ask for "Protecting Your Health Insurance Coverage." These publications and other useful information are available on the Internet at: http://www.dol.gov/ebsa, the DOL's interactive web pages - Health Elaws, or http://www.cms.hhs.gov.

Contact Information

To receive more information about the Trust's privacy practices or your rights, or if you have any questions about this Notice, please contact the Trust at the following address:

Contact Office or Person:	**Privacy Officer**
Health Plan Name:	**Teachers Health Trust**
Telephone:	**702-794-0272 or 800-432-5859**
Address:	**2950 E. Rochelle Avenue, Las Vegas, NV 89121**
E-mail:	**privacyofficer@teachershealthtrust.org**
Website:	**www.teachershealthtrust.org**

Copies of this Notice are also available on the Trust's website, **www.teachershealthtrust.org**. A paper copy of this Notice is also available by sending an e-mail request to the above address.

Effective and Last Updated on February 17, 2010

Family Medical Leave Act

On February 5, 1993, Family and Medical Leave Act of 1993 (FMLA) was enacted and amended on January 28, 2008. FMLA requires that most employers who employ 50 or more Employees allow an Employee with 12 months or more service a total of 12 weeks of leave during any 12-month period for one or more of the following events:

1. For the birth and care of the newborn child of the Employee;
2. For placement with the Employee of a son or daughter for adoption or foster care;
3. To care for an immediate family member (spouse, child, or parent) with a serious health condition;
4. To take medical leave when the Employee is unable to work because of a serious health condition;
5. To care for an immediate family member (spouse, child, or parent) or next of kin (nearest blood relative of the individual) for a qualifying serious injury or illness arising out of active military duty, not to exceed 26 weeks of leave in a single 12-month period; or
6. To care for an immediate family member (spouse, child, or parent) who is on covered active duty or call to covered active duty status. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

Family Medical Leave Act

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is 1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness*; or 2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness*.

*The FMLA definitions of "serious injury or illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition".

Employees are eligible to take FMLA leave if they have worked for their employer for at least 12 months, and have worked for at least 1,250 hours over the previous 12 months, and work at a location where at least 50 Employees are employed by the employer within 75 miles. Any Employee taking a leave will be entitled to continue to use their benefits during the leave if they participate in a "group health plan" as defined in §5000(b)(1) of the Internal Revenue Code of 1996. The employer must continue the benefits at the level and under the conditions of coverage that would have been provided if the Employee had remained employed. If the Employee for any reason fails to return from the leave, the employer may recover from the Employee that premium or portion of the premium that the employer paid, provided the Employee fails to return to work for any other reason other than the recurrence of the health condition or circumstances beyond the control of the Employee. Leave taken under FMLA does not constitute a "qualifying event" to trigger COBRA rights. However, a qualifying event triggering COBRA coverage may occur when it becomes known that the Employee is not returning to work. Therefore, if an Employee does not return at the end of 12 weeks of FMLA, the COBRA qualifying event occurs at that time.

This is only a summary of FMLA. Please see Teachers Health Trust for more information.

COBRA Continuation of Health Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires that most employers sponsoring group health plans offer the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This General Notice of Group Health Continuation Coverage Under COBRA is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of the law. You should take the time to read this notice carefully. If you are eligible for continuation coverage you are called a Qualified Beneficiary.

Initial Notice of COBRA Rights

Teachers Health Trust will notify Employees of their COBRA rights by including this General Notice of Group Health Continuation Coverage Under COBRA in the Summary Plan Description. They will send a General Notice of Group Health Continuation Coverage Under COBRA if you are not an Employee.

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

COBRA Continuation of Health Coverage

Eligibility for Continuation Coverage

An eligible Employee of Teachers Health Trust covered by this Plan has a right to choose continuation coverage if the Employee loses group health coverage for either of the following reasons:

1. A reduction in the Employee's hours of employment; or
2. The Employee is terminated for reasons other than gross misconduct on the Employee's part.

An eligible Spouse of an Employee covered by this Plan has the right to choose continuation coverage if group health coverage under this Plan is lost for any of the following reasons:

1. A reduction in the Employee's hours of employment;
2. The Employee's termination of employment for reasons other than gross misconduct on the Employee's part;
3. The death of the Employee;
4. Divorce or legal separation from the Employee; or
5. The Employee becomes entitled to and enrolls in Medicare under Title XVII of the Social Security Act.

An eligible Dependent child of an Employee covered by this Plan has the right to continuation coverage if group health coverage under this Plan is lost for any of the following reasons:

1. A reduction in the Employee's hours of employment;
2. The Employee's termination of employment for reasons other than gross misconduct on the Employee's part;
3. The death of the Employee;
4. The Employee's divorce or legal separation;
5. The Employee becomes entitled to and enrolls in Medicare under Title XVII of the Social Security Act; or
6. The Dependent child ceases to be a Dependent child as defined by this Plan.

Any Qualifying Beneficiary has the right to elect continuation coverage even if the beneficiary, at the time of the Qualifying Event or election of continuation coverage, has another employer-sponsored group health plan or Medicare.

The event described above that enables you to become qualified for continuation coverage is called a Qualifying Event.

If you are, or become incapacitated or die, your legal representative or your estate, or your Spouse may make the election.

Date of Notification

A required notice to you is generally considered "furnished" as of the date of mailing, if mailed by first class mail, certified mail, or Express Mail; or as of the date of electronic transmission, if transmitted electronically.

Notification of a Qualifying Event

You are required to inform Teachers Health Trust of the Employee's loss of coverage, a divorce, a legal separation, or a child losing Dependent status under this Plan within 60 days of the date of the event. Similar requirements may apply to certain retirees, Spouses, and Dependent children if the employer commences a bankruptcy proceeding and these individuals lose coverage.

Failure to notify Teachers Health Trust of the Employee's loss of coverage, a divorce, a legal separation, or a child losing Dependent status under this Plan within 60 days of the date of the event may result in loss of your rights to continuation coverage.

COBRA Continuation of Health Coverage

Notification of a Qualifying Event (cont.)

When the Trust is notified that one of these events has occurred, they will notify you within 14 days at your last known address of any right you have to choose continuation coverage. A notice to you is considered to be furnished as of the date of mailing, if mailed by first class, certified mail, or Express Mail, or the date of the electronic transmission, if transmitted electronically. Under the law, you have 60 days after the later of the following dates to inform Teachers Health Trust that you want continuation coverage:

1. The date you would lose coverage because of one of the events described above; or
2. The date you are notified of your right to choose continuation coverage.

If you fail to notify the Trust that you are choosing continuation coverage on a timely basis, your group health insurance coverage will end. If claims are paid in error due to your failure to notify the Trust on a timely basis, you will be required to reimburse the Plan for all of your claims that are paid as Benefits in error.

If you choose continuation coverage, Teachers Health Trust is required to provide coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated Participants. If the coverage for similarly situated Participants is modified, your continuation coverage will also be modified. You must fulfill and otherwise comply with any requirements that Participants must meet to continue participation in the Plan. For example, if other Participants may be asked to complete a health questionnaire, you may also be asked to complete the questionnaire for your continuation of coverage.

Eligibility for Continuation of Coverage/Trade Adjustment Reform Act

The Trade Adjustment Assistance Reform Act of November 2002 (TAA) expanded benefits for workers who become unemployed due to competition from foreign trade or the shift of production to other countries. It has been extended and modified by The Trade Preferences Extension Act of 2015.

TAA requires that Teachers Health Trust make a second 60-day COBRA election period available to TAA-certified former Employees. An Employee is eligible for this COBRA election period if they meet the following qualifications:

1. They are certified to receive TAA Benefits on or after November 4, 2002;
2. They have lost health coverage because of a trade-related termination of employment, which resulted in becoming TAA-certified; and
3. They did not elect continuation coverage when it was offered during the first election period following termination.

For further information on the Trade Adjustment Assistance Reform Act of November 2002, please refer to http://www.doleta.gov/tradeact/2002act_index.cfm. For information on the Trade Preferences Extension Act of 2015, please refer to https://www.irs.gov/Individuals/HCTC-Latest-News-and-Background

The Employee must notify the Trust if they are eligible for continuation coverage under TAA.

Notice of Unavailability

If the determination is made that you are not a Qualified Beneficiary, and therefore not eligible for continuation coverage, Teachers Health Trust will notify you within 14 days. This notification will include an explanation of why you are not eligible for continuation coverage.

Effective Date of Continuation Coverage

Continuation coverage will begin on the first day following the Qualifying Event.

COBRA Continuation of Health Coverage

Length of Continuation Coverage

All Qualified Beneficiaries are eligible to maintain continuation coverage for up to 18 months. However, for an eligible Dependent Qualified Beneficiary, continuation coverage may be maintained for up to a total of 36 months in the event of the death of an Employee, divorce, legal separation, loss of Dependent status, or Medicare entitlement.

In no event will continuation coverage last beyond 36 months from the date of the event that originally made a Qualified Beneficiary eligible to elect coverage. The 18 months may be extended to 29 months if a Qualified Beneficiary is determined by the Social Security Administration (SSA) to be Disabled (for Social Security disability purposes). The 11-month SSA disability extension is available to all individuals who are Qualified Beneficiaries due to a termination or reduction in hours of employment. To benefit from the SSA disability extension, a Qualified Beneficiary must notify Teachers Health Trust of the Social Security Administration determination within 60 days after the date of the Social Security Administration determination and before the end of the original 18-month COBRA period. The 60-day period is measured from the latest of the following dates:

1. The date of the Social Security Administration determination;
2. The date of the Qualifying Event;
3. The date that you would lose coverage under the Plan; and
4. The date you are informed of your obligation to provide the disability notice to TRISTAR by the Plan's Summary Plan Description or initial notice.

You must also notify the Trust within 30 days of any final Social Security Administration determination that you are no longer Disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) makes changes to the current law to provide that the disability extension will also apply if you become Disabled at any time during the first 60 days of COBRA continuation coverage. HIPAA provides that if you are entitled to a disability extension but have non-Disabled family members who are entitled to COBRA continuation coverage, then those non-Disabled family members are also entitled to the 29-month disability extension.

Coverage Changes While Under Continuation Coverage

A child who is born to, adopted by, or placed for adoption with the Employee during a period of COBRA coverage will be eligible to participate in the continuation coverage, and can be added to COBRA coverage upon proper notification to Teachers Health Trust of the birth, adoption, or placement for adoption, as permitted by federal law and the Plan.

Second Qualifying Event Extension

If a Qualified Beneficiary experiences another Qualifying Event while on continuation coverage, the Spouse and Dependent children (if applicable) may obtain an additional period of continuation coverage, up to a maximum of 36 months from the date of the original Qualifying Event. The extension is available for the Spouse and Dependent children if the Employee dies, enrolls in Medicare Part A, Part B, or both Parts A and B, divorces, or becomes legally separated. The extension also applies to a Dependent child when the Dependent child ceases to be eligible under the Plan.

In all cases you must notify Teachers Health Trust of the second Qualifying Event within 60 days of the second Qualifying Event.

COBRA Continuation of Health Coverage

Termination of Continuation Coverage

The law provides that your continuation coverage may be terminated for any of the following reasons:

1. Teachers Health Trust no longer provides group health coverage to any of its Employees;
2. You do not pay the premium for continuation coverage on time;
3. You become covered under a group health plan other than the coverage you had at the time of the COBRA Qualifying Event.
4. You extend coverage for up to 29 months due to disability and there has been final determination that you are no longer Disabled; or
5. You become entitled to and enroll in Medicare under Title XVII of the Social Security Act.

In the case of Social Security Disability Certification, the COBRA continuation period will end the first of the month beginning more than 30 days after you are no longer certified Disabled by Social Security Administration, or sooner, if for any of the other reasons stated above.

Continuation coverage under COBRA is subject to your eligibility for coverage. Teachers Health Trust reserves the right to terminate your COBRA coverage retroactively when determined to be ineligible. Teachers Health Trust will notify you as soon as practicable after you are determined to be ineligible. This notification will include an explanation of why you are no longer eligible for continuation coverage.

Payments for Continuation Coverage

By law, you may be required to pay up to 100% of the premium for the continuation coverage plus a 2% administrative fee. If you qualify for the 11-month SSA disability extension, during those additional 11 months you may also be subject to an administrative fee not to exceed 50%. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

Before or on the 45th day after you choose continuation coverage, you must make your first premium payment for the months that end on or before the 45th day after the date you choose continuation coverage. All other premiums are due on the first of the benefit month. You will have a 30-day grace period. Your premium payment is considered made on the date it is postmarked.

Questions About Continuation Coverage

If you have any questions about COBRA, you should contact Teachers Health Trust. If your marital status changes, or your address changes, you should notify the Trust. The name and address of Teachers Health Trust are located on the Information Requirements of ERISA and related sections of this Plan Document.

Patient Protection Model Disclosure

The Teachers Health Trust generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Teachers Health Trust designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Teachers Health Trust at 702-794-0272.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Teachers Health Trust or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Teachers Health Trust at 702-794-0272.

Newborns and Mothers Health Protection Act

This Plan complies with all provisions of the Newborns' and Mothers' Health Protection Act of 1996.

On September 26, 1996, the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) was signed into law. NMHPA requires plans that offer maternity coverage to pay for at least a 48-hour Hospital stay following a vaginal delivery and a 96-hour Hospital stay after a cesarean section.

The Mothers' Health Protection Act of 1996 (NMHPA) provides that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a Hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by Cesarean section. However, the attending Physician may decide, after consulting with the mother, to discharge the mother and/or newborn child earlier.

NMHPA and its regulations prohibit incentives (either positive or negative) that could encourage less than the minimum protections provided by NMHPA.

A mother cannot be encouraged to accept less than the minimum protections available to her under NMHPA, and an attending Physician cannot be induced to discharge a mother or newborn earlier than 48 hours following a vaginal delivery or earlier than 96 hours after Cesarean section delivery.

Under NMHPA, plans and issuers may not require that a Physician obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours following a vaginal delivery or 96 hours following a delivery by Cesarean section.

Mental Health Parity and Addiction Equity Act

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was passed on October 3, 2008. This law applies to plan years beginning on or after October 3, 2009.

Under MHPAEA, a group health plan providing both mental health benefits and medical/surgical benefits may comply with the MHPAEA requirements in any of the following general ways:

1. Any financial requirement or treatment limitation that applies to Mental and Nervous Disorder or substance use disorder benefits cannot be more restrictive than the "predominant" financial requirements or treatment limitations applied to substantially all medical and surgical benefits;
2. There cannot be separate cost sharing or treatment limitation requirements that apply to Mental and Nervous Disorder or substance use disorder benefits; and
3. If a plan covers Out of Network medical/surgical benefits, it must provide Out of Network Mental and Nervous Disorder or substance use disorder benefits in a manner consistent with the law's parity requirements.

Genetic Information Nondiscrimination Act

This plan complies with all provisions of the Genetic Information Nondiscrimination Act of 2008.

The Genetic Information Nondiscrimination Act of 2008 (GINA) is a federal law that protects individuals from genetic discrimination in health insurance and employment. Genetic discrimination is the misuse of genetic information. Health plans may not request, require, or use genetic information to make decisions regarding your eligibility for health insurance, your health insurance premium, contribution amounts, or coverage terms.

The Women's Health and Cancer Rights Act

This plan complies with all provisions of the Women's Health and Cancer Rights Act of 1998.

Under federal law, group health plans and health insurance issuers providing benefits for a mastectomy must also provide, in connection with the mastectomy for which the Participant or Qualified Beneficiary is receiving benefits, coverage for:

- All states of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of mastectomy, including lymphedema; in a manner determined in consultation between the attending Physician and the patient.

These benefits may be subject to Annual Deductible, Copayment, and Coinsurance provisions that are appropriate and consistent with other benefits under the Trust.

General Plan Provisions

Headings

The headings of the various sections and subsections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

Non-Duplication of Services

Any service that is considered an Covered Expense under one portion of the Plan, (e.g. the medical, prescription drug, or dental plan) will not also be considered an Covered Expense under any other portion of the Plan, including any other plan that is offered by Teachers Health Trust and/or not administered by TRISTAR Benefit Administrators, Inc. For example, if charges related to a dental Accident are a Covered Expense under the medical portion of the Plan, it will not also be an Eligible Expense under the dental plan.

Misstatement of Age

If your age has been misstated on an enrollment form, the misstated age will be immediately changed to the correct age. If the age is a determining factor in your eligibility, the availability of a Benefit or the amount of a Benefit, any Benefit affected by the misstatement of age will be adjusted immediately, and any paid Benefits will be requested back from you, the provider(s) of service and/or the Employee. You will not be eligible for any extended benefits under the Plan.

Misstatement of Relationship

If the relationship of the Employee to a covered Dependent has been misstated on an enrollment form, and the correct relationship results in you failing to be eligible to participate in the Plan, you will be terminated as of the original Effective Date, and any paid Benefits will be requested back from you, the provider(s) of service and/or the Employee. You will not be eligible for any extended benefits under the Plan.

Misuse of Identification Card

If you or a Covered Dependent allows a non-covered person to use any Plan or affiliate-issued identification card for any reason, any Benefit issued will be requested back from you, the provider(s) of service and/or the Employee.

General Plan Provisions

Amendment, Waiver, and Termination

Upon notice to covered Employees, Teachers Health Trust may amend, add, limit, change, eliminate, or terminate any benefit or provision of the Plan, or the Plan itself, at any time and in any manner, within its sole and final discretion, without consent of or advance notice to covered Employees and Dependents, or to any other party, subject to applicable law and regulation. All Amendments and terminations must be in writing and will be binding on all covered Employees and Dependents, and any other party of interest.

No term, condition, or provision of the Plan will be waived, unless upon notice to a covered Employee, stated in writing by Teachers Health Trust (specifically stating it is a waiver). No such written waiver will be deemed a continuing waiver unless specifically stated, and any such waiver will operate only as to the specific term or condition waived and will not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

Subrogation, Reimbursement and/or Third Party Liability

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

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

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

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

General Plan Provisions

Subrogation, Reimbursement and/or Third Party Liability (cont.)

A. Subrogation

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

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

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

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

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

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

B. Right of Reimbursement

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

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

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

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

General Plan Provisions

Subrogation, Reimbursement and/or Third Party Liability (cont.)

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

C. Excess Insurance

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

The Plan's benefits shall be in excess to:

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

D. Wrongful Death

In the event that the Plan Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Plan Participant(s) and all others that benefit from such payment.

E. Obligations

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

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

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

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

General Plan Provisions

Subrogation, Reimbursement and/or Third Party Liability (cont.)

F. Offset

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

G. Minor Status

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

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

H. Language Interpretation

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

I. Severability

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

Conformity with Law

If any provision of the Plan Document is found to be contrary to any law to which it is subject, the provision will be changed to meet the law's minimum requirement.

Payment of Claims

Any accrued indemnities unpaid at the Covered person's death will be paid to the nearest living relative, by blood or marriage, who is deemed by the Trust to be equitably entitled thereto. All other indemnities, if any, provided by the Plan on account of Hospital, nursing, medical or surgical service will, upon written request of the covered person no later than the time required for filing such claims, be paid directly to the Hospital or person rendering such services, but it is not required that the service be rendered by a particular Hospital or person.

Legal Action

No action at law or in equity shall be brought to recover on the Trust or its Plan prior to the expiration of 60 days after a claim has been furnished in accordance with the requirements of this plan. No such action shall be brought after the expiration of the time a claim is required to be furnished.

General Plan Provisions

Change or Discontinuance of the Plan

This Plan Document and any group insurance policies are the entire instruments for establishing the Teachers Health Trust. The Trust expects the benefits described to be an ongoing program. However, it does reserve the right to change, suspend or discontinue all or any part of the plan at any time.

Health benefits are not a vested right but may be changed, reduced or modified at the discretion of the Board of Trustees. The cost of benefits described in this Plan Document are paid directly from the assets of the Teachers Health Trust, and there is no liability on the Board or Trustees, any individual or entity to provide payments over and above the amounts the Teachers Health Trust collected and has available for such purposes. Any benefits provided by a plan can be paid only to the extent that the Teachers Health Trust has adequate resources available for payment. The CCSD is only obligated to make contributions per the Collective Bargaining Agreement; providing necessary payroll deductions, including eligibility lists; and verifying employment. The District's function is solely ministerial. There is no obligation on the Board of Trustees, either individually or collectively, nor upon the CCSD, or upon any person or entity, to provide benefit payments if the Teachers Health Trust does not have sufficient assets to provide benefit payments.

Legal Jurisdiction

The laws of the State of Nevada shall govern all Plan provisions.

Independent Examination and Request for Information

The Trust has the right to have you examined, at the Trust's expense, at reasonable intervals while you are claiming benefits. Any such examinations will be conducted by one or more Physicians or vocational specialists of the Trust's choice.

It is your responsibility to inform the Trust of any change in Dependent status, such as marriage, divorce, or birth (or adoption) of a child. All Eligible Dependents acknowledge the right of the Trust to require and promptly receive from all Participants proof of eligibility status, such as marriage certificates, birth certificates, Certificates of Registered Domestic Partnership, or any other proof of eligibility as the Teachers Health Trust Board of Trustees, at its sole discretion, may demand. All Participants agree to furnish such proof as a pre-condition to the payment of any benefits for or on behalf of Eligible Employees and their Dependents.

Your failure to comply with any request made or condition imposed by the Trust could result in denial of your benefits.

Overpayment of Benefits

If, at any time, payment by the Trust exceeds the benefits actually payable in accordance with the plan, the Trust shall have the right to recover the excess of such payments from the person to or for whom payments were made or from any organization from which similar benefits remain payable. The Trust, in its sole discretion, may deduct or offset any such monies from your future benefits. The Trust has the right to take all appropriate action to recover payments. If the Trust files any legal action against you to recover any such monies, it will be entitled to reimbursement for all attorney fees and costs incurred, whether or not such an action proceeds to judgment.

Interpretation of the Plan

Claims are payable provided the patient meets all eligibility requirements of Trust Participation, the service is a Covered expense, and the insured complied with the terms and conditions of the Plan. In the event of conflict of opinion regarding eligibility and/or claims determination, this official Plan Document, as well as the Trust's Internal Administrative Guidelines, will be the determining documents for all questions of policy and coverage. The Trust shall exercise sole and exclusive authority and discretion to resolve any ambiguities in this Plan Document, to render decisions concerning eligibility for benefits, and to otherwise interpret the terms of this Plan Document and all rules and regulations established hereunder in accordance with the intent of the Plan Document.

Claims Filing/Filing Limit

When a claim is submitted to the Trust by a Trust Participant or a health care Provider, it is reviewed to determine if the expense was a covered benefit, if you were eligible for coverage at the time of the service, and if you complied with all the terms and conditions of the Plan. A determination of your claim will be mailed to you. This determination is known as an Explanation of Benefits (EOB). Claim payments will be issued to the Provider of services if the claim contains an Assignment of Benefits authorizing payment to be made to the Provider.

An Assignment of Benefits allows the patient to assign to the Provider his/her right to receive payment for services, and file a claim on his/her behalf. The Providers then charge the Plan for payment directly.

The Plans use various reference sources during the administration process, including CPT, HCPCS, ASA, ADA, ICD-9 and/or ICD-10 guidelines, and Medicare Correct Coding Initiatives. Payable benefits are determined in accordance with the corresponding Plan provisions and internally established claims administration procedures. Claims paid using negotiated contract rates with Providers will be based on the contract in place as of the date of service and not (in the case of an Inpatient admission) based on the date of admission.

If additional information is required before the claim can be processed, you and your Provider will be sent a written notice of what is needed. The information must be provided within the specified time period. If the information is not submitted within the required time, the claim will be denied.

If a claim is denied in whole or in part, and/or you disagree with the benefit determination, you have the right to appeal the benefit denial.

All claims must be received within 1 year of the day charges are incurred, or the claims will not be eligible for payment consideration.

A paper claim will be considered filed on the date it is received by the Trust. Electronic claims will be considered received the day subsequent to the transmission of the claim by the provider.

All medical claims must be mailed to the address printed on the front of the identification card.

Failure to include all applicable information may result in a delay in processing or the denial of the claim.

Clean Claim

A clean claim is one that can be processed without obtaining additional information from the provider of the service or a third party. For claims filed on a UB-04 a clean claim must include the following information:

- The date(s) the services, drugs, or supplies were received;
- The diagnosis;
- A description of the treatment received;
- The type of service and the charge for each service, drug, or supply;
- The name, address, tax I.D. number, license number and professional status of the Provider; and
- The full name of the patient.

It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation or a particular circumstance requiring special treatment which prevents timely payment from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for medical necessity, or for which services must be clarified, or the patient eligibility for benefits be verified.

Definitions

Business Associate means (as defined in 45 CFR § 160.103) a third-party administrator that provides certain services to the Trust.

Designated Record Set means (as defined in 45 CFR § 164.501) a group of records maintained by the Trust that consists of:

- the enrollment, Payment, claims adjudication, medical records and case or medical management record systems maintained by the Trust; or
- records that are used, in whole or in part, by or for the Trust to make decisions about Individuals.

For purposes of this definition, the term "record" means any item, collection, or grouping of information that includes PHI and is maintained, stored, collected, used, or disseminated by or for the Trust.

Employee means an individual employed by the CCSD, CCEA or Teachers Health Trust who meets the eligibility requirements for Trust coverage.

Health Care means (as defined in 45 CFR § 160.103), care, services, or supplies related to the health of an Individual. Health Care includes, but is not limited to, the following:

- Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an Individual or that affects the structure or function of the body, and
- Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

Health Care Operations (as defined in 45 CFR § 164.501) includes, but is not limited to quality assessment and improvement, reviewing competence or qualifications of Health Care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse compliance programs, business management and general administrative activities.

Health Care Provider means generally (as defined more fully in 45 CFR § 160.103), a Provider of medical or health services, as well as any other person or organization who furnishes, bills, or is paid for Health Care in the normal course of business.

Health Information means information (whether oral, written or electronic in nature) that is created or received by the CCSD, CCSD Charter School, CCEA, Teachers Health Trust, a Health Care Provider, life insurer, school or university, or health care clearinghouse that relates to the past, present or future physical or mental health or condition of an Individual, the provision of Health Care to an Individual, or the past, present, or future Payment for the provision of Health Care to an Individual.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 and any amendments thereto.

HIPAA Privacy Regulations means, collectively, the Standards of Privacy of Individually Identifiable Health Information, codified at 45 CFR Part 160 and 164, Subparts A and E, including all subsequent amendments thereto or federal guidance thereon.

Individual means (as defined in 45 CFR § 164.501) the person who is the subject of Protected Health Information.

Individually Identifiable Health Information means (as defined in 45 CFR § 160.103) Health Information, including demographic information, collected from an Individual and created or received by the CCSD, CCSD Charter School, CCEA, Teachers Health Trust, a Health Care provider, or a Health Care Clearinghouse that identifies the Individual involved or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual involved.

Mental Health Professional means a person who conducts or provides mental Health Care or Treatment to an Individual and who may create Psychotherapy Notes (within the meaning of 45 CFR § 164.501) for purposes of such mental Health Care or Treatment, or for use by practitioners in the field of mental Health Care, Treatment, training or other purposes permitted under HIPAA.

Definitions

Notice or Privacy Notice means this document in its entirety, which sets forth the HIPAA privacy practices of the Teachers Health Trust.

Payment includes, but is not limited to, actions to make coverage determinations and Payment (including billing, claims management, subrogation, Trust reimbursement, reviews for medical necessity and appropriateness of care and utilization review and prior authorizations).

Plan Sponsor or Health Plan Sponsor as defined in ERISA, 29 U.S.C. § 3(16) (B), means the CCSD, CCSD Charter School, CCEA, and the Teachers Health Trust.

Privacy Officer means the designated Privacy Official of the Teachers Health Trust.

Protected Health Information or PHI means Individually Identifiable Health Information that is transmitted or maintained by or for the Trust, regardless of its form or medium, including oral, written and electronic information.

Psychotherapy Notes means (as defined in 45 CFR §164.501) the notes recorded (in any medium) by a Health Care Provider who is a Mental Health Professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the Individual's medical record. Psychotherapy Notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of Treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the Treatment plan, symptoms, prognosis, and progress to date.

Treatment or Health Care Treatment means (as defined in 45 CFR §164.501) the provision, coordination, or management of Health Care and related services by one or more Health Care Providers, including the coordination or management of Health Care by a Health Care Provider with a third party; consultation between Health Care Providers relating to a patient; or the referral of a patient for Health Care from one Health Care Provider to another.

ERISA Statement of Rights

As Participants in the Teachers Health Trust Employee Health Care Plan, covered Participants are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA provides that all plan Participants will be entitled to receive the following information about the plan and benefits:

Receive Information About the Plan and Benefits

1. Examine, without charge, at the Trust'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 and available at the Public Disclosure Room of the Employee Benefits Security Administration;
2. Obtain, upon written request to the Trust, copies of documents governing the operation of plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (form 5500 series), and updated Plan Document. The Trust may make a reasonable charge for the copies;
3. Receive a summary of the plan's annual financial report. The Trust is required by law to furnish each Participant with a copy of this summary annual report;

Continue Group Health Plan Coverage

4. Continue health care coverage for the Employee, spouse, or Dependents if there is a loss of coverage under the plan as the result of a qualifying event. The Employee, spouse, or Dependents may have to pay for such coverage. Review this Plan Document and the documents governing the plan on the rules governing the COBRA continuation coverage rights.

ERISA Statement of Rights

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan Participants, ERISA imposes duties upon the individuals who are responsible for the operation of the Employee Benefit Plan. The individuals who operate this plan, called "fiduciaries" of the plan, have a duty to do so prudently, and in the interest of the Employee and other covered Participants, and beneficiaries. No one, including the employer or any other person may fire the Employee or otherwise discriminate against them in any way to prevent them from obtaining a welfare benefit or exercising their rights under ERISA.

Enforce a Covered Participant's Rights

If a covered Participant's claim for a welfare benefit is denied or ignored, in whole or in part, they have the right to know why this was done, to obtain copies of the documents relating to this decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a covered Participant can take to enforce the above rights. For instance, if they request a copy of the Plan Documents or the latest annual report from the plan and do not receive them within 30 days, they may file suit in a Federal court. In such a case, the court may require the Trust to provide the materials and pay the covered Participant up to $110 a day until they receive the materials, unless the materials were not sent because of reasons beyond the control of the Teachers Health Trust. If a covered Participant has a claim for benefits that is denied or ignored, in whole or in part, they may file suit in state or Federal court. In addition, if they disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, they may file suit in a Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if an Employee is discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or they may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If they are successful, the court may order the person they sued to pay these costs and fees. If the covered Participant loses, the court may order them to pay the costs and fees, for example, if it finds the claim frivolous.

Assistance with Questions

If a covered Participant has any questions about this plan, they should contact the Trust. If a covered Participant has any questions about this statement or about their rights under ERISA, or if they need assistance in obtaining documents from the Trust they should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210. A covered Participant may also obtain certain publications about their rights and responsibilities under ERISA by calling the hotline of the Employee Benefits Security Administration at (202) 693-8673.

Information Requirements of ERISA

Named Fiduciary / Plan Sponsor:	Teachers Health Trust
Employer Identification Number:	88-0195176
Type of Plan:	Welfare Benefit Plan
Group Number:	THT20660
Plan Year:	January 1 through December 31
Participants:	Eligible Employees and their eligible Dependents
Plan Administrator and Plan Agent for Service of Legal Process:	Teachers Health Trust P.O. Box 96238 Las Vegas, NV 89193-6238
Source of Funding:	The plan is funded by direct benefit payments from the general assets of the employer and Employee contributions.
Source of Contributions:	The Employee's contribution toward the cost of this plan is at a rate determined by the employer.
Type of Plan:	The plan described in this Summary Plan Description is a "Welfare Benefit Plan" for the purposes of ERISA.
Type of Benefits:	Health Care
Type of Administration:	Contract Administration
Benefit Services Administrator:	TRISTAR Benefit Administrators P.O. Box 65887 West Des Moines, IA 50265 800-456-4584

Service of legal process may be made on Teachers Health Trust.

If the employer is unable to fund the plan, the Employee may be financially responsible for any incurred and unpaid claims.

Your Rights As a Participant

As a Teachers Health Trust Plan Participant, you have the following rights:

1. Upon written request, you may examine without charge, at the Trust office, all Plan Documents, including insurance contracts and copies of all documents filed by the Plan with the appropriate governmental agencies. You must give ten working days' written notice to the Trust of your desire to examine any documents.
2. You may request a summary of the Plan's annual report.
3. Upon written request to the Plan Administrator, you may obtain copies of all Plan documents and other Plan information for the three most recent fiscal years. The Plan Administrator may make a reasonable charge for the copies, and you may only request documents for the period of time during which you were enrolled in the Plan. You must give ten working days' written notice to the Plan Administrator of your desire to obtain any documents.
4. You will receive any Plan amendments within a reasonable period of time after the amendments are adopted.

All copies of documents you request must be picked up from the Trust office within 30 days of the date the request was made. You are limited to one (1) request for documents in a fiscal year. You may contact the Trust at the following:

Teachers Health Trust

2950 E. Rochelle Avenue
Las Vegas, NV 89121
702-794-0272 or 800-432-5859
E-mail: serviceteam@teachershealthtrust.org

Chapter 12

DEFINITIONS

In addition to the definitions provided throughout this Plan Document, the following terms also apply to the Plan provided by the Trust. (These definitions do not apply to the **Life Insurance** chapter of this Plan Document, or to the **HIPAA Notice of Privacy Practices** located in the **Legal** chapter of this Plan Document, both of which contain their own definitions.)

In addition to the definitions provided throughout this Plan Document, the following terms also apply to the Plans provided by the Trust. (These definitions do not apply to the **Life Insurance** chapter of this Plan Document, or to the **HIPAA Notice of Privacy Practices** located in the **Legal** chapter of this Plan Document, both of which contain their own definitions.)

100 Days Maximum Services: Types of services that are covered by the Trust at 100 days maximum combined benefit per calendar year. Days of usage for any or all of these services are combined for a maximum benefit of 100 days per calendar Year, if determined to be medically necessary by the Trust's medical review organization. The services that fall under the 100 Days Combined Maximum are Inpatient skilled nursing, inpatient acute rehabilitation, outpatient, comprehensive day or half-day rehabilitation; inpatient long term acute care; mental health inpatient care, partial hospitalization and residential treatment; chemical dependency, inpatient care, partial hospitalization and/or residential treatment.

Adoption Order: Copy of the initial placement order. Within six months following initial placement, a copy of the finalized adoption order must be submitted. Both the initial placement and the finalized adoption order must include the first page with filing date stamp and the final page with judge's signature.

Ambulatory Surgical Center: A permanent freestanding facility, other than the private office of a Physician, which satisfies all of the following conditions:

- The facility is licensed or accredited by a government or professional accrediting organization such as the Joint Commission on Accreditation of Healthcare Organization (JCAHO), American Association of Ambulatory Health Care (AAAHC), or by the Health Care Financing Administration (HCFA) under Title XVIII of the Social Security Act;

- The facility is established and operated to provide an environment for the performance of minor surgical procedures on an Outpatient basis and has equipment and supplies not normally found in the office of a Physician, including supplies of blood, drugs and equipment adequate for the surgeries performed and for emergencies which may occur in connection with such surgeries;

- The facility maintains equipment including fully-equipped operating rooms, monitoring equipment and post-anesthesia recovery rooms. Furthermore, the facility maintains an appropriately organized medical staff including supervisory Physicians, anesthesiologists and registered nurses trained in operating room and recovery room techniques;

- The facility has a written agreement with at least one licensed acute care general Hospital within a reasonable distance providing for the immediate transfer and acceptance of patients requiring post-operative Hospital confinement. (Such agreement shall provide for the transmittal of complete patient information at the time of transfer, and the Hospital shall have the right to review care rendered in the ambulatory surgical facility);

- Each patient is admitted by authority of the medical staff of the facility and supervised by a member of that staff. Complete medical records are maintained for each patient and shall include admitting diagnosis, physical examination report, medical history, laboratory and X-ray reports, operative reports, anesthesia records and discharge summary. The facility, furthermore, has an active Utilization Review Program; and

- Members of the medical staff of the facility are also members of the medical staff of an acute care general Hospital in the community.

Assignment of Benefits: Authorization by the Covered person for benefits to be paid directly to the qualified care Provider

Calendar Year: Any one (1) year period commencing on January 1, and ending on December 31. However, when a person first becomes Covered by the Plan, the first Calendar Year begins for him or her on the effective date of his or her coverage and ends on the following December 31.

Case Management: Case Management is a voluntary, at no charge program for Participants and/or their covered Dependents. The purpose of Case Management is to provide assistance in coordinating plan benefits with the medical providers involved in the treatment plan.

In addition to the definitions provided throughout this Plan Document, the following terms also apply to the Plans provided by the Trust. (These definitions do not apply to the **Life Insurance** chapter of this Plan Document, or to the **HIPAA Notice of Privacy Practices** located in the **Legal** chapter of this Plan Document, both of which contain their own definitions.)

Certificate of Registered Domestic Partnership: The Certificate of Registered Domestic Partnership from the state of Nevada certifies the Participant and his or her partner meet the criteria to be eligible for the benefit.

Certified Birth Certificate: This document includes at least one or both of the parents' names, issued by either the state or county of birth. If the Birth Certificate is from a foreign country, a translation must accompany the Birth Certificate. The Trust will not pay for the translation. Birth Certificates issued by a hospital are not acceptable.

Certified Marriage Certificate: A certified marriage certificate refers to a document issued by the county, state, or country where the ceremony was performed. It must have a stamp or seal and signature showing the marriage has been recorded.

Chemical Dependency: A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) criteria.

COBRA: Group health care plan continuation coverage required by the Consolidated Omnibus Budget Reconciliation Act of 1986, including any amendments as may be adopted from time to time.

COBRA Election Form: Form completed by the participant for plan selection and names of dependent(s) who will be covered under COBRA.

Coinsurance: Coinsurance is the percentage of the Eligible Medical Expenses (EME) that you pay for a particular service.

Consent to Discuss/Disclose PHI: Form completed by the participant that allows the Trust to discuss protected health information with individuals the participant chooses.

Contracted: A term that refers to a Provider who is part of the Trust's In-Network Provider group.

Coordination of Benefits (COB) Form: Form used to determine if a participant has insurance coverage through a company other than the Trust.

Copayment: The fixed amount that you pay for a particular service you received from an In-Network Provider.

Court-Ordered Documentation of Guardianship: Court document including the first page showing the filing date stamp and the last page with the judge's signature.

Covered: Covered expenses are the eligible dental and Eligible Medical Expenses (within the Plan's limits) for those services and supplies specifically described under the terms and conditions of the Plan. Expenses for a work-related Illness or Injury will be excluded from the Trust Plan if a claim could be made under the workers' compensation provision of the appropriate jurisdiction.

Covered person means an Eligible Employee or Eligible Dependent of an Eligible Employee enrolled in a Trust Plan.

Day Surgery: Elective surgical procedures performed in an approved facility, including a Physician's office, which do not require confinement in a Hospital as a registered bed patient.

Deductible: When the Participant is receiving Out-of-Network services, the amount of money a Participant must pay before the Trust will pay.

Divorce Decree: A legal document issued by a court which terminates the marriage relationship.

In addition to the definitions provided throughout this Plan Document, the following terms also apply to the Plans provided by the Trust. (These definitions do not apply to the **Life Insurance** chapter of this Plan Document, or to the **HIPAA Notice of Privacy Practices** located in the **Legal** chapter of this Plan Document, both of which contain their own definitions.)

Eligible Dental Expenses (EDE): The Eligible Dental Expenses (EDE) are the amounts of the dental Provider's billed charges that the Trust will consider for payment.

Eligible Medical Expenses (EME): The Eligible Medical Expenses (EME) are the amounts of the Provider's billed charges that the Trust will consider for payment.

Emergency Services: Medically Necessary services received in connection with an unforeseen Injury or Illness requiring surgical or medical attention within 24 hours after the onset. In the absence of such care, the Covered employee or Covered Dependent could reasonably be expected to suffer serious physical impairment or death.

Experimental Treatment: Any accommodations, services, supplies or other items that are determined, in conjunction with the terms and conditions of these Plan, to be a medical, Mental Health, or Chemical Dependency procedure or treatment:

- that is not recognized as conforming to accepted medical, Mental Health, or Chemical Dependency practice as defined by the Health Care Finance Administration (HCFA);
- in which the scientific assessment of the technique, or its application for a particular condition, has not been completed or its effectiveness has not been established; and
- for which the required approval of a governmental agency has not been granted at the time the services are rendered.

Such determination will be made by the Trust with reference to current applicable literature, federal and state laws and regulations and HCFA guidelines.

Extended Network Benefit: The Extended Network Benefit is applicable to all Out-of-Network services for the PERFORMANCE PLUS PLAN that cannot be performed within the Teachers Health Trust Network, including the UCLA Medical Center Network. The benefit is only applied prior to services being performed and billed to the Trust.

The Plan will consider medically necessary inpatient and outpatient facility services at an allowance of two (2) times the Trust's eligible medical expense (EME) amount. If EME is not established, 70% of billed charges will be considered the EME. This EME will be paid at 100 percent after the Out-of-Network deductible ($2,500) has been satisfied. All professional charges and other services will be subject to the EME amount as established by the Teachers Health Trust. The participant will be responsible for all amounts over the Trust EME amount and any non-covered services.

Generic Drug: A drug that contains the same active ingredients as—and is equivalent in strength and dosage to—the original brand-name drug

Genetic Counseling: A genetic counselor assists with any ethical or psychological problems that arise for a patient as a result of genetic testing.

Genetic Testing: Genetic testing analyzes samples of blood, hair, skin, amniotic fluid or other tissue to diagnose vulnerabilities to inherited diseases. Usually, testing is used to find changes that are associated with inherited disorders. The results of a genetic test can confirm or rule out a suspected genetic condition or help determine a person's chance of developing or passing on a genetic disorder.

Global Copay: A single copay which combines several different copay amounts for services provided, resulting in one flat rate. An example of where global copays may be applied include cases where a surgical service includes a surgeon, assistant surgeon, anesthesiologist and in-patient stay.

Illness: A bodily disorder, disease, physical sickness, or pregnancy of a Covered person. A recurrent Illness is considered an Illness

In addition to the definitions provided throughout this Plan Document, the following terms also apply to the Plans provided by the Trust. (These definitions do not apply to the **Life Insurance** chapter of this Plan Document, or to the **HIPAA Notice of Privacy Practices** located in the **Legal** chapter of this Plan Document, both of which contain their own definitions.)

Incarcerated: Police officers and other law enforcement officers are authorized by federal, state and local lawmakers to arrest and confine persons convicted of crimes. This confinement, whether before or after a criminal conviction, is called incarceration.

Injury: A physical harm or disability that is the result of a specific unexpected incident caused by an external force. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include Illness or infection of a cut or wound.

In-Network Provider: An In-Network Provider is within the Trust's approved list of Providers. Generally, the In-Network Provider maintains a contract with the Trust to provide you with negotiated fees for their medical services. Those negotiated fees are the basis for the Eligible Medical Expenses (EME) listed throughout the Medical chapter.

Using an In-Network Provider for your health care services will help keep your personal expense down. You can find out if your Provider is an In-Network Provider by accessing the Trust's website at **www.teachershealthtrust.org**.

In-Network Retail Pharmacies: Independently owned Pharmacies and chain Pharmacies which are contracted by MedImpact on behalf of the Trust. A list of In-Network Pharmacies is available on MedImpact's website at **https://mp.medimpact.com**.

Inpatient: A stay for which at least one (1) day's room and board is charged; an individual confined to a facility or residential center for at least one day when room and board is charged.

Internal Administrative Guidelines: The Trust's internal written policies that clarify certain provisions of this Plan Document and/or that define administrative procedures used to determine eligibility, enrollment and claims administration

Mail Order Pharmacy: A pharmacy owned and operated by CVS Caremark which is used primarily for filling maintenance medication for treatment of on-going health conditions, such as high blood pressure. All medications are delivered, postage paid, to your home.

Medically Necessary Treatment: Any health care service and/or supplies required to preserve the Participant's health which meet the following guidelines:

- Consistent with the symptoms or diagnosis and treatment of the Participant's illness or injury;
- Appropriate with regard to standards of good medical practice;
- Not solely for the convenience of the Participant, his or her physician, hospital, other Providers, or family;
- The most appropriate supply or level of service which can be safely provided to the Participant;
- Not educational or experimental or designed primarily for medical research;
- The appropriate amount in order to safely preserve the Participant's health.

Services, supplies, and accommodations will not automatically be considered Medically Necessary because they were prescribed by a physician. The Trust may consult with professional medical consultants, peer review committees or other appropriate sources for recommendation regarding the Medical Necessity of the services, supplies or accommodations a Participant receives.

Medicare: The basic Hospital portion (Part A), voluntary supplemental medical portion (Part B), and Medicare + Choice (Part C) of Title XVII of the Social Security Act ("Federal Health Insurance for the Aged Act"), including any amendments as may be adopted from time to time.

Mental Health: Nervous and mental disorders which are defined by the American Psychiatric Association to include, but not limited to, a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind. Diagnosis of these conditions will be determined based on standard DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) criteria.

Non-Preferred Drugs: Drugs that are not on the Preferred Drug list. The Copayments for Non-Preferred Drugs are higher than the Copayments for Preferred Drugs.

In addition to the definitions provided throughout this Plan Document, the following terms also apply to the Plans provided by the Trust. (These definitions do not apply to the **Life Insurance** chapter of this Plan Document, or to the **HIPAA Notice of Privacy Practices** located in the **Legal** chapter of this Plan Document, both of which contain their own definitions.)

Nurse-Midwife: A person certified to practice as a Nurse-Midwife, who has an active license as a registered nurse granted by a board of nursing and who has completed a state-approved program for the preparation of Nurse-Midwives. A certified Nurse-Midwife may, under the supervision of a licensed Physician (this does not require the physical presence of the supervising Physician), attend cases of normal childbirth and provide prenatal, intrapartum and postpartum care including family planning care for the mother and immediate care for the newborn. A Nurse-Midwife may assist a woman in childbirth as long as progress meets criteria accepted as normal. These services may be performed in a variety of settings.

Nurse Practitioner: A nurse who has specialized advanced skills in diagnosis, psychosocial assessment, and patient management and is permitted to prescribe certain drugs.

Out-of-Network Provider: An Out-of-Network Provider is not on the Trust's approved list of Providers. Since the Trust does not have negotiated fees with Out-of-Network Providers, your personal expense for Out-of-Network services will be much greater than your expense for In-Network services. This is also applicable to any providers outside of the United States. Additionally, any foreign language translations of the billed services or medical records will be the participant's responsibility.

Out-of-Network Retail Pharmacies: Independently owned pharmacies and chain pharmacies which are not contracted by MedImpact on behalf of the Trust.

Outpatient: A Covered person who is treated at a Hospital as other than a registered bed patient, at a Physician's office, or at an Ambulatory Surgical Center. Confinement is less than twenty-four (24) consecutive hours.

Participant: An Eligible Employee, Eligible Retiree or Eligible Dependent covered under a Trust health plan.

Patient Centered Medical Home: The Patient Centered Medical Home (PCMH) is a health care delivery model that provides primary health care that is coordinated and focuses on quality and safety while improving accessibility. It is not a physical place; it is the way your healthcare is accessed.

Your assigned/chosen PCMH provider will be a Primary Care Physician (PCP), Family Practice, Internal Medicine, or Pediatrician Provider. Women may also choose to have an OB/GYN as her second PCMH physician. Services provided within the PCMH by your PCMH Provider are defined only as approved office, consult, and preventive services. Services included in the 'Office Visit Co-Pay' include charges for the office visit or consult only. 20% coinsurance applies to all other services such as, but not limited to, urinalysis, pulse oximetry, administration of injections, medications, procedures, surgery, and testing.

Physician or Practitioner: A Doctor of Medicine (MD) or a Doctor of Osteopathy (DO) licensed to practice medicine in all its branches, prescribe and dispense all drugs, and perform all surgery under applicable laws of the place where treatment is rendered.

An individual Provider, including but not limited to a podiatrist, chiropractor, psychologist or clinical psychologist with Ph.D. degree, clinical social worker with masters degree (MSW), dentist, optometrist, dispensing optician, Nurse-Midwife, licensed physical therapist; speech therapist; audiologist; occupational therapist, or certified marriage, family and child therapist, but only when:

- The Provider is qualified and duly licensed or certified to practice in the state in which care is provided;
- The services rendered are within the scope of that Provider's license;
- The services rendered are a Covered benefit under the Plan; and
- Benefits would be payable if the services were provided by a Physician as defined above.

Plan: Any health plan offered by the Teachers Health Trust to an Eligible Employee, Eligible Retiree and/or his/her Eligible Dependent(s).

Plan Document (PD): This Teachers Health Trust Employee Benefits Plan Document.

In addition to the definitions provided throughout this Plan Document, the following terms also apply to the Plans provided by the Trust. (These definitions do not apply to the **Life Insurance** chapter of this Plan Document, or to the **HIPAA Notice of Privacy Practices** located in the **Legal** chapter of this Plan Document, both of which contain their own definitions.)

Preferred Drugs: Drugs that have been carefully selected based on their clinical effectiveness and cost savings to you and the Trust. The Copayments for Preferred Drugs are lower than the Copayments for Non-Preferred Drugs. A list of Preferred Drugs is sometimes known as a "Formulary."

Prenatal Care: Care of the woman during the period of gestation. It consists of periodic examinations for determination of blood pressure, weight, changes in the size of the uterus, condition of the fetus; urinalysis; instruction in nutritional requirements, preparation for labor and delivery, care of the newborn; and provision of suggestions and support to deal with the discomforts of pregnancy. Scheduled visits at regular intervals offer the opportunity to detect any unusual changes in the condition of the mother and/or fetus so the necessary treatment can be instituted.

Prenatal Care Physician (PCP): Your selected physician from the approved list of in-network Family Practice, Internal Medicine, Pediatric and/or OB/GYN providers.

Primary Eye Care (PEC): The Vision Service Plan (VSP) program for plan coverage under the Trust's Vision Plan, which is provided by VSP in-network optometrists who perform services optometrists are licensed to perform, including (but not limited to) treatment of symptoms such as ocular discomfort or pain, transient loss of vision, flashes, floaters, ocular trauma, recent ocular foreign body sensation, red eyes, and pain in or around the eye as well as treatment of conditions such as pinkeye, sties, corneal abrasions, and glaucoma.

Provider: Any facility, Physician, Practitioner, Nurse Practitioner, Physicians Assistant or other person who or which is qualified and duly licensed or certified by the state in which it is located to furnish services to you.

Psychosocial Rehabilitation: Psychosocial Rehabilitation Services (PSR) are interventions that are rooted in social, behavioral, educational, vocational and cognitive principles that address the deficit of an individual from a social rather than medical approach. The emphasis is on the direct environment of the individual which includes the immediate and extended family, education or work-related activities, and social support.

Qualified Beneficiary: An individual who is entitled to elect to receive continuation coverage under COBRA as a result of a loss of employer-provided group health coverage; and/or an individual eligible for benefits under the Women's Health and Cancer Rights Act of 1998.

Qualifying Event: An event which gives a Qualified Beneficiary the right to retain coverage under a Trust Plan in accordance with COBRA.

Reside within the Service Area: You and your Dependents live or work in the Service Area at least nine months of each Calendar Year and you and your Dependents have not moved out of the Service Area prior to receiving Services.

Routine Vision Care: A vision exam conducted for the purpose of determining a prescription level and choosing materials such as contacts or glasses.

Service Area: Generally, the Service Area is the area in which the Trust maintains contracts with In-Network Providers. The Service Area includes the following locations and their immediate surroundings:

- Clark County, Nevada (including Henderson, Las Vegas, Laughlin, Logandale, Mesquite, and Overton)
- Bullhead City, Arizona
- St. George, Utah

Locations may be added or deleted from the Service Area, depending upon the availability of In-Network Providers. To confirm a Provider's In-Network status, log on to the Trust's website at **www.teachershealthtrust.org**.

In addition to the definitions provided throughout this Plan Document, the following terms also apply to the Plans provided by the Trust. (These definitions do not apply to the **Life Insurance** chapter of this Plan Document, or to the **HIPAA Notice of Privacy Practices** located in the **Legal** chapter of this Plan Document, both of which contain their own definitions.)

Specialty Laboratory/Pathology: Any Laboratory or Pathology Testing requested by an In-Network Provider that cannot be performed In-Network and for which no similar test is available In-Network.

Spouse: A man or a woman who is legally married to a person. This does not include common law marriage.

Surgery: The use of operative manual and instrumental techniques on a patient to investigate and/or treat a pathological condition such as disease or injury, or to help improve bodily function or appearance. May include incision, scopes, plastic repair, amputation, laser robotics and microscope.

Tertiary Care Center: A major hospital equipped with personnel and facilities to perform highly specialized investigation and treatment.

Trust: The Teachers Health Trust.

Two CCSD Employees Form: Form completed by both employees to combine plans to take advantage of premium savings. CCSD licensed employees must either be married or domestic partners in order to combine plans.

Urgent Care: Any Medically Necessary service received for an Injury or Illness of a less serious nature than Emergency Services which are required to prevent a serious deterioration in the patient's health.

Waiver of Coverage Statement: Form signed by Participant which waives all coverage offered by the Trust. This includes the Life Insurance Benefit.

Ward of the State/Court: A participant who is temporarily or permanently in the custody of, or committed to, a public or private agency through the action of the court.

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IMPORTANT PHONE NUMBERS

Teachers Health Trust

702-794-0272
service@teachershealthtrust.org
www.teachershealthtrust.org

MEDICAL PRIOR AUTHORIZATION

WellHealth Quality Care
702-832-4658 (local)
844-586-2244 (toll-free)
702-318-2404 (fax)

Prior Authorization for medical services covered under the PERFORMANCE PLUS PLAN
(see **Prior Authorizations** in the **Medical** chapter of this Plan Document)

MENTAL HEALTH/CHEMICAL DEPENDENCY PRIOR AUTHORIZATION

Human Behavior Institute (HBI)
702-248-8866 or 800-441-4483

Prior Authorization of mental health and chemical dependency services covered under the PERFORMANCE PLUS PLAN
(see **Prior Authorizations** in the **Medical** chapters of this Plan Document)

PRESCRIPTION DRUG PLAN INFORMATION

MedImpact
844-336-2676
https://mp.medimpact.com

Mail Order
CVS/Caremark
855-298-2486
www.caremark.com

PERFORMANCE PLUS PLAN information regarding mail order procedures, In-Network Pharmacies, Preferred or Non-Preferred Drugs, Copayments or ordering new ID cards

VISION SERVICE PLAN INFORMATION

Vision Service Plan (VSP)
800-877-7195
www.vsp.com

Information regarding In-Network Providers, benefits, billing and reimbursement