HEALTH TRAXX

A Publication for Teachers Health Trust Participants

Volume 14, Issue 4
For Teachers by Teachers

Special 2016 Open Enrollment Edition

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HEALTH TRAXX
The Teachers Health Trust
Quarterly News Publication

Health Traxx is published quarterly by the Teachers Health Trust to help participants make life-saving decisions about health care. Although editorial content is based on sound medical information, we ask that you consult a health care professional regarding all medical concerns. We encourage you to keep copies of this news publication for the purpose of building a handy home medical reference guide or to recycle issues to friends and family.

Any opinions expressed by an author/source whose article appears in this publication are solely the opinions of the author/source and do not necessarily reflect the views of the Trust. If you have questions or comments regarding this issue, e-mail the Trust at **wellness@teachershealthtrust.org** or write to:

Teachers Health Trust
c/o Philip DiGiacomo
P.O. Box 96238
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A Message from the CEO

Thank you for attending our Teachers Health Trust Open Enrollment Sessions. Here is what to expect:

The Teachers Health Trust (Trust), WellHealth Quality Care (WellHealth) and the Clark County Education Association (CCEA) will guide you through our presentation on the new Performance Plus Plan. During this presentation, all three organizations will take some time to introduce the new plan and how the partnership between the Trust and WellHealth was forged as a way to ensure you continue to receive the quality health care you have come to expect.

Our partners at WellHealth will also be utilizing this time to explain the Patient Centered Medical Home model of health care, how it works and their role in assisting you to manage this cutting-edge approach to health care management.

CCEA will also take some time to bring you up to date on the months of negotiations and discussion that led to the plan we are presenting.

Finally, we will be taking some time to address many of the most common questions that the Trust has received since the announcement of the new plan.

In addition to the aforementioned topics, we will also be providing you with:

- A detailed explanation on how to re-enroll yourself and your dependents online.
- A list of In-Network Patient Centered Medical Home Providers will be available in order for you to select your primary care provider for yourself and your dependents.
- A chance to meet and greet some of our network providers after the presentations.

If all of your questions and concerns are not addressed during the presentation, an index card will be made available to you in order to submit them to the Trust. We assure you that your questions will be addressed within three business days.

Please note that if you and your dependents are currently enrolled in a Teachers Health Trust Plan, eligibility documents are ***NOT*** required.

We know that this change has not always been easy, but our number one priority has been to minimize any disruption of care for you and your family. While any change is always difficult, the Trust was not going to be able to continue beyond 2015 unless we found a way to provide an improved healthcare delivery model. We sincerely believe that this new model will allow us to remain fiscally viable and responsible, while at the same time providing quality health care.

Thank you for your time and cooperation.

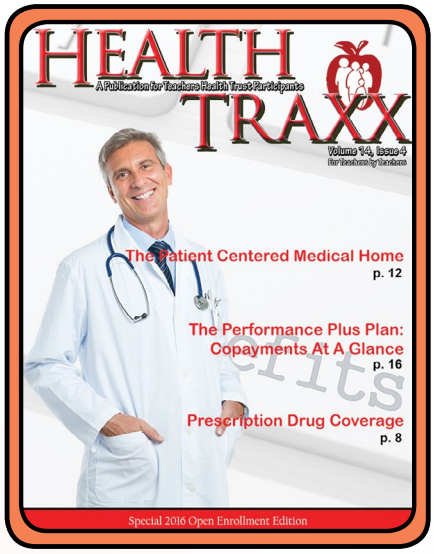
Sincerely,

Chief Executive Officer
October, 2015

What's Inside

2016 Health Care Benefits Updates Overview

The Teachers Health Trust continuously works to ensure that a proper balance between the benefits offered and their cost is maintained. Additionally, the Trust considers it pivotal that all of our participants receive information about the annual updates and adjustments that are important to managing the health care for themselves as well as their families. For this reason, the Trust has included information about updates to your benefits that are pertinent to you and your family.



Our current partnership with WellHealth Quality Care is designed to help us continue the balance of benefits and cost. Needless to say, though, while this partnership will serve to benefit you and your family, there are numerous important changes that you will need to become familiar with in order to manage your family health care.

Please carefully review the following pages for the effective dates of plan changes that may require action by you to ensure a smooth transition for you and your dependents. If you have any questions or require additional information, please contact the Service Department at 702-794-0272 or 800-432-5859 between 7:00 a.m. and 5:45 p.m., Monday through Thursday, and 9:00 a.m. and 11:45 a.m., Friday. You may also e-mail the Service Team at serviceteam@teachershealthtrust.org.

What is the Teachers Health Trust

Who We Are

Teachers Health Trust is a non-profit, self-funded health trust which provides medical, dental and vision benefits to all licensed employees of the Clark County School District.

Mission Statement

To achieve proven excellence in the delivery of health and welfare benefits of the highest quality for our participants.

Objectives

The Teachers Health Trust objective adopted by the Trustees is to give participants the right to obtain accurate, readable information about all aspects of the health plan. We believe that with good information, participants will be able to decide how best to maximize their own health condition. We provide this opportunity by allowing participants to:

- Choose health care providers from a network of health care providers. Choice is imperative. It is our objective to provide choice. The Trust provides a broad array of choice that meets the specific needs of its participants.
- Access emergency health care when and where it is needed.
- Receive services to encourage early intervention and not to impede access to care because of cost. The Health Trust continues its efforts to contain all out–of–pocket costs to participants.

In addition, the Health Trust:

- Provides financial security to participants and their families by holding down health care costs.
- Promotes full participation by all participants as partners.
- Treats all participants with respect. It is important to work with each individual with full empathy and respect.
- Allows you access to all information concerning yourself and the Health Trust. All medical records will be treated with utmost confidentiality. The Trust encourages full access to information by participants.

Board of Trustees

The CCEA formed the Teachers Health Trust and established a Board of Trustees as the governing body. The CCEA President serves as a non-voting observer and appoints seven Trustees (all of whom are licensed employees) who serve a three–year term and may serve consecutive terms. The Chairperson is elected from among the Trustees of the Teachers Health Trust.

The Trustees establish policies, direct overall Trust operations, including employing professional staff to run the day–to–day operations, consider and approve changes in plan benefits, manage Trust funds, and approve Trust expenditures.

Your current Board of Trustees is made up by:

Michael Steinbrink, Chairperson; William Vick, Vice Chairperson; Carol Mondares, Secretary; Teresa Boucher; Dave Tatlock; Isela Stellato and Brad Truax.

Your current Trust Management Team is made up by:

Brenda Kelley, Chief Executive Office
Years of Service: 15

Felipe Danglapin, MS, PAHM; Chief Operating Officer
Years of Service: 15

Carol Dias, Director of Accounting & Eligibility
Years of Service: 7

Roni Miles, RN, BSN, CCM, Director of Case Management
Years of Service: 10

Joni Rechsteiner, Director of Claims Administration
Years of Service: 22

Lori Fletcher, Director of Internal Audit
Years of Service: 20

Lance Osweiler, Director of Information Technology
Years of Service: 21

Sheri Purtil, Director of Provider Relations & Contracting
Years of Service: 10

Candy Smith, Director of Member Services
Years of Service: 12

Philip DiGiacomo, MS; Director of Wellness and Comm.
Years of Service: 7

A Brief History of the Trust

How and Why the Teachers Health Trust Came to Be

Before the Teachers Health Trust was formed, benefits for licensed employees were managed by the Clark County School District (CCSD). In the period July 1982 to September 1983, there were three major premium increases – 23.9%, 17.9%, and 29.4%. These increases in the District–managed plan caused the Clark County Education Association (CCEA) to begin negotiations with the CCSD for a change. The result of these negotiations was the formation by CCEA of a welfare benefit trust. The purpose was to enable licensed employees to make decisions relating to their own welfare benefits.

The CCEA is the exclusive bargaining agent for licensed employees and the Teachers Health Trust is the exclusive employee welfare benefit carrier for these employees. The CCEA bargains with the District for funds to provide the basic individual benefits to licensed employees.

From 1983 to 1987, the Teachers Health Trust enjoyed stable rates for all licensed employees to the extent that it became feasible to add dental and vision benefits. In 1987, the Trust self–funded the medical indemnity plan and purchased stop–loss insurance to protect itself from catastrophic loss. The Teachers Health Trust was successful with this type of arrangement because it allowed the Trustees to purchase specific services directly from vendors. In 1990, the Teachers Health Trust's Board of Trustees decided to discontinue the services of its third–party administrator and to self–administer the health and welfare benefits.

As a self–administered plan, the Trust can focus on development of a full complement of benefits including medical, dental, and vision plans, as well as a term life plan specifically designed for its participants. However, all substantial changes in benefits and premium contributions must be negotiated between the District and CCEA and the District has the final decision to allow such changes.

Since January 1, 2002, Diamond PPO Plan participants have only seen one premium increase of $10.00 per participant per paycheck on September 1, 2014, while Platinum PPO Plan participants have never seen any premium increase since then. While the Trust has hardly increased its participants' contribution, the District contribution has not increased since July 1, 2008.

With our limited source of revenue, the Trust was able to maintain high quality healthcare benefits to its participants throughout the years due to its good relationship and favorable contract rates with our local healthcare providers and partners. The Trust also operates at a very low administrative cost, currently at less than 5% of its revenue, compared to the industry standard.

There is little doubt that the Teachers Health Trust has come a long way from its humble origins. One thing remains just as true today, though, as it was at the time of its formation. The Trust is, always has been and shall remain an institution for teachers by teachers. Maintaining its long and storied mission to achieve proven excellence in delivering the highest quality of health and welfare benefits for our participants remains at the forefront of all we do. We may not know what the next decade holds, but we are sure it will be full of a new set of milestones as the mission continues.

Accountability & Transparency

The Trust takes its responsibilities seriously on protecting your healthcare funds. Our financial statement was audited annually by an independent Certified Public Accountant. In addition to an annual financial audit, our claim system was also audited biennial by an independent healthcare claims auditor to guarantee that claims are paid timely and correctly according to our contracts. The Trust also contracted with investment managers, actuarial companies, benefit consultants, and pharmacy managers. The Trust's annual audited financial statements are also open to the public and were published on the Trust website at www.teachershealthtrust.org under Financials.

The table on the following page represents the audited financial results from the last five fiscal years:

AUDITED FINANCIAL RESULTS (In Millions)

	FISCAL YEAR 2014		FISCAL YEAR 2013		FISCAL YEAR 2012		FISCAL YEAR 2011		FISCAL YEAR 2010	
	Amount	%	Amount	%	Amount	%	Amount	%	Amount	%
ADDITIONS:										
Contributions	$143.01	96.1%	$138.94	96.9%	$141.56	97.8%	$144.42	94.8%	$143.93	96.5%
Investment Income	$3.12	2.1%	$1.95	1.4%	$0.20	0.1%	$3.91	2.6%	$2.90	1.9%
Other Income	$2.62	1.8%	$2.48	1.7%	$2.91	2.0%	$3.98	2.6%	$2.39	1.6%
Total Revenue	$148.75	100.0%	$143.38	100.0%	$144.67	100.0%	$152.31	100.0%	$149.23	100.0%
DEDUCTIONS:										
Insurance Premiums	$2.10	1.4%	$2.03	1.4%	$2.11	1.5%	$2.16	1.4%	$2.24	1.5%
Benefits Paid for Participants										
• Medical	$96.65	65.0%	$91.57	63.9%	$95.47	66.0%	$100.11	65.7%	$87.68	58.8%
• Prescription Drugs	$31.82	21.4%	$29.02	20.2%	$32.92	22.8%	$32.75	21.5%	$31.65	21.2%
• Dental	$12.90	8.7%	$12.34	8.6%	$12.62	8.7%	$12.56	8.2%	$11.38	7.6%
• Vision	$2.33	1.6%	$2.26	1.6%	$2.33	1.6%	$2.29	1.5%	$2.12	1.4%
	$143.71	96.6%	$135.19	94.3%	$143.34	99.1%	$147.71	97.0%	$132.82	89.0%
Administrative Expenses*	$6.82	4.6%	$7.56	5.3%	$7.86	5.4%	$7.95	5.2%	$8.28	5.6%
Total expenses	$152.63	102.6%	$144.77	101.0%	$153.31	106.0%	$157.82	103.6%	$143.34	96.1%
Net increase / (decrease)	($3.88)	-2.6%	($1.39)	-1.0%	($8.64)	-6.0%	($5.52)	-3.6%	$5.88	3.9%
Number of covered lives	36,762		35,569		35,865		35,812		34,322	

*NOTE: *Administrative expenses includes wellness and health education programs.*

Prescription Drug Coverage

The Teachers Health Trust will continue the partnership with MedImpact to provide your prescription benefits in 2016. This program is designed to provide high quality care while simultaneously helping to manage the increasing costs of prescription drugs.

Using Your Pharmacy Benefit Plan

1. Visiting Your Local Retail Pharmacy

The Trust Universal Card includes the information your pharmacy needs to process prescriptions with MedImpact. Please show the card to your pharmacist to assist in filling your prescription. **The pharmacy will be unable to fill your prescription without you first providing them with your insurance card.** Your network pharmacies are CVS, Lin's Supermarket (Overton, NV), Sam's Club, Vons and Wal-Mart.

If you choose to use MedImpact pharmacies other than those listed above, you will have a $10 Pharmacy Choice Fee in addition to the regular co-pay or co-insurance for covered drugs. For a complete listing of MedImpact pharmacies, visit mp.medimpact.com.

2. Filling Mail-Order Prescriptions

You can obtain a 90-day supply for maintenance medication(s) through CVS/Caremark. If you use mail-order, you can save money and time by having prescriptions for maintenance medication(s) delivered right to your home. To learn more about the mail-order program, you may visit CVS/Caremark online at www.caremark.com or speak to a representative by phone at 800-552-8159.

3. Filling Specialty Prescriptions

Your specialty pharmacy is CVS/Caremark. This program supports patients with complex health conditions who need injectable medications, or 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, physician's office or other designated location. For more information, you may visit the CVS/Caremark website at www.caremark.com or speak to a representative by phone at 800-552-8159.

4. Using the MedImpact Member Website and/or Mobile Patient Applications

Information to help you understand your prescription benefit and drug coverage details, along with formulary and pharmacy information, is available online through the MedImpact Member website and mobile applications. Go to the Member link at mp.medimpact.com and follow the registration prompts. Be sure to have your insurance card available during registration.

5. A Few Money-Saving Tips

- If the Dispense as Written (DAW) box on your prescription is marked, it will automatically be filled with a brand-name drug and you will be responsible for a higher cost. Ask your physician if a generic medication is available, if appropriate, as they will generally save you money.
- If a generic is not available and if appropriate, ask your physician to prescribe a drug on the preferred drug list. Preferred medications are generally less expensive than non-preferred medications. The preferred drug list can be found on either the Trust website (www.teachershealthtrust.org) or the MedImpact website (mp.medimpact.com).

Questions?

If you have a question about your pharmacy coverage, please contact a MedImpact Customer Representative by phone at 844-336-2676. MedImpact is available 24 hours a day, 7 days a week. You may also visit MedImpact online at mp.medimpact.com. For TDD assistance, please call 711, reference 1-844-336-2676 and you will be connected with an agent who can assist you. MedImpact is here to help you.

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Routine & Preventive Care Coverage

Essential Health Benefits

The services listed below are covered under the Preventive/Routine Care Benefit when no diagnosis is present. Prior authorization requirements established throughout the Teachers Health Trust Plan Document apply to all Preventive/Routine Care.

Preventive Health Services for Adults

- Abdominal Aortic Aneurysm Screening
- Alcohol Misuse Screening/Counseling
- Aspirin Use (to prevent cardiovascular disease)
- Blood Pressure screening for all adults
- Cholesterol Screening
- Colorectal Cancer Screening
- Depression Screening
- Diabetes (Type 2) Screening
- Diet Counseling
- HIV Screening
- Immunization Vaccines
- Obesity Screening/Counseling
- Sexually Transmitted Infection (STI) Prevention Counseling
- Syphilis Screening
- Tobacco Use Screening/Cessation Interventions

Preventive Health Services for Women

- Anemia Screening for Pregnant Women
- Breast Cancer Genetic Test Counseling (BRCA)
- Breast Cancer Mammography Screenings
- Breast Cancer Chemoprevention Counseling
- Breastfeeding Comprehensive Support/Counseling
- Cervical Cancer Screening
- Chlamydia Infection Screening
- Contraception: FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling
- Domestic and Interpersonal Violence Screening/ Counseling
- Folic Acid Supplements
- Gestational Diabetes Screening
- Gonorrhea Screening
- Hepatitis B Screening (Pregnant at 1st prenatal visit)
- HIV Screening/Counseling
- Human Papillomavirus (HPV) DNA Test
- Osteoporosis Screening
- Rh Incompatibility Screening
- Sexually Transmitted Infections Counseling
- Syphilis Screening
- Tobacco Use Screening and Interventions
- Urinary Tract/Other Infection Screening
- Well-woman Visits for recommended services for women under 65

Preventive Health Services for Children

- Alcohol and Drug Use Assessments for Adolescents
- Autism Screening for Children at 18 and 24 Months
- Behavioral Assessments
- Blood Pressure Screening
- Cervical Dysplasia Screening
- Depression Screening for Adolescents
- Developmental screening for children under age 3
- Dyslipidemia Screening
- Fluoride Chemoprevention Supplements
- Gonorrhea Preventive Medication (Newborns)
- Hearing Screening (Newborns)
- Height, Weight and Body Mass Index Measurements
- Hematocrit or Hemoglobin Screening
- Hemoglobinopathies or Sickle Cell Screening (Newborns)
- HIV Screening
- Hypothyroidism Screening (Newborns)
- Immunization Vaccines
- Iron Supplements (Ages 6-12 mos. at risk for anemia)
- Lead screening for Children at Risk of Exposure
- Medical History Throughout Development
- Obesity Screening/Counseling
- Oral Health Risk Assessment
- Phenylketonuria (PKU) Screening (Newborns)
- Sexually Transmitted Infection (STI) Prevention Counseling and Screening
- Tuberculin Testing
- Vision screening for all children

Many of the screenings listed above are inclusive as part of a single preventive care office visit. To review complete and detailed descriptions of screening/counseling requirements, age groups and vaccine types in respect to all preventive health services, please visit www.healthcare.gov/preventive-care-benefits.

Your Healthcare Delivery System

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Your healthcare, your voice! Healthcare Advocates are available to assist with any need you may have. Speak with an advocate today at (855)404-9355.

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My.WellHealthQC.com allows patients to access in-network providers, email health advocates, and read healthy living articles.

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The Patient Centered Medical Home

In Brief: What Does Being in a "Medical Home" Mean to Me

The medical home model is intended to improve the quality and coordination of care you receive by addressing concerns that patients experience with the traditional health care system. Unlike the traditional health care system, a Patient Centered Medical Home is not a physical location. It is a group of providers that you have chosen to become your partner in good health.

	Current Health Care System	Patient-Centered Medical Home Model
Continuity of Care	Care is fragmented; based on "today's visit" with "today's provider"	Care is coordinated; based on patient's health over time and across providers
Focus of Care	Illness-based through "sick visits"	Wellness-based through ongoing preventive care/screenings
Provider Payment	Based on number of visits/services provided	Based on performance related to quality & efficiency of care
Center of Care Model	Physician-centric; physician or NP/PA provides all care and follow-up	Patient-centric; physician leads a team that coordinates care, provides education, follows up on overdue services, etc.

History

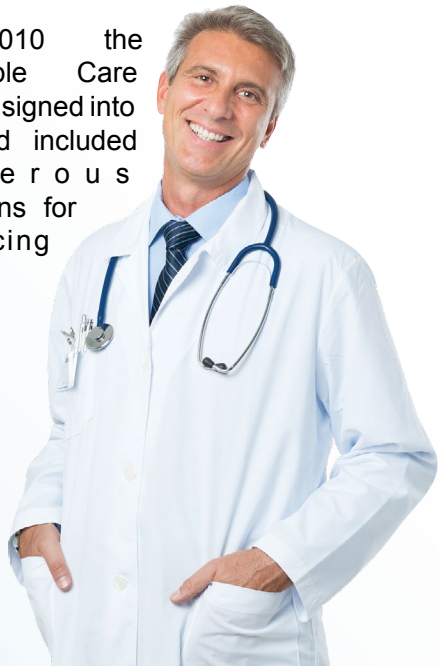
In the last decade Americans have engaged in a national conversation about reforming health care. Rapidly rising health care costs without an increase in health care quality has challenged employers and the federal government alike to finance ever increasing costs. Additional attention has recently focused on providing coverage for the uninsured as well. Increasing "out of pocket" costs for consumers has not addressed the problem of fragmented uncoordinated care, excessive waste, and skyrocketing costs. The system remains plagued by access and quality issues. In the United States roughly $700 billion is spent on unnecessary health care services. Recently, the Teachers Healthcare Trust (THT) and the Clark County School District (CCSD) has found themselves challenged by these same issues.

In response to these problems, a new model has emerged. What began in 2002 as a "personal medical home" evolved by 2007 into a comprehensive delivery model called the Patient Centered Medical Home (PCMH) that works to rein in costs, coordinate care and improve outcomes and overall satisfaction. Endorsed by the American Academy of Family Physicians, the American College of Physicians, The American Academy of Pediatrics, and the American Osteopathic Association, the PCMH connects patients to a primary care team that is responsible for providing seamless and coordinated care to help the patient navigate the increasingly complex health care system. The system becomes "patient centered" and not "doctor-centered". Furthermore, patients become engaged with their providers and become partners in their care.

How Did a Patient Centered Medical Home Come to Be?

The concept of a "medical home" was introduced by the American Academy of Pediatrics in 1967, and by 1992 it had evolved into a strategy for delivering family-centered, comprehensive, continuous, and coordinated care. A few years later, seven national family medicine organizations launched The Future of Family Medicine project and recommended that "every American [have] a personal medical home." In 2004, the medical home was credited for "better health, with lower overall costs of care and with reductions in disparities in health." In 2006 the Patient Centered Primary Care Collaborative (PCPCC) based in Washington D.C. was formed through funding by a group of large employers. This collaborative promoted the joint principles of the PCMH and continued to be a national advocate for this delivery model today. By 2009 PCPCC membership included over 500 employers, insurers, consumer groups, and doctors. In 2008 The National Committee for Quality Assurance (NCQA) launched PCMH accreditation programs.

In 2010 the Affordable Care Act was signed into law and included numerous provisions for enhancing



primary care and the PCMH. Further advancements in health information technology and innovative compensation models in the following years have led to significant growth in the PCMH in the United States.

The concept of Accountable Care completes the PCMH concept by ensuring the providers manage the full continuum of care and be accountable for the overall costs and quality of a defined population. The PCMH and the Accountable Care concept work together to enable delivery system changes that reduce the cost of health care while improving quality.

The Core Principles of the Patient Centered Medical Home

Personal physician – Each patient chooses and has an ongoing relationship with a personal physician who is trained to provide continuous and comprehensive care.

Physician directed medical practice – The personal physician leads his team of individuals at the practice level who collectively handle the ongoing care of patients and their outcomes.

Whole person orientation – The personal physician handles providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This encourages a compassionate, robust partnership between physicians, patients, and the patient's family.

Accessibility - Patients have access to same day appointments as necessary. PCMH also can minimize office wait times, and encourages extended office hours to help meet the needs of Clark County School District Teachers.

Care Coordination – The physician team coordinates across the elements of the complex healthcare system including referral tracking. Care is facilitated by advanced information technology to assure that patients obtain care when and where they need it. PCMH also supports the use of a Telemedicine program.

Quality – Patient care is physician directed using evidence-based guidelines and performance measures in delivering clinical services. Emphasis is on continual quality improvement activities and measurement.

Summary of the Patient Centered Medical Home

- ✓ Patients are more likely to seek the right care in the right place at the right time.
- ✓ Patients are less likely to seek care from an emergency room or leave conditions untreated.
- ✓ Providers are less likely to order duplicate tests, labs, or procedures.
- ✓ Better management of chronic diseases to improve health outcomes.
- ✓ Focused on wellness and prevention to reduce incidence and severity or chronic diseases.
- ✓ Cost saving results from (1) appropriate use of medication, and (2) fewer avoidable ER visits, hospitalizations, and readmissions.

Dr. Keith Boman,
CMO, WellHealth Quality Care

Prescription Drug Coverage & Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Teachers Health Trust and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Teachers Health Trust has determined that the prescription drug coverage offered by the Teachers Health Trust is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join A Medicare Drug Plan

If you decide to join a Medicare drug plan, your current Teachers Health Trust coverage will be affected.

If you do decide to join a Medicare drug plan and drop your current Teachers Health Trust coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) to Join A Medicare Drug Plan?

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and **each year from October 15 through December 7**. Beneficiaries terminating Trust active coverage may be eligible for a special enrollment period during which they may sign up for a Medicare prescription drug plan. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you drop or lose your coverage with Teachers Health Trust and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later. **Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.**

If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

88 papers passed out

17 minutes for assembly

5 parent drop ins

3 tutoring sessions

1 standardized test given

Just another day on the job.

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SB-26219-0813

The Performance Plus Plan

Copayments At-A-Glance
Effective 01/01/2016

This Copayments-At-A-Glance section provides important copayment and coinsurance information for the most commonly utilized benefits. We encourage all participants to visit www.teachershealthtrust.org to review the Plan Document for detailed information. The complete 2016 Plan Document will be available to all participants in the coming weeks.

	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible Maximum Per Individual	$600 Per Year	$2,500 Per Year
Calendar Year Deductible Maximum	$600 per family member annually, not to exceed $1,800 per family	$2,500 per family member per year, not to exceed $10,000 per family
Calendar Year Total Out-of-Pocket Maximum Per Individual	$6,850 Per Individual	No Maximum for Out-of-Network Providers
Calendar Year Total Out-of-Pocket Maximum per Family	$13,700 Per Year	No Maximum for Out-of-Network Providers

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.

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% co-insurance 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	$0 Co-pay, Office Visit (deductible does not apply)
PCMH Provider	$10 Co-pay for Office Visit (deductible does not apply) 20% co-insurance for all other services (deductible does not apply)
Specialist Physician	$20 Co-pay for Office Visit with referral (deductible does not apply) 20% Co-insurance for all other services (deductible does not apply)
Medical Home Identified Chronic Condition Patients (Primary Care or Specialist Physician Office Visit - Diabetes, High-Risk Pregnancy, Cardiovascular, COPD and Asthma)	$0 Co-pay Office Visit (deductible does not apply) 20% co-insurance for all other services (deductible does not apply)
In-Office Surgery, without Anesthesiologist	20% co-insurance (deductible does not apply if at a Medical Home provider and in conjunction with a Medical Home Office Visit; otherwise, deductible applies)
Obstetrics (full pregnancy/delivery care bundle - Normal Pregnancy)	$10 copay for office visits, 20% co-insurance for all other services (deductible does not apply)
Obstetrics (full pregnancy/delivery care bundle - High Risk Pregnancy, pregnancies identified as High Risk by PCMH Provider and enrolled and compliant in that PCMH extension)	$0 copay for office visits, 20% co-insurance for all other services (deductible does not apply)

ALL OTHER SERVICES PROVIDED OUTSIDE OF THE MEDICAL HOME

	IN-NETWORK	OUT-OF-NETWORK
Preventive Care	Not Covered Outside the Medical Home	Not Covered for Out-of-Network Providers
Primary Care Physician	20% co-insurance after deductible	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*

ALL OTHER SERVICES PROVIDED OUTSIDE OF THE MEDICAL HOME	IN-NETWORK	OUT-OF-NETWORK
Specialist Physician	WITHOUT REFERRAL 20% co-insurance after deductible	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Office Surgery	WITHOUT REFERRAL 20% co-insurance after deductible	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Obstetrics (Full Pregnancy/Delivery Care Bundle - Normal Pregnancy)	20% co-insurance after deductible	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Obstetrics (full pregnancy/delivery care bundle - High Risk Pregnancy, pregnancies identified as High Risk by PCMH Provider and enrolled and compliant in that PCMH extension)	20% co-insurance after deductible	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Anesthesia	WITH OR WITHOUT REFERRAL 20% co-insurance after deductible	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Facility (Includes Skilled Nursing & Mental Health/Chemical Dependency Facilities, Inpatient, Outpatient, Ambulatory Surgical Center, Long-Term Acute Care, or Acute Rehabilitation) **Daily flat rate does not apply to all other outpatient services, such as but not limited to; clinics, radiation, radiology services, chemotherapy, sleep studies, physical therapy.**	WITH OR WITHOUT REFERRAL $400 per day; $800 Max Per Stay (deductible does not apply) 20% co-insurance	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses* 20% co-insurance
Home Health/Hospice/Infusion	WITH OR WITHOUT REFERRAL 20% co-insurance (deductible does not apply)	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Durable Medical Equipment - prosthetics & orthotics, including foot orthotics	WITH OR WITHOUT REFERRAL 20% co-insurance (deductible does not apply)	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Ambulance	NO REFERRAL REQUIRED 20% co-insurance (deductible does not apply)	20% co-insurance (deductible does not apply)
Urgent Care	NO REFERRAL REQUIRED $50 co-pay (deductible does not apply)	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Minute Clinics	NO REFERRAL REQUIRED $15 co-pay (deductible does not apply)	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
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% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Laboratory	WITH OR WITHOUT REFERRAL $0 co-pay at Quest Diagnostics	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*

ALL OTHER SERVICES PROVIDED OUTSIDE OF THE MEDICAL HOME	IN-NETWORK	OUT-OF-NETWORK
Radiology (All other radiology services not listed above)	**Freestanding Diagnostic Facility (Steinberg):** $0 copay (deductible does not apply) **Hospital/Facility:** 20% coinsurance (deductible does not apply) **PCMH Office:** Not covered **All Other In-Network Providers:** Not covered	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
CAT Scan	**Freestanding Diagnostic Facility (Steinberg):** $50 copay (deductible does not apply) **Hospital/Facility:** 20% coinsurance (deductible does not apply) **PCMH Office:** Not Covered **All Other In-Network Providers:** Not Covered (deductible does not apply)	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
MRI	**Freestanding Diagnostic Facility (Steinberg):** $75 copay (deductible does not apply) **Hospital/Facility:** 20% coinsurance (deductible does not apply) **PCMH Office:** Not Covered **All Other In-Network Providers:** Not Covered (deductible does not applicable)	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
PET Scan	**Freestanding Diagnostic Facility (Steinberg):** $200 copay (deductible does not apply) **Hospital/Facility:** 20% coinsurance (deductible does not apply) **PCMH Office:** Not Covered **All Other In-Network Providers:** Not Covered	40% co-insurance 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.***

Prior Authorization for medical necessity requirements will be made available in the full 2016 Plan Document.

ADDITIONAL LINE ITEMS	IN-NETWORK	OUT-OF-NETWORK
Acupuncture	WITH OR WITHOUT REFERRAL $20 co-pay (deductible does not apply), Limit of 20 visits per year	40% co-insurance after deductible, plus any charges over Eligible Medical Expenses*
Assistant Inpatient Surgeon	WITH OR WITHOUT REFERRAL 20% co-insurance after deductible	
Assistant Outpatient Surgeon	WITH OR WITHOUT REFERRAL 20% co-insurance after deductible	
Chemical Dependency, Mental Health Office Visit, Therapy	WITH OR WITHOUT REFERRAL $20 co-pay (deductible does not apply)	
Chemotherapy	WITH REFERRAL $20 co-pay (deductible does not apply) WITHOUT REFERRAL 20% co-insurance after deductible	
Chiropractic	WITH OR WITHOUT REFERRAL $20 co-pay (deductible does not apply), Limit of 20 visits per year	
Diabetic Education	WITH REFERRAL $0 co-pay (deductible does not apply) WITHOUT REFERRAL 20% co-insurance (deductible does not apply)	
Diagnostic Interpretation	NO REFERRAL NEEDED $0 co-pay	
Dialysis	WITH OR WITHOUT REFERRAL $20 co-pay (deductible does not apply)	
Hearing Aids	NO REFERRAL NEEDED Plan pays $1,000 per ear, every 5 years (deductible does not apply)	
In-Patient Routine Newborn Circumcision	NO REFERRAL NEEDED $20 co-pay (deductible does not apply)	
Inpatient surgeon	NO REFERRAL NEEDED 20% co-insurance after deductible	
Outpatient surgeon	NO REFERRAL NEEDED 20% co-insurance after deductible	
Inpatient Physician Visits	NO REFERRAL NEEDED 20% co-insurance after deductible	
Laboratory Pathology Interpretation	NO REFERRAL NEEDED $0 co-pay (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 co-pay (deductible does not apply), 20 Visits Per Year	
Prosthetic, Brace, Orthotic	NO REFERRAL NEEDED 20% (deductible does not apply)	
Radiation	WITH REFERRAL $20 co-pay (deductible does not apply)	
	WITHOUT REFERRAL 20% co-insurance after deductible	
Sleep Studies	WITH REFERRAL $75 co-pay (deductible does not apply) WITHOUT REFERRAL 20% co-insurance after deductible	
Transplant Services	$1,500 in addition to all other copayment/coinsurance	Not Covered

Performance Plus Plan: Dental & Vision

The Trust provides a Dental & Vision Plan for Participants—the Performance Plus Dental & Vision Plan. In-Network Services are available from providers 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 and vision services. Coverage under the Performance Plus Plan also includes orthodontia treatment. Participants enrolled in a Trust Medical Plan are automatically enrolled in the Dental and Vision Plan.

A few important things to be aware of about the Perfromance Plus Dental Plan include:

- There is one Dental/Vision Plan available.
- The plan has a $1,500.00 per calendar year maximum.
- All participants must have Medical, Dental & Vision.
- Dependents that have Dental/ Vision Only under the Diamond or Platinum Plans must enrolled in the Performance Plus Medical Plan.
- Orthodontia is included, a two-year waiting period applies. Time accrued for the two-year period under the Diamond Plan will carry over to the Performance Plus Plan.
- Two cleanings per calendar year are included.

YOU MUST FILE A REPORT ON ALL INJURIES AND/OR ILLNESSES INCURRED AT WORK WITHIN SEVEN DAYS!

Claims resulting from work-related injuries must be filed through your Workers' Compensation carrier, not the Teachers Health Trust. This includes, but is not limited to, coaching injuries, environmental illnesses, etc.

If you are injured on the job, 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.

If a timely-filed claim and all permissible appeals (including court reviews) are denied as not being work-related, the Trust will review your claims for payment. The Trust will not consider claims if Workers' Compensation denied them because you failed to file your claims in a timely manner.

Regardless of the severity or type, any injury or illness sustained on the job should be submitted to Workers' Compensation. Notify your administrator immediately and then call the School District's Risk Management office at 702-799-2967.

Notice of Privacy Practices for the Use and Disclosure of Private Health Information

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.

Effective Date: March 26, 2013

Teachers Health Trust (Trust) is required by law to maintain the privacy of Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This Notice of Privacy Practices (Notice) describes how we may use and disclose PHI to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. This Notice also describes your rights with respect to PHI about you.

The Trust is required to follow the terms of this Notice. We will not use or disclose PHI about you without your written authorization, except as described in this Notice. We reserve the right to change our practices and this Notice, and to make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised Notice to you.

Notice of PHI USES and Disclosures

Required PHI Uses and Disclosures.
Upon your request, the Trust is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Trust's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment, and health care operations.
The Trust and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Trust also will disclose PHI to the Teachers Health Trust for purposes related to treatment, payment and health care operations. The Trust Sponsor has amended its plan documents to protect your PHI as required by federal law.

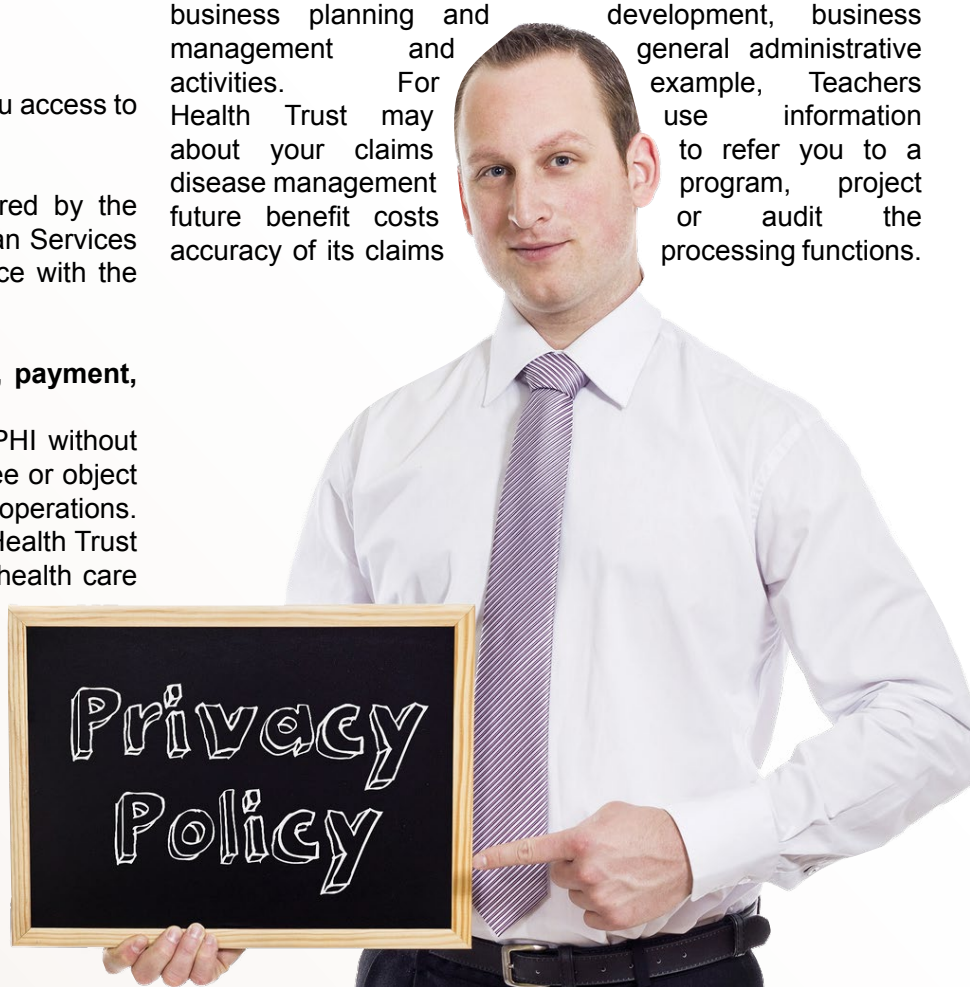
Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Trust may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

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 preauthorizations).

For example, Teachers Health Trust may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Trust.

Health care operations include but are 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 planning and development, business management and general administrative activities. For example, Teachers Health Trust may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.



2016 Annual Plan Legal Notices

This contains annual plan legal notices regarding Teachers Health Trust Plans. The following mandated notices are included:

- Special Enrollment Notice
- Health Insurance Portability and Accountability Act (HIPAA)
- General Notice of Pre-Existing Conditions
- Newborns' and Mothers' Health Protection Act of 1996
- Women's Health and Cancer Rights Act
- Patient Protection Disclosure
- California Maternity Coverage
- Premium assistance under Medicaid and CHIP
- Medicare Part D Notices Creditable/ Non-Creditable/Important notice regarding prescription drug coverage
- New Health Insurance Marketplace Coverage Options

Understanding Your Rights: Read All Notices

Special Enrollment Notice

If an eligible employee declines enrollment in this group health plan for the employee or the employee's spouse or dependents because of other health insurance or group health plan coverage, the eligible employee may be able to enroll him/herself and eligible dependents in this plan if the employee or dependents lose eligibility for the other coverage (or because the employer stops contributing toward this other coverage). However, the eligible employee must request enrollment within 30 days after the other coverage ends (or after the employer ceases contributions for the coverage).

In addition, if an eligible employee acquires a new dependent as a result of marriage, birth, adoption or placement for adoption, the eligible employee may be able to enroll him/herself and any eligible dependents, provided that the eligible employee requests enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. If the eligible employee otherwise declines to enroll, he/she may be required to wait until the group's next open enrollment to do so.

To request special enrollment or obtain more information, contact Service Department at (702) 794-0272 or e-mail serviceteam@teachershealthtrust.org.

Loss of Other Health Coverage

For purposes outlined above, loss of other health coverage is defined as an employee, or a dependent of an employee, losing other health coverage, therefore triggering a special enrollment opportunity in the group health plan. This may be a result of:

- The employee or dependent must have had other health coverage when he or she previously declined coverage under our group health plan.
- If the other coverage was COBRA continuation coverage, special enrollment can be requested only after the COBRA continuation coverage is exhausted.
- If the other coverage was not COBRA continuation coverage, special enrollment can be requested when the individual loses eligibility for the other coverage.

Health Insurance Portability & Accountability Act (HIPAA)

Teachers Health Trust recognizes the confidentiality of you and your enrolled dependents' personal health information, and we are committed to keeping that information private. In addition to our company's commitment, in April 2003, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) established privacy rules for individually identifiable health information.

The Standards for Privacy of Individually Identifiable Health Information (Privacy Rule) established a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services ("HHS") issued the Privacy Rule to implement requirements under HIPAA.

The Privacy Rule standards address the use and disclosure of individuals' health information—called "protected health information" by organizations subject to the Privacy Rule — called "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used.

A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and wellbeing. The Rule strikes a balance that permits

important uses of information, while protecting the privacy of people who seek care and healing.

General Notice of Pre-Existing Condition Exclusion

Effective for plan years beginning on, or after January 1, 2014, group health plans are not permitted to exclude individuals from coverage or limit or deny benefits on the basis of preexisting medical conditions. (The prohibition on exclusions of children under 19 years of age on the basis of pre-existing conditions began 6 months from the date the law was enacted.)

Newborns' and Mothers' Health Protection Act of 1996

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

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: Please refer to your benefit plan summary.

If you would like more information on WHCRA benefits, call your Plan Administrator or the health care plan whose number is located on the back of your ID card.

Patient Protection Disclosure – Notice of Right to Designate a Primary Care Provider

Your HMO plan (if applicable) 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, the plan or carrier designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, you may contact member services at the number listed on the back of your ID card.

You do not need prior authorization from your health plan 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 that 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 member services at the number listed on the back of your ID card. For children, you may designate a pediatrician as the primary care provider.

California Maternity Coverage

Group health plans and health insurance issuers with policies or contracts issued in the State of California generally may not, under California law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the law generally does not prohibit the mother's or newborn's treating physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In addition, California law requires the Plan to cover a post-discharge follow up visit for the mother and newborn within 48 hours of discharge when prescribed by the treating physician. The visit shall be provided by a licensed health care provider whose scope of practice includes postpartum care and newborn care. The visit shall include, at a minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The treating physician shall disclose to the mother the availability of a post-discharge visit,

including an in-home visit, physician office visit, or plan facility visit. The treating physician, in consultation with the mother, shall determine whether the post-discharge visit shall occur at home, the plan's facility, or the treating physician's office after assessment of certain factors.

These factors shall include, but not be limited to, the transportation needs of the family, and environmental and social risks.

Furthermore, the Plan may not:

- Reduce or limit the reimbursement of the attending provider for providing care to an individual enrollee in accordance with the coverage requirements.
- Provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual enrollee in a manner inconsistent with the coverage requirements.
- Deny a mother or her newborn eligibility, or continued eligibility, to enroll or to renew coverage solely to avoid the coverage requirements.
- Provide monetary payments or rebates to a mother to encourage her to accept less than the minimum coverage requirements.
- Restrict inpatient benefits for the second day of hospital care in a manner that is less than favorable to the mother or her newborn than those provided during the preceding portion of the hospital stay.
- Require the treating physician to obtain authorization from the Plan prior to prescribing any services covered by this section.

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low- Cost Health Coverage to Children and Families

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

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

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

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

To view the complete document for this notice, visit www.teachershealthtrust.org.

This is Healthcare. The WellHealth Way.

In 2011, WellHealth was established as Nevada's first and only commercial Accountable Care Network. Our network is built on a comprehensive healthcare delivery system, designed specifically to improve the patient, provider, and payor experience by delivering healthcare through a model driven by outcomes.

WellHealth approaches healthcare differently, because patients should never feel like a number. The Healthcare Industry is constantly changing and developing, and that affects every one of us. At WellHealth, we want to do more than just stand by as healthcare moves forward; we want to make healthcare easier for everyone involved.

We help families get the right care while avoiding frustrating and sometimes costly missteps along the way. We've built an approach that is personalizing healthcare again. We have created fast, easy access for patients. Healthcare should be about caring for one's health and nothing more.

This is Healthcare. The WellHealth Way.

Quick Facts About WellHealth Quality Care:

- WellHealth Quality Care is a healthcare delivery organization – NOT an insurance company.
- Healthcare Delivery Systems are NOT mandated by the healthcare reform act.
- Our goal is to create positive and lasting change in the healthcare Industry by facilitating collaboration between all three elements of healthcare:Providers, Payors, and Patients.

Did you hear the joke?

"Where do you go for great health care in Las Vegas?"

"The Airport."

We did. We did not laugh. We simply accepted the challenge.

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- TEE
- Stress Echo
- Echocardiogram

Cardiology consultations also available at our Mesquite location.