Washoe County School District
Every Child, By Name And Face, To Graduation

Risk Management Office
425 East Ninth Street
PO BOX 30425
Reno, NV 89520-3425
(775) 348-0343

October 5, 2015

To: All Employees Eligible for District Health Insurance Coverage

Fr: Risk Management

Re: **Health Insurance, Voluntary Benefits & Section 125 Open Enrollment – Benefit Year 2016**

Open Enrollment will run from October 12 through November 25, 2015. During *Open Enrollment**,** you may:

1. Change your District health plan.
2. Add/delete dependents.
3. Apply for or change voluntary benefits.
4. Enroll for all Section 125 Benefits for 2016.

*All changes will be effective January 1, 2016.

Enclosed, you'll find information on the District's health plans, benefit comparisons of the plans, premium schedules, and summary information on other District-paid and voluntary benefits.

Important – All Section 125 Plan elections, including pretax premiums and flexible spending accounts, **must be renewed annually; your signature is required for all renewed options**. Therefore, to assist in the Section 125 Plan and voluntary benefits enrollment, the District will again use the services of American Fidelity. American Fidelity currently administers the District's Section 125 Plan and also offers several of the voluntary benefits available to you. **These changes will not be available through the Risk Management Office.**

The District will be providing Health Insurance exclusively through Renown Health and Hometown Health as the Third Party Administrator effective January 1, 2016. To assist you with this change, if you are currently covered on a CDS/St. Mary's EPO or PPO plan, you will be moved to the comparable plan under Renown/Hometown Health (HTH). For Instance, if you are currently on St. Mary's EPO plan, you will be placed on the Renown EPO Plan. If you wish to make a change between the EPO and the PPO plan with Renown/HTH, please make sure you meet with an American Fidelity Representative.

American Fidelity representatives will be at your work site on designated days. Please see your site administrator to schedule a specific time to meet with a representative. If you cannot meet with an American Fidelity representative when they are at your work site, you may schedule a time to meet with a representative at another work site by calling American Fidelity at 775/829-1313.

DISTRICT HEALTH PLANS
QUESTIONS & ANSWERS

IMPORTANT!

Please remember that you may earn a $40 per month premium discount if you complete Healthy Tracks on-line Health Appraisal by December 1, 2015.

The premium for your spouse, if covered by District medical insurance, may also be discounted by $40 per month by having your spouse complete Healthy Tracks on-line Health Appraisal by December 1, 2015.

Please note that if your health insurance coverage with the District became effective on or after April 1, 2015 you will not need to complete and submit a Health Appraisal and you will automatically receive the premium discount for 2016. However, you will need to complete this for the next year 2017.

For more information, please visit http://www.washoeschools.net/wellness

Have premiums changed?
See the "Premium Schedule" on page 9.

What is the effective date of coverage changes? January 1, 2016

Are there any "Pre-existing Condition Limitations" if I change plans? No

What health plan options do I have to select from? The District offers **two** options. These include:

1. Renown (HTH) Group Health Plan (PPO) – Uses **Renown (HTH)** provider network
2. Renown (HTH) Exclusive Provider Plan (EPO) – Uses **Renown (HTH)** provider network

Can I select one plan for myself and a different plan for my dependents? No, dependents must take the same plan as the employee.

How do I change plans?

- Schedule a time to meet with an American Fidelity Representative when they are at your worksite.

How do I add and/or delete a dependent?

- Schedule a time to meet with an American Fidelity Representative when they are at your worksite.
  If you are adding dependents, you will need to provide their SSN's and verification of dependent status (marriage certificate, birth certificate or front page of last year's tax return). American Fidelity will not be able to assist you in adding a dependent if you do not have this information.

What is the Effective Date of Coverage if I add my dependent? January 1, 2016.

- **Is Evidence of Insurability Required?:** No
- **Are there Pre-existing Condition Limitations:** No there are no Pre-Existing Conditions.

To what age may I enroll/cover my child/children? Under the new Health Care Reform bill, you may cover your child/children up until age 26. They do not have to be a full-time student, living with you and/or dependent upon you for financial support.

How long will *Open Enrollment* last? From October 12, through November 25, 2015. After that date you will not be able to make a change until next year's Open Enrollment.

If enrolling family members, please include the appropriate documentation for eligibility verification: marriage/birth certificate, domestic partnership, or latest tax return.

Have questions? Call the Risk Management Office at 775/348-0343.

DISTRICT'S DENTAL PLAN

What type of plan is the District's Dental Plan?
It's a Self-funded Dental Plan with a Preferred Provider Dentist component.

Who processes the claims?

- Hometown Health, 830 Harvard Way, Reno, NV 89502; 775/982-3232; 800/336-0123

Are there any plan changes?
No

What happens if I don't use a Preferred Provider Dentist?
Any expenses from a non-preferred dentist that exceed the amount the plan would allow a preferred provider dentist would be your responsibility.

How do I find out if my dentist is on the PPO dentist list?
https://www.guardiananytime.com/#

Phone Number
888-600-9200

What is the annual limit?
$2,000 per person; Children up to age 19 - unlimited

What are the deductibles and co-insurance percentages for this plan?

- $50/member deductible
- Covers preventive care at 100% with no deductible
- Covers restorative care at 80% after deductible is met
- Covers major care at 80% after deductible is met

What are the premiums?
See the Premium Schedules on page 9. The premiums listed included both medical and dental premiums.

Are my dependents covered for dental?
Yes, if they are covered by a District medical plan.
Is orthodontia covered? No

RENOWN (HTH) PPO/EPO
HIGHLIGHTS

Benefits	*EPO Plans*	*PPO Plans*	
GAP Plan	GAP Plan will reimburse up to $1,000/inpatient hospital admit; up to $200 for certain outpatient services; and up to $25 per non-routine doctor's visit, outpatient services, X-ray & Lab services, or urgent care services ($125 maximum for all services/year/ family)		
		PPO PROVIDERS	**NON-PPO PROVIDERS**
Calendar Year Deductible: • Per Member • Per Family	NA	$500 $1,000	$1,500 $3,000
Out-of Pocket Maximum:	$3,000 per member	$3,000 per member $6,000 per family	$6,000 per member $12,000 per family
Inpatient Hospital Services	$1,250 co-payment/admit	80% After Deductible	50% of UCR After Deductible
Outpatient Surgery	$200 co-payment	80% After Deductible	50% of UCR After Deductible
Primary Care Physician Office Visit	$25 co-payment	$25 co-payment	80% of UCR After Deductible
Specialist Physician Office Visit	$30 co-payment	$35 co-payment	80% of UCR After Deductible
Urgent Care Facility	$30 co-payment	$35 co-payment	80% of UCR After Deductible
Chiropractic ($2,000/yr)	$30 co-payment	$35 co-payment	80% of UCR After Deductible
Physical Therapy (50 visits/yr.)	$30 co-payment	$35 co-payment	80% of UCR After Deductible
Ambulance	$100 co-payment	80% After Deductible	80% of UCR After Deductible
Freestanding X-ray & Lab Services	$25 co-payment	80% After Deductible	80% of UCR After Deductible
Home Health Care (100 visits/year)	$25 co-payment	80% After Deductible	80% of UCR After Deductible
Emergency Room	$100 co-payment if Emergency $150 co-payment if Non-Emergency	80% After Deductible if Emergency 50% After Deductible if Non-Emergency	80% of UCR After Deductible if Emergency 50% of UCR After Deductible if Non-Emergency
Prescription Drugs **Retail:** -Deductible -Co-payment: Generic -Co-payment: Preferred Brand -Co-payment: Non-Preferred **Mail Order** (Maintenance Drugs Only; 90 Day Supply; No Deductible) -Co-payment: Generic -Co-payment: Preferred Brand -Co-payment: Non-Preferred	 $50 per member $5 $25 $50 $10 $50 $100		

Note: UCR is defined at the PPO Allowable Rate

BASIC GROUP TERM LIFE - QUESTIONS & ANSWERS

What type of life insurance coverage is it? It's Group Term Life Insurance with Accidental Death & Dismemberment Coverage. It does not build "cash value".

How much coverage do I have? Certified/Classified: $40,000 Term Life; Confidential Classified/Administrative Assistants: $50,000; and Administrators: $250,000 Term Life.

How much does this coverage cost me? Your life insurance and AD&D coverage is District-paid so there is no cost to you unless you are a part-time contracted teacher in which case your District-paid premiums will be prorated based on FTE.

Can I continue this coverage when I retire? Yes, up to a maximum of $200,000 but certain restrictions and limitations on coverage amounts will apply and the retiree pays the premium.

Will my limits ever change? Yes, currently the amount will reduce by 50% at age 70. This is also subject to change.

What do I need to do if I need to change my beneficiary? Contact Risk Management immediately if you need to change your life insurance beneficiary for any reason, e.g., marriage, divorce, or death.

ADDITIONAL GROUP TERM LIFE INSURANCE - QUESTIONS & ANSWERS

What type of life insurance coverage is it? It is Additional Group Term Life Insurance only and does not include Accidental Death & Dismemberment and it does not build "cash value".

How much will this coverage cost me for Plan Year 2016? Premiums are **age rated**. Below are the current monthly rates per $1,000 of coverage by age band. These rates are subject to change.

Age				
	< 29	$0.05	30-34	$0.08
	35-39	$0.09	40-44	$0.10
	45-49	$0.18	50-54	$0.28
	55-59	$0.50	60-64	$0.77
	65-69	$1.11	70-72	$1.32
	73-74	$1.57	75-76	$1.66
	77-78	$1.78	79-80	$2.40
	81-82	$3.42	83-84	$3.81
	85-86	$4.23	87-88	$5.89
	89-90	$6.35	91-92	$7.10
	93-94	$9.58	95-96	$11.05
	97-98	$13.15	99+	$25.00

To calculate your premium: 1. Find the rate for your age band. (Use the age you will be as of December 31, 2015.) 2. Multiply your current supplemental term life limits by this rate; 3. Divide the total by $1,000.

Example: Employee age 47 with $50,000 of limits would be $9.00/month ($50,000 x $.18 / $1,000 = $9.00).

Will my limits ever change? At age 70 limits reduce by 50%, e.g., if you have $50,000 of term life and you turn 70, the amount will reduce to $25,000.

When can I add this coverage or increase limits? You can add/increase limits in increments of $25,000 up to a maximum of $250,000 during Open Enrollment **(subject to acceptable evidence of insurability). Contact the Risk Management Office for forms.**

May I purchase coverage for my spouse?
Yes, so long as you have or are purchasing additional life for yourself, you may purchase up to 50% of your additional life limit not exceed $25,000.

How much will my spouse's coverage cost me for Plan Year 2016? See rate schedule above.

To calculate the premium: 1. Find the rate for your spouse's age band. (Use the age your spouse will be as of December 31, 2015. 2. Multiply your spouse's current supplemental term life limits by this rate; 3. Divide the total by $1,000.

Will my spouse's limits ever change?
Yes, at age 65 they will reduce by 35% and will terminate the earlier of age 70 or when the employee ceases to be eligible.

May I purchase coverage for my child(ren)?
Yes, you may purchase coverage for your child(ren) who are of the age of 6 months to age 19 (25 if full-time student) with a choice of limits of $5,000 or $10,000 per child.

How much will my child(ren)'s coverage cost me?
The premium is $.86/month for the $5,000 limit and $1.72/month for the $10,000 limit. These rates are subject to change. These premiums are per family unit (if you have one child or five children, the premium is the same - $.86/month for the $5,000 limit and $1.72/month for the $10,000 limit.)

VISION BENEFITS

Who provides my vision coverage? Vision Service Plan (VSP).

Who is covered and do I have to pay any premiums for this coverage? You and your eligible dependents are covered and the premium is District-paid so there is no cost to you unless you are a part-time contracted teacher in which case your District-paid premiums will be prorated based on FTE. For example, if you are a .5 FTE, your cost would be $6.16/month; or if you are a .8 FTE, your cost would be $2.46/month.

Do I have to have my dependents covered by District medical coverage to have vision coverage? No

How do I find out when I am or my dependents are eligible for exam, lenses and frames? Please visit our website at www.washoeschool.net and click on "Vision - Benefits" or the VSP website at www.vsp.com.

What are the benefits?

- Eye Examination — Once each 12 months (On the day following your last date of service)
- Spectacle Lenses — Once each 24 months (On the day following your last date of service)
- Frame — Once each 24 months (On the day following your last date of service)

Does the vision plan have a preferred provider list? Yes

Do I have to use a preferred provider? No, but benefits will be paid at a reduced reimbursement schedule.
Are there any "out-of-pocket" costs for me? Yes, there is a $10 per member co-payment for the eye examination. There may also be additional charges for such items as: Blended and/or Oversize Lenses; Contact Lenses; Progressive Lenses; Photochromic or tinted lenses other than Pink 1 or 2; Coated or Laminated Lenses; A frame that exceeds the plan allowance; UV protected Lenses.

COMPREHENSIVE GROUP LEGAL SERVICES PLAN

What is the Comprehensive Group Legal Services Plan? It's a voluntary benefit through Hyatt Legal Plans and it covers certain legal services for you.

What is the cost of the plan? Premiums $19.80/month or $9.14 biweekly. These premiums are payroll deducted.

What does it cover? In addition to the fully covered services such as wills, real estate closings and debt collection defense, the plan also includes unlimited telephone advice and office consultation with a local attorney. If you use a Participating Attorney, there are no claim forms or out-of-pocket expenses for the attorney's fees.

How can I get more information about the plan? If you have questions or would like to see the list of attorneys, call Hyatt's Client Service Center at 800/821-6400.

When may I enroll? During Open Enrollment. Contact the Risk Management Office to enroll. **Important: If you enroll, you must stay in the plan and continue payroll deductions for the entire 2016 benefits year**. Your enrollment will continue after the first year until you notify the Risk Management Office that you want to terminate the plan.

SECTION 125 BENEFIT PROGRAM

What is a Section 125 Benefit Program? It's a program under Section 125 of the Internal Revenue Code that allows an employer to take certain employee deductions on a "pretax" or "before tax" basis.

What kind of deductions can I make under the Section 125 Benefit Program? It consists of two parts:

- **Premium Conversion Plan** – Allows employee-paid health and cancer insurance premiums to be paid on a pretax basis.
- **Flexible Spending Accounts** – There are two types:
  - Dependent Day Care Expenses – Allows you to set aside up to $5,000 per year on a pretax basis to pay for day care expenses for your children under the age of 13.
  - Non-reimbursed Medical Expenses – Allows you to set aside up to $2,500 per year on a pretax basis to pay for expenses not covered by insurance such as deductibles, co-payments, and orthodontia.

How does the Premium Conversion Plan work?

Example: **After-Tax**

Monthly Salary	$2,000
Tax – 25%	$ 500
Net Income before Deductions	$1,500
Monthly Insurance Premium	$ 200
Final Net Income	**$1,300**

Pretax Under Section 125 Program	
Monthly Salary	$2,000
Monthly Insurance Premium	$ 200
Income before Tax	$1,800
Tax – 25%	$ 450
Final Net Income	**$1,350**

As you can see, you would have an extra $50 in your take-home pay under the Section 125 Program.

How does a Flexible Spending Account work? Assume you have a dependent in braces & you pay $100 per month for this service, the program would work as follows:

After-Tax	
Monthly Salary	$2,000
Tax – 25%	$ 500
Net Income before Deductions	$1,500
Monthly Dentist Payment	$ 100
Final Net Income	**$1,400**

Pretax Under Section 125 Program	
Monthly Salary	$2,000
Monthly Dentist Payment	$ 100
Income before Tax	$1,900
Tax – 25%	$ 475
Final Net Income	**$1,425**

As shown, you'd have an extra $25 in your take-home pay under the Section 125 Program.

When does the Section 125 Plan Year start and end? It runs from January 1 through December 31.

When are deductions made? They're taken from your check each month if you're Certified/Administrator and biweekly if you're a classified employee.

Are there any fees for the Premium Conversion Plan and/or the Flexible Spending Accounts? No

Who administers the Flexible Spending Accounts? American Fidelity

How do I get reimbursed if I sign up for a Flexible Spending Account? You simply submit a receipt and voucher to American Fidelity. You will receive additional information and vouchers from American Fidelity after you enroll.

When can I enroll into a Section 125 Benefit Program? During Open Enrollment.

What happens if I don't use all the money set aside in my Flexible Spending Account by the end of December? IMPORTANT! You will forfeit any unused moneys.

Can I stop my Section 125 Benefit Program deductions at anytime? IMPORTANT! No, you cannot stop your deductions until the beginning of the next plan year unless you have a qualifying event. However, remember that all Section 125 changes/elections must be renewed every year.

Please note that this *Open Enrollment* information is a summary of the various benefit programs offered to Plan Members. It is not meant as a full explanation of the benefits provided by these programs. Please refer to the plan document or contract for specific benefits and provisions. Copies are available from the Risk Management Website. Any conflict between the information contained herein and any plan document or contract shall be governed by the provisions of said plan document or contract.

2016 Premium Schedule for EPO and PPO Plans (includes Premium Discount)

Renown (HTH) EPO

Coverage Level	26 Pay Periods 12 Month Classified EEs	18 Pay Periods 9/10/11 Month Classified EEs	Monthly Premium Full-Time Certified & Administrative EEs	Monthly Premium .5 FTE Certified & Administrative EEs
Employee Only	$89.38	$129.10	$193.65	$511.72
Employee + Spouse	$310.84	$449.00	$673.50	$991.56
Employee + 1 Child	$224.82	$324.75	$487.12	$805.18
Employee + 2 Children	$353.41	$510.48	$765.73	$1083.79
Employee + Family	$436.20	$630.06	$945.09	$1263.16

Renown (HTH) PPO

Coverage Level	26 Pay Periods 12 Month Classified EEs	18 Pay Periods 9/10/11 Month Classified EEs	Monthly Premium Full-Time Certified & Administrative EEs	Monthly Premium .5 FTE Certified & Administrative EEs
Employee Only	$0	$0	$0	$318.07
Employee + Spouse	$168.02	$242.69	$364.04	$682.10
Employee + 1 Child	$104.85	$151.45	$227.18	$545.25
Employee + 2 Children	$200.59	$289.75	$434.62	$752.68
Employee + Family	$266.74	$385.29	$577.94	$896.00

NOTE: District-paid premiums for Certified Employees on part-time contracts are prorated based on FTE.

GROUP HEALTH PROGRAM
IMPORTANT ANNUAL NOTICES

October 5, 2015

To: Washoe County School District Group Health Program Members:

To Participants in the
Washoe County School District Group Health Program

SPECIAL NOTICES

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

The Women's Health and Cancer Rights Act
The health benefits of most plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending physician and the patient: (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce symmetrical appearance, (3) breast prostheses, and (4) physical complications of all stages of mastectomy, including lymphedemas.
Plan participants must be notified, upon enrollment and annually thereafter, of the availability of benefits required due to the WHCRA.

LETTER OF CREDITABLE COVERAGE
Important Notice from Washoe County School District About Your Prescription Drug Coverage and 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 Washoe County School District 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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. Washoe County School District has determined that the prescription drug coverage offered by the District 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 15th to December 7th.

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 District coverage will not be affected.
If you do decide to join a Medicare drug plan and drop your current District coverage, be aware that you and your dependents will be able to get this coverage back. For more information about reinstatement to the District coverage, please contact the Risk Management Office.

When will you pay a higher premium (Penalty) to join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Washoe County School District and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage:

Contact the Risk Management Office at 775/343-0343. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the District changes. You also may request a copy of this notice at any time by contacting the Risk Management Office.

For more information about your options under Medicare prescription drug coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov,
- Call your State Health Insurance Assistance Program (see the inside cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	September 24, 2015
Name of Entity/Sender:	Washoe County School District
Contact--Position/Office:	Risk Management Office
Address:	425 East Ninth Street Reno, NV 89520
Phone Number:	(775) 348-0343

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: 09-01-2015

The WCSD Health Plan (Plan) 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 Plan is required to follow the terms of this Notice. We will not use or disclose PHI about you without your written authorization, except as describe 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 Plan 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 Plan's compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment, and health care operations.

The Plan 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 Plan also will disclose PHI to the Plan Sponsor (Washoe County School District) for purposes related to treatment, payment and health care operations. The Plan 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 Plan 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, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations).

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

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, the Plan 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.

If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes.

Uses and disclosures that require your written authorization.

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you. In addition, your written authorization will be obtained for uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and,
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and disclosures for which consent, authorization or opportunity to object is not required.

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

1. When required by law.

2. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

3. When authorized by law to report information about abuse, neglect, or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose or reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law

when the parents or other representatives may not be given access to the minor's PHI.

4. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

5. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

6. When required for law enforcement purposes (for example, to report certain types of wounds).

7. For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Covered Entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

8. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

9. The Plan may use or disclose PHI for research, subject to conditions.

10. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

11. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

RIGHTS OF INDIVIDUALS

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operation, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.
The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.
You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.
Such requests should be made to the following officer: (Washoe County School District Risk Manager, PO Box 30425 Reno, Nevada 89520-3425, 775-348-0343).

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set", for as long as the plan maintains the PHI.

- **Protected Health Information** (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.
- **Designated Records Set** includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the Covered Entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.
You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following officer: (Washoe County School District Risk Manager, PO Box 30425 Reno, Nevada 89520-3425, 775-348-0343).
If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of U.S. Department of Health and Human Services.

Right to Amend PHI

You have the right to request the plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.
The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is

denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.
Requests for amendment of PHI in a designated record set should be made to the following officer: (Washoe County School District, Risk Manager).
You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

The Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made:

1. to carry out treatment, payment or health care operations;

2. to individuals about their own PHI;

3. prior to the compliance date; or,

4. based on your written authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given 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 Plan will charge a reasonable, cost-based fee for each subsequent accounting.

The Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice contact the following officer: (Washoe County School District, Risk Manager).

The Right to Be Notified of a Breach of Unsecured PHI

The Plan is required by law to notify you following a breach of any Unsecured PHI.

A Note about Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;

- a court order of appointment of the person as the conservator or guardian of the individual; or,

- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

THE PLAN'S DUTIES

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices.

This notice is effective beginning (September 1, 2013) and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided (to all past and present participants and beneficiaries) for whom the Plan still maintains PHI. (Notice will be posted on web-site).

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another Covered Entity, the plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and,
- uses or disclosures that are required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is to reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA.

YOUR RIGHT TO FILE A COMPLAINT WITH THE PLAN OR THE HHS SECRETARY

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the following officer: (Washoe County School District Risk Manager, PO Box 30425 Reno, Nevada 89520-3425, 775-348-0343, Riskmanagement@washoeschools.net).
You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.
The Plan will not retaliate against you for filing a complaint.

WHOM TO CONTACT AT THE PLAN FOR MORE INFORMATION

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following officer: (Washoe County School District Risk Manager, PO Box 30425 Reno, Nevada 89520-3425, 775-348-0343, Riskmanagement@washoeschools.net)