TO: **SOUTHERN NEVADA DISTRICT BOARD OF HEALTH** **DATE:** **November 27, 2012**

RE: *Approval of Amendment to Interlocal Agreement between Clark County; Clark County Water Reclamation District; University Medical Center of Southern Nevada; the Las Vegas Convention and Visitors Authority; the Las Vegas Valley Water District; Clark County Regional Flood Control District; the Regional Transportation Commission of Southern Nevada; and the Southern Nevada Health District and the Henderson District Public Libraries for Establishing New Rates and Adopting the Amended Self-Funded Health Benefits Plan, effective January 1, 2013*

PETITION #37-12

That the Southern Nevada District Board of Health *approve the Amendment to Interlocal Agreement between Clark County; Clark County Water Reclamation District; University Medical Center of Southern Nevada; the Las Vegas Convention and Visitors Authority; the Las Vegas Valley Water District; Clark County Regional Flood Control District; the Regional Transportation Commission of Southern Nevada; the Southern Nevada Health District and the Henderson District Public Libraries for Establishing New Rates and Adopting the Amended Self-Funded Health Benefits Plan, effective January 1, 2013.*

PETITIONERS:

Robert Gunnoe, *Human Resources Administrator*
Rory Chetelat, *Acting Director of Administration*
Dr. Middaugh, *Chief Health Officer*

DISCUSSION:

The purpose of this agreement is to allow SNHD to renew the Amended Self-funded Health Benefits Plan group medical and dental portion of the benefit plan for SNHD employees, retirees and their dependents. The Plan year is on a calendar year basis. The Amended Self-Funded Health Benefit Plan offers a group medical/dental plan preferred provider (PPO) option. This insurance benefit program was adopted on August 1, 2009 pursuant to the labor agreements. The interlocal is in compliance with the District's collective bargaining agreement (CBA) with SEIU that became effective January 22, 2009. There will be no rate increase for the plan year 2013.

The following are Plan modifications that will be effective January 1, 2013:

1. Expand dental coverage to include dental implants;
2. Remove exclusion for non-surgical treatment of the feet;
3. Remove prior authorization requirement for durable medical equipment supplies that cost less than $400
4. Increase annual maximum of $1,500,000 to $2,000,000 for medical benefits

The Self-Funded Health Benefits Plan continues to maintain an exemption from the Health Insurance Portability and Accountability Act of 1996, as permissible by Federal Law.

The above noted changes have been accepted by the Southern Nevada Health Insurance Study Committee, as established in the Southern Nevada Health District SEIU agreement.

FUNDING:

Previous Board action on July 26, 2012 provided authorization for funding the employer-portion of the premiums based on the labor agreements through FY2014.

ATTACHMENTS:

SNHD Group Rates for Plan Year 2013
Plan Document and Summary Plan Description for Self-Funded Group Medical and Dental Benefit Plan
Clark County Self-funded Group Medical Plan: Summary of Benefits and Coverage
Self-funded Benefit Plan: Plan Changes, Dental and Vision Benefits

IN WITNESS WHEREOF, the parties hereto have caused this contract to be signed and intend to be legally bound thereby.

DATE:_____

COUNTY OF CLARK

ATTEST:

BY:_____
SUSAN BRAGER, Chair
Board of County Commissioners

BY:_____
DIANA ALBA, County Clerk

CLARK COUNTY WATER RECLAMATION DISTRICT

ATTEST:

BY:_____
LAWRENCE L. BROWN, III, Chairman
Board of Trustees

BY:_____
DIANA ALBA, County Clerk

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA

ATTEST:

BY:_____
LAWRENCE WEEKLY, Chairman
Board of Trustees

BY:_____
DIANA ALBA, County Clerk

LAS VEGAS CONVENTION AND VISITORS AUTHORITY

ATTEST:

BY:_____
TOM COLLINS, Chair

BY:_____
SCOTT NIELSON, Vice Chair

LAS VEGAS VALLEY WATER DISTRICT

ATTEST:

BY:_____
STEVE SISOLAK, President
Board of Directors

BY:_____
PATRICIA MULROY, Secretary

CLARK COUNTY REGIONAL FLOOD CONTROL DISTRICT

ATTEST:

BY:_____
LAWRENCE L. BROWN, III, Chairman

BY:_____
CAROLYN M. FRAZIER, Secretary

REGIONAL TRANSPORTATION COMMISSION OF SOUTHERN NEVADA

ATTEST:

BY:_____
LAWRENCE L. BROWN, III, Chairman

BY:_____
COURTNEY LANCASTER, Executive Secretary

SOUTHERN NEVADA HEALTH DISTRICT

ATTEST:

BY:_____
MARYBETH SCOW, Chair

BY:_____
JOHN MIDDAUGH, M.D.

Interim Chief Health Officer

HENDERSON DISTRICT PUBLIC LIBRARIES

ATTEST:

BY:_____
M.J. MAYNARD, CHAIR
Board of Trustees

BY:_____
TRUDY CASEY, Notary

APPROVED AS TO FORM:

STEVEN WOLFSON, District Attorney

BY:_____
STEPHANIE BARKER
Deputy District Attorney

Southern Nevada Health District
Group Insurance Rates – Active Employees
Plan Year January 1, 2013 – December 31, 2013

Clark County Insurance

Medical Plan(s)	PPO or HMO listed below
Dental Plan	PPO Dental or HMO Dental
Vision Benefit(s)	VSP (PPO Plan) or HPN Vision (Eyemed)
Employee Life	$20,000, reduced at age 70
Spouse Life	$5,000 if on health plan
Child Life	age 6 months or more-$2,500 if on health plan
Child Life	age 14 days to 6 months-$1,000 if on health plan
Long Term Disability	60% of pay
AD&D	$20,000

Clark County Self Funded PPO Plan

Coverage	***Actual Cost*	*SNHD Pays* up to	*Monthly employee cost*
Employee Only	$469.04	$515.00	$ 0.00
Employee + Spouse	$866.51	$715.00	$ 151.51
Employee + Child(ren)	$848.32	$715.00	$ 133.32
Employee + Family	$1,206.57	$915.00	$ 291.57

***Actual Cost includes health premium, LTD and life insurance*
Funding by Health District includes subsidy for health premium, LTD and life insurance

Health Plan of Nevada - HPN

Coverage	***Actual Cost*	*SNHD PAYS* up to	*Monthly employee cost*
Employee Only	$413.50	$515.00	$ 0.00
Employee + Spouse	$764.16	$715.00	$ 49.16
Employee + Child(ren)	$747.70	$715.00	$ 32.70
Employee + Family	$1,060.80	$915.00	$145.80

***Actual Cost includes health premium, LTD and life insurance*
Funding by Health District includes subsidy for health premium, LTD and life insurance

Southern NV Health District **Voluntary Product Offerings**

- ✓ Supplemental Life, Supplemental Accidental Death & Dismemberment – Employee & Dependent(s) (Western–*Broker* Sun Life Financial- *Carrier*).
- ✓ Cancer Protection and Short Term Disability Plan (American Fidelity)
- ✓ AFLAC (STD, Accident, Cancer, Hospital Intensive Care Protection, Specified Health Event Protection, Flexible Spending
- ✓ Pretax 125 Premium Only Plan (Dependent Premiums, AFLAC and AF Cancer Plan*)*

Clark County: Self-funded Group Medical Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2013 – 12/31/2013
Coverage for: Individual + Family | Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.clarkcountynv.gov or by calling **1.702.455.4544**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$275**/person; **$550**/family. Does not apply to accidental injuries, hospital admissions at **University Medical Center of Southern Nevada (UMCSN)**, contracted free-standing surgical center, participating primary care and specialist physician, and outpatient prescription drugs. Co-payments and penalties for failure to obtain precertification do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. **Deductible** starts over January 1st. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	**Yes, $550**/non-contracted hospital admission (waived if employee or retiree resides over 100 miles outside Clark County NV or if admission due to accidental injury), **$55** for an emergency room (ER) visit (waived at UMCSN, or if service due to accidental injury). Dental Plan deductible is **$50**/person or **$100**/family. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes, In-network PPO Participating Providers: **$2,200**/person Non-PPO Non-Participating Providers: **$4,400**/person	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you pay for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, non-covered services, co-payments, deductibles, charges in excess of annual maximum benefits, charges over the usual and reasonable allowable, penalty for failure to obtain precertification, outpatient retail/mail order prescription drug expenses do not count toward the **out-of-pocket limit**.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	Yes, $2 million per person through 12-31-13, then the Plan no longer has an overall annual limit on medical plan benefits.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes *specific* coverage limits, such as limits on the number of office visits.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. For a list of **in-network PPO/Participating providers, see** www.clarkcountynv.gov/DEPTS/finance/Pages/default.aspx **or call 1.702.455.4544.**	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network PPO/Participating/Contracted **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 co-payment/visit, no deductible.	$275 deductible plus 40% co-insurance.***	For in-office surgery with Participating PCP: $10 co-payment per procedure. ***In this Chart, where you see ***, it means that for non-participating providers, you pay amounts above the Plan's usual and customary allowance.**
	Specialist visit	20% co-insurance, no deductible.	$275 deductible plus 40% co-insurance.***	----none---

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Other practitioner office visit	20% co-insurance, no deductible.	$275 deductible plus 40% co-insurance.***	Chiropractor: Max. 20 visits/year. Acupuncture: Max. 20 visits/year.
	Preventive care/screening/ immunization	Children to age 7: 20% co-insurance, no deductible. Children age 7-18 years: Preventive services not covered. **Limited Preventive Services** for individuals age 19 and over: $20-co-payment/visit, 20% coinsurance/screening, no deductible.	$275 deductible plus 40% co-insurance.*** Subject to age limitations.	**Limited Preventive Services** for individuals age 19 and older: annual pap smear & CA 125 test for women 18 yrs. & older; Mammogram baseline test at age 35-40, then annually; PSA test for men 40 yrs. and older; Colonoscopy once every 10 years starting at age 50.
If you have a test	Diagnostic test (x-ray, blood work)	**UMCSN:** No charge. **Participating lab/radiology:** 20% co-insurance, no deductible.	$275 deductible plus 40% co-insurance.***	Annual Dexascan for members over age 50.
	Imaging (CT/PET scans, MRIs)	**UMCSN:** No charge. **Participating lab/radiology:** 20% co-insurance, no deductible.	$275 deductible plus 40% co-insurance.***	Certain imaging tests, and tests over $400 require preapproval.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available from Catalyst/ Catamaran at www.catalystrx.com or call 1.888.869.4600.	Generic drugs	Retail Pharmacy for up to a 30-day supply: $6 co-payment; Mail Order for up to a 90-day supply: $12 co-payment.	You pay 100%. Plan reimburses no more than it would have paid had you used an In-Network Retail pharmacy, minus the applicable co-payment.	If the pharmacy's usual & customary price is less than your co-payment, the pharmacy will collect the usual & customary price, not your co-payment. **Catalyst/Catamaran – Diabetic Sense Program:** $10 co-payment for a 90-day supply of test strips. Free glucose meter – annually. Cookbooks and education material also available. Enrollment is required in the Diabetic Sense Program. Please call 1.877.852.3512 for information.
	Preferred brand drugs	Retail Pharmacy for up to a 30-day supply: $35 co-payment; Mail Order for up to a 90-day supply: $70 co-payment.		
	Non-preferred brand drugs	Retail Pharmacy for up to a 30-day supply: 50% co-insurance up to $200/prescription. Mail Order: no coverage.		
	Specialty drugs	Specialty Drugs require enrollment through Catalyst/Catamaran. Up to a 30-day supply you pay a $6 co-payment for generic drugs; $35 co-payment for preferred brand drugs.	Not covered.	Specialty drugs require pre-approval by calling Catalyst/Catamaran at 1.888.869.4600.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**UMCSN:** No charge. **Contracted (non-hospital based) Surgicenter:** 20% co-insurance.	$275 deductible plus 40% co-insurance.***	Outpatient surgery over $400 requires preapproval.
	Physician/surgeon fees	**PCP:** $60 co-payment per surgery. **Specialist:** 20% co-insurance, no deductible.	$275 deductible plus 40% co-insurance.***	Outpatient surgery over $400 requires preapproval.
If you need immediate medical attention	Emergency room services	**UMCSN:** 10% co-insurance, no deductibles. **Contracted hospital ER:** $275 deductible plus $55 ER deductible plus 20% co-insurance.	$275 deductible plus $55 ER deductible plus 40% co-insurance.***	ER deductible waived for an accidental injury or subsequent hospital admission.
	Emergency medical transportation	Not Applicable	$275 deductible plus 20% co-insurance.	Medically necessary local ground transport within 100 miles to the nearest hospital or skilled nursing facility where necessary treatment can be provided.
	Urgent care	**UMCSN Quick Care:** No charge. **Contracted Urgent Care Facility:** 20% co-insurance, no deductible.	$275 deductible plus 40% co-insurance.***	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	**UMCSN:** No charge. **Contracted hospital:** $275 deductible plus 20% co-insurance.	$550 per admission deductible plus $275 calendar year deductible plus 40% co-insurance.***	Elective hospital admission requires preapproval or else benefits reduced by 25%.
	Physician/surgeon fee	PCP: No charge for non-surgery services; $100 co-payment per surgery. Specialist: 20% co-insurance, no deductible.	$275 deductible plus 40% co-insurance.***	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office visit: 50% co-insurance, no deductible.	50% co-insurance plus you pay costs over $100 per visit, no deductible.***	This plan has opted out of compliance with Mental Health Parity Addictions Equity Act (MHPAEA).
	Mental/Behavioral health inpatient services	**Contracted hospital:** $275 deductible plus 20% co-insurance.	$275 deductible plus 40% co-insurance.***	Elective hospital admission and day treatment requires preapproval. Max. benefit 30 days/calendar year.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Substance abuse disorder outpatient services	Office visit: 20% co-insurance, no deductible, up to max benefit.	$275 deductible plus 40% co-insurance up to max benefit.***	Max. benefit $2,500/calendar year.
	Substance abuse disorder inpatient services	**Contracted hospital:** $275 deductible plus 20% co-insurance.	$275 deductible plus 40% co-insurance.***	Elective hospital admit requires pre-approval. Max. inpatient is $10,000/year. Max inpatient & outpatient treatment benefit is 3 courses of treatment up to $39,000/lifetime. For withdrawal, max. benefit is 7 days not to exceed $1,500.
If you are pregnant	Prenatal and postnatal care	PCP: $100 co-payment per pregnancy. Specialist: 20% co-insurance, no deductible.	$275 deductible plus 40% co-insurance.***	OB Ultrasound requires preapproval.
	Delivery and all inpatient services	PCP: $100 co-payment per pregnancy. Specialist: 20% co-insurance, no deductible.	$275 deductible, 40% co-insurance, plus $550 per hospital stay.***	Preapproval required if hospital stay is more than 48 hours for vaginal delivery or 96 hours for C-section.
If you need help recovering or have other special health needs	Home health care	20% co-insurance, no deductible.	$275 deductible plus 40% co-insurance.***	Max. benefit 60 visits/year. Home Health over $400 requires preapproval.
	Rehabilitation services	20% co-insurance, no deductible.	$275 deductible plus 40% co-insurance.***	Inpatient rehab. max benefit: 60 days/yr. Outpatient rehab max benefit: 30 visits/yr. Preapproval required for inpatient rehab, all occupational & speech therapy, plus physical therapy after the 6th outpatient visit.
	Habilitation services	20% co-insurance, no deductible.	$275 deductible plus 40% co-insurance.***	Applied Behavior Analysis Treatment: max. benefit $36,000 per year.
	Skilled nursing care	20% co-insurance, no deductible.	$275 deductible plus 40% co-insurance.***	You pay any costs that exceed half the cost of an avg. hospital semi-private room. Max benefit 120 days per year.
	Durable medical equipment	20% co-insurance, no deductible.	$275 deductible plus 40% co-insurance.***	Maximum DME benefit $25,000 per lifetime. DME over $400 requires preapproval.
	Hospice service	20% co-insurance, no deductible.	$275 deductible plus 40% co-insurance.***	Covered if terminally ill. Hospice services over $400 requires preapproval.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No charge when obtained during a preventive care office visit.	Not covered.	Covered for children up to 7 yrs.
	Glasses	Not covered.	Not covered.	You pay 100% of these expenses.
	Dental check-up	No charge for preventive dental services.	No charge up to the allowed charge.***	Preventive dental cleaning covered twice per calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Eyeglasses
- Hearing aids
- Long-term care
- Preventive services for children age 7-18 years.
- Routine eye care (Adult) (Child)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (max 20 visits/year)
- Bariatric Surgery (once per lifetime)
- Chiropractic care (max 20 visits/year)
- Dental care (Adult) (Child)
- Infertility treatment (certain treatments not covered)
- Private duty nursing
- Routine foot care when treating a metabolic or peripheral vascular disease.
- Skilled nursing care facility (you pay costs that exceed half the cost of the average hospital semi-private room).

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1.702.455.4544. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Clark County Risk Management Office at 1.702.455.4544.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1.866.415.7246.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,620
- **Patient pays** $1,920

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$280
Co-payments	$110
Coinsurance	$1,380
Limits or exclusions	$150
Total	**$1,920**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,510
- **Patient pays** $890

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-payments	$320
Coinsurance	$360
Limits or exclusions	$210
Total	**$890**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or pre-existing condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Self-Funded Benefit Plan

Plan Changes For 2013

- Expand dental coverage to include dental implants;
- Remove exclusion for non-surgical treatment of the feet;
- Remove prior authorization requirement for durable medical equipment supplies that cost less that $400.
- Increase annual maximum of $1,500,000. to $2,000,000. for medical benefits.

Dental Benefits

Deductible *(Individual)*	$50
Deductible *(Family)*	$100
Preventive Care Co-Payment Rate *(Exam, Cleaning & 2 Bitewing X-Rays Twice A Year)*	100% *(No Deductible)**
Basic & Major Co-Payment Rate	80%*

Calendar Year Maximum	Individual	Family
First Calendar Year	$1,500	$3,000
Second Calendar Year	$1,750	$3,500
Third & Subsequent Calendar Years	$2,000	$4,000

Orthodontic Treatment

Benefits for Orthodontic Treatment are only available to qualified dependent children under the age of 19.
Lifetime maximum payable of $3,000 per dependent child.

Vision Benefits

Coverage Provided by Vision Service Plan (VSP)

$10 Co-Payment for Annual Exam • $25 Co-Payment for Lenses/Frames/Contacts
Benefit Allows One Vision Exam Every 12 Months and Lenses/Frames/Contacts Every 24 Months

Excludes those employees that retired prior to 2/1/96, and did not elect Vision Coverage.

Request Forms & Direct Questions To:

Clark County Risk Management	455-4544
Clark County Water Reclamation District	668-8066
University Medical Center of Southern Nevada	383-2230
Las Vegas Convention & Visitors Authority, Personnel Office	892-7527
Las Vegas Valley Water District	258-3115
Retirees, Clark County Risk Management	455-4544
Regional Transportation Commission	676-1522
Southern Nevada Health District	759-1101
Henderson District Public Libraries	492-6583

NOTE: The above is shown as a summary only. Please refer to your Health Benefits Summary Plan Description for a full explanation of the benefits.
** Usual and customary is determined by our third party claims administrator. Any charges in excess of usual and customary will be the employee's responsibility.*

Frequently Asked Questions

1. **May I add dependents not previously insured during re-enrollment without Evidence of Insurability?**

   Yes, during the open enrollment period you have the opportunity to add **eligible dependents** *not currently covered by one of the health plans. However, newly added* **dependents** *will be subject to a 12 month medical pre-existing limitation, unless he/she has a HIPAA creditable coverage certificate. The late participant dental limitation as required by the Plan will also apply. Please see your Self-Funded Health Benefits Summary Plan Description for further details.*

2. **Does my adult child age 19 to 26 have to be a full-time student in order to be covered by my Plan?**

   No, effective January 1, 2011 an adult child is no longer required to be a full-time student in order to be covered as your dependent. However, if your child is eligible for a health benefit program provided by their employer or their spouse's employer, they are not eligible for coverage as your dependent.

3. **Does my spouse have to enroll in his/her own employer sponsored health insurance program?**

   Yes, if the health coverage available to your spouse is $80.00 or less per month for member only coverage. Please refer to the Self-Funded Plan Document for additional details.

4. **If my spouse is eligible for his/her own employer medical insurance benefit can he/she be covered under my Clark County Health Plan?**

   Yes, as long as he/she is not employed by Clark County, UMC, LVCVA, Water District, Water Reclamation District, RTC, Health District, Regional Flood Control, or the Henderson Library.

5. **What if I go to a PPO doctor and he refers me to a non-PPO lab, x-ray facility, or hospital, are these charges covered under the PPO Co-Payment Program?**

   No, all charges must be incurred with a doctor or facility listed on the PPO Program in order to receive PPO benefits. Any charges incurred with a non-contracted doctor or facility will be considered under the Major Medical Program.

6. **If I have a claim that is denied or reduced, what recourse do I have?**

   You may file an appeal to be heard by the Self-Funded Group Health Committee, which is comprised of fellow co-workers representing each of the various entities that participate in our benefit program. The Committee will review all information presented and will advise you of the final decision in writing. For a more detailed explanation please refer to the Self-Funded Health Benefits Summary Plan Description.

7. **Do all inpatient hospital confinements require pre-authorization, and if so, who is responsible?**

   Yes, all hospitalizations (with the exception of emergencies and O.B.) require pre-authorization. It is your responsibility to confirm with the physician or hospital that pre-authorization has been obtained. Emergency admissions require a call to the utilization review company within 48 hours.

   (Please refer to the reverse side of your I.D. card for the telephone number of the utilization review organization.)

8. **Do I have a time limit when adding newly acquired dependents to my health benefits coverage?**

   Yes, all newly acquired dependents must be added within 60 days of birth/marriage. Forms are available at your Risk Management or Human Resources Office. If dependents are not added within the specified 60 day period, you may add them during the following annual open enrollment period.

9. **If I sign up for the Self-Funded Plan do I have to choose the major medical option or the PPO option?**

   No, if you sign up for the Self-Funded Plan you have the availability of both options. If the provider is on the PPO list then you must use the PPO option. If the provider is not on the PPO list then you must use the major medical option.

10. **Can I really see any doctor I want?**

    Yes, if you go to one of the hundreds of doctors on the list it will only cost you a $20.00 co-payment for the office visit with a primary care doctor, and a 20% co-payment for a specialist. If you go to any other physician it will cost you 40% of usual and customary, after you have satisfied the applicable deductible.*

11. **Can I switch back and forth between PPO and major medical?**

    Yes, going to see a PPO provider doesn't in any way prohibit you from using a major medical provider in the future and vice versa.

** Usual and customary is determined by our third party claims administrator. Any charges in excess of usual and customary will be the employee's responsibility.*

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

SELF-FUNDED GROUP MEDICAL AND DENTAL BENEFIT PLAN

EFFECTIVE JANUARY 1, 2013

TABLE OF CONTENTS

1. INTRODUCTION

This document is a description of Self-Funded Group Medical and Dental Benefit Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

The Self-Funded Group Medical and Dental Benefit Plan continues to maintain an exemption from the Health Insurance Portability and Accountability Act of 1996.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, eligibility and the like. Your employer believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 702.455.4544, or the U.S. Department of Health and Human Services at www.healthreform.gov.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, the rights of Covered Persons are limited to covered charges incurred before termination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Enrollment, Dual Choice, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid. See your ID card for more details.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

COBRA Continuation Options. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

IT IS THE PARTICIPANT'S RESPONSIBILITY TO INSURE ALL ELIGIBILITY REQUIREMENTS ARE MET, AND TO OBTAIN THE NECESSARY DOCUMENTATION TO VERIFY ELIGIBILITY.

2. ELIGIBILITY, FUNDING, ENROLLMENT, DUAL CHOICE, EFFECTIVE DATE AND TERMINATION PROVISIONS

A. ELIGIBILITY

Eligible Classes of Employees.

All Active and Retired Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first of the month following the day that he or she:

(1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 20 hours per week and is on the regular payroll of the Employer for that work and

(2) is continuously employed for a period of two consecutive months as an Active Employee or

(3) is a Retired Employee of the Employer or

(4) is a surviving Spouse of a Retired Employee, provided such spouse was covered under the Plan at the time of the Retired Employee's death or

(5) is in a class eligible for coverage under the terms of the Plan in effect prior to the Effective Date, who, within 31 days of the date of termination of employment, becomes an Employee of another public entity which provides coverage under the group health plan, or

(6) is currently covered as a dependent spouse of an employee or retiree, and who was a former covered employee or retiree covered by the Plan and has remained continuously covered under the Plan at the time of the employee or retiree's termination of coverage, may revert back to employee or retiree status within 31 days of such date of termination of coverage providing the member submits a completed enrollment form within that time-frame to Clark County Risk Management & Safety.

(7) is recalled, after a reduction in force or layoff, for re-employment by the Employer as a full-time employee, and who has remained continuously covered by the Plan as a COBRA participant.

Eligible Classes of Dependents.

A Dependent is any one of the following persons:

A covered Employee's Spouse.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator will require documentation proving a legal marital relationship. A Spouse who also qualifies as an eligible Employee will not be considered a Dependent for purposes of the Plan as long as such Spouse continues in the employ of an Employer.

A covered Employee's Domestic Partner.

A covered employee's Domestic Partner is a Dependent for purposes of eligibility upon the following terms and conditions: 1) the Employee and the claimed Domestic Partner must have a registered, valid domestic partnership pursuant to NRS 122A.100; and 2) the Employee and the claimed Domestic Partner must not have terminated that domestic partnership pursuant to NRS 122A.300; and 3) the Employee and the claimed Domestic Partner must be persons of the same gender. A covered member's Domestic Partner, as defined above, will be considered the "Spouse" of the employee/retiree.

A covered Employee's children from birth to the limiting age of 26 years.

The term "children" shall include:
natural children,
adopted children,

children placed in the home for adoption,
step-children,
natural child of the covered Domestic Partner, and
children for whom a court has ordered coverage through a National Qualified Medical Child Support Order.

The Plan Administrator may require documentation such as birth certificates, adoption decrees, or copies of certified court orders.

Guardianship/Legal Custody Children: If a covered Employee or spouse is the court appointed Legal Guardian or has court ordered Legal Custody of a child or children, these children may be enrolled in this Plan as covered Dependents. As court ordered legal custody, or guardianship are granted of a minor until that minor reaches majority (age eighteen in Nevada), the plan shall require that the dependent be dropped from the coverage upon reaching majority as ineligible. In the case of extended guardianship (if applicable through state statutes), the plan shall require copies of the new petition for extended guardianship and Letters of Guardianship issued as a result of this petition. The Plan Administrator shall also request annually a copy of the member's tax return verifying the continued dependency of the minor child covered by this Plan through court appointed guardianship/custody. This coverage is only available to those guardianship/legal custody children who the Employee covered as a dependent on December 31, 2010. Guardianship/legal custody children who were not covered on December 31, 2010, are not eligible to be enrolled at a future date.

If both the father and mother are Employees, their children or guardianship/legal custody children will be covered as Dependents of one employee, but not of both.

A covered Dependent child who is Totally Disabled, incapable of self-sustaining employment by reason of mental retardation or physical disability, primarily dependent upon the covered employee for support and maintenance, and covered under the Plan when reaching age 26.

Documentation that a Dependent satisfies these conditions must be provided to the Plan Administrator within 31 days of the Dependent reaching age 26. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching age 26, subsequent proof of the child's Total Disability and dependency.

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

Requirement for adult children enrollment in an employer-sponsored group health plan. If an adult child (age 19 – 26) is eligible to enroll in an employer sponsored health plan, other than a group health plan of a parent, the adult child is not eligible for coverage under this Plan whether or not they actually enrolled in their employer sponsored health plan. This provision does not apply to adult children who are continuing coverage as a Totally Disabled Child.

If the adult child misses his/her employer's open enrollment period, or his/her spouse's employer open enrollment period for the calendar year for which the employee is enrolling the newly eligible adult child in this coverage, coverage under this Plan will extend to the end of the month prior to the next available coverage effective date with the child's employer. Coverage under this Plan will not exceed 12 months from the effective date of the adult child's coverage with this Plan.

These persons are excluded as Dependents:

Individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced/annulled former Spouse of the Employee; Parents of any Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee. Any individual who is not considered a legal resident of the United States.

B. FUNDING

Cost of the Plan.

Some Employers provide Employee and Dependent coverage on a non-contributory basis and do not require Employees to contribute a share of the cost of coverage.

Other Employers share the cost of Employee and Dependent coverage under this Plan with the covered Employee. The enrollment application for coverage will include a payroll deduction authorization.

The level of any Employee contributions is set by the Plan Administrator, subject to the provisions of any applicable collective bargaining agreement. The Plan Administrator reserves the right to change the level of Employee contributions, also subject to the provisions of any applicable collective bargaining agreement.

C. ENROLLMENT

Enrollment Requirements for New Employees. An Employee must enroll for coverage by completing and signing an approved enrollment application. The covered Employee is required to enroll for Dependent coverage also. **Submission of this application is required before coverage will begin, even if the Employer provides coverage on a non-contributory basis.**

The completed form must be received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, or enrollment can only take place during the annual Re-Enrollment period, or the first of the month following approval of evidence of insurability.

If enrolled, a family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

Enrollment Requirements for Newborn Children. Newborn children will automatically be covered for the first 31 days following birth. Coverage will cease beginning with the 32nd day unless the newborn child has been enrolled as a Dependent in the plan by completing and submitting an approved enrollment change form within 60 days from the date of birth. Additionally, the employee will be required to submit a copy of the birth certificate, either with the approved enrollment form or as soon as a copy can be obtained.

If the child is required to be enrolled and is not enrolled within 60 days of birth, enrollment can only take place as provided in the Re-enrollment Provisions and will be subject to plan re-enrollment limitations, or the first of the month following approval of evidence of insurability.

Enrollment Requirements for Newly Eligible Dependents. When an employee acquires dependents through marriage, birth, adoption or placement for adoption, they may add these dependents to their coverage by completing and submitting an approved enrollment form. Additionally, the employee will be required to submit a copy of the applicable documentation (i.e. certified marriage certificate, certified adoption orders, etc.).

The Enrollment Period for newly eligible dependents is a period of 60 days and begins on the date of the marriage, birth, adoption or placement for adoption. If the dependent is not enrolled within 60 days, enrollment can only take place as provided in the Re-Enrollment Provisions and will be subject to plan re-enrollment limitations.

Member shall have 90 days from the date of the Plan's receipt of the enrollment request, to provide a copy of the birth certificate, marriage certificate, or other necessary dependent documentation, as required by the Administrator, to verify dependent eligibility.

Enrollment Requirements for Dependents who suffer Involuntary Loss of Coverage. In the event an eligible dependent loses other group health insurance coverage involuntarily the employee may enroll such dependent within 31 days of such involuntary loss of coverage. To enroll the dependent, the employee must complete and submit an approved dependent enrollment/change form within 31 days of such loss. Additionally, the employee will be required to submit a copy of verification of such loss from the former employer/plan administrator, and any other applicable documentation (i.e., marriage certificate, birth certificate, etc.). If the dependent, who suffers involuntary loss of coverage, is not enrolled within 31 days, enrollment may only take place as provided in the Re-Enrollment Provisions.

The effective date for dependents enrolled above will be as follows:

(a) in the case of marriage, the date of the marriage;

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

(c) in the case of a Dependent's adoption or placement for adoption, the date the adoption is finalized and the child is physically residing in the member's home; or the date the child is placed for adoption, and is physically residing in the member's home; or

(d) in the case of involuntary loss of coverage, the first of the month beginning after the date of the completed request for enrollment and supporting documentation is received, or the date of the loss of coverage, whichever is later.

Enrollment Requirements for Retirees and Surviving Spouses. Employees who retire from entities participating under the Plan or the surviving spouse of such a retired employee who is deceased, provided that the surviving spouse was a covered individual at the time of the retiree's death, are eligible for coverage on a contributory basis. To retain coverage upon retirement you, or your spouse if you are physically incapacitated, must make written application within 31 days of retirement. Failure to make written application within 31 days of retirement will cause your coverage to terminate.

Other Miscellaneous Enrollment Requirements. If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent child terminates coverage, the Dependent coverage may be continued by the other covered Employee with no waiting period as long as coverage has been continuous. Written notification of such change must be made within 31 days.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

D. TIMELY ENROLLMENT AND NOTIFICATION

The notification will be "timely" if the approved enrollment or change form is completed and is received by the Plan Administrator within the following time frames:

(1) For New Employees the form must be received within 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period;

(2) For Newly eligible dependents the form must be received within 60 days, beginning on the date of the qualifying event;

(3) For Employees and Retirees notification of an address change must be received within 31 days of the change of address;

(4) For Retirees the form must be received within 31 days of retirement;

E. DISENROLLMENT OF INELIGIBLE DEPENDENTS AND NOTIFICATION OF MEDICARE ENTITLEMENT

You must notify your Employer within 31 days of a change in family status or when a covered dependent is no longer eligible for coverage or becomes eligible for other group health insurance coverage, or if there is a change in Medicare entitlement. This notification must be made by completing and submitting an approved change form to the Plan Administrator and/or providing appropriate documentation. These changes include:

(1) Date of death of spouse;
Effective date of the dissolution of marriage or final divorce decree;
Date of legal separation;

(2) Guardianship/legal custody children who are no longer legally or financially dependent on the employee.

(3) Retiree or covered dependent of Retiree that becomes eligible or ineligible for Medicare;

(4) Employee changes family status (i.e. no eligible Dependents, eligible Spouse only, eligible Spouse and children only, eligible children only).

(5) Adult child becomes eligible for other employer sponsored group health insurance coverage.

F. DUAL CHOICE OF HEALTH CARE AND DENTAL CARE BENEFITS

If you live in an area served by a "Health Maintenance Organization" (HMO), which has arranged with our group to make available to Employees a dual choice of health care benefits, you may enroll yourself and your eligible dependents for the benefits provided by the HMO, in place of this Plan's coverage. This choice is available to new Employees upon becoming eligible for coverage. For those already covered under our Plan, it will be possible to transfer to the HMO during established annual re-enrollment periods.

An Employee who is enrolled in the HMO may transfer to the Plan's coverage at specified times as follows: (a) during the annual re-enrollment periods (see page 10), (b) the first of the month following your move out of the HMO service area (coverage will be subject to the new employee pre-existing limitations as outlined on page 23 of this document), and (c) upon the HMO ceasing operation.

G. EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

(1) The Eligibility Requirement.

(2) The Actively at Work Requirement.

(3) The Enrollment Requirements of the Plan.

(4) Appropriate premium has been paid.

Actively at Work Requirement.

Active Employees - An Employee must be Actively at Work for a benefit or a benefit increase to take effect. An Employee will be considered Actively at Work if the Employee is performing the essential duties of employment on that day, either at the Employer's place of business or at some location to which the Employee is required to travel for the Employer's business.

An Employee is considered to be Actively at Work on each day of a regular paid vacation and on each regular non-work day if the Employee was Actively at Work on the last preceding regular work day.
If the Employee does not comply with the active work requirement when the Employee would otherwise become covered for Employee Benefits, or where any adjustment of the benefits under such coverage would take effect, the effective date of such coverage or adjustment will be deferred until the first day of the month following the date the Employee returns to active work. This provision does not apply to any Employee who, until the effective date of the Group Plan, was a covered individual under any group policy or plan, which provided insurance or benefits for the Employees of the Employer.

Under certain circumstances, an Employee may be considered to be Actively at Work while on a leave qualified under the Family and Medical Leave Act of 1993.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the first day of the month following notification the Eligibility Requirement is met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

H. TERMINATION OF COVERAGE

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Option).

(1) The date the Plan is terminated.

(2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of employment of the covered Employee. (See the COBRA Continuation Option.)

(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

The Employer has issued coverage in reliance upon all information furnished to the Plan Administrator by the employee/retiree. In the event such information shall be untrue, inaccurate or incomplete, the Plan Administrator shall have the right to declare the coverage null and void as of the original effective date of coverage. **Any misuse of an identification card or fraudulent submission of information related to a claim or enrollment, or any other misrepresentation of fact material to Plan coverage or payment will also be grounds for dis-enrollment from this coverage.**

Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance.

For leave of absence or layoff only: the end of the six (6) calendar month period that next follows the month in which the person last worked as an Active Employee. Any Employee on authorized leave without pay who fails to make premium payments as required by the Employer, will have coverage under the Group Plan terminated on the first date for which no premium payments have been paid.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

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

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

If an Employee fails to return to work following the FMLA leave, the Employee must repay to the Employer all costs of their coverage absorbed by the Employer during the leave to subsidize the monthly cost of coverage.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

Employees on Military Leave. Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights include up to 18 months of

extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage with no preexisting conditions exclusions applied in the Plan upon return from service. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

Plan exclusions and Waiting Periods may be imposed for any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Option):

(1) The date the Plan is terminated.

(2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Option.)

(3) The date Dependent coverage is terminated under the Plan.

(4) On the last day of the calendar month that he or she ceases to be a Dependent as defined by the Plan. (See the COBRA Continuation Option.)

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) The end of the 90 day period following the Administrator's initial request for birth certificates, marriage certificates or other necessary dependent documentation.

Extension of Benefits. In the event coverage terminates for any reason while benefits are being paid, and it is established that:

(1) You or your Dependent was totally disabled when such coverage terminated, and

(2) You provide a statement from a physician verifying the disability, and your disability was certified by our utilization review company, and

(3) Expenses are incurred in connection with the accident or illness causing such total disability, and

(4) The total Maximum Annual Benefit Amount of benefits has not been paid.

Then, benefits with respect to expenses incurred in connection with the injury or illness causing such disability will be continued during such total disability until either:

(1) Twelve months from the date on which coverage terminated,

(2) The total Maximum Annual Benefit Amount has been paid,

(3) The Employee or Dependent ceases to be totally disabled, or

(4) Termination of the Plan, whichever occurs first.

3. RE-ENROLLMENT

During the annual re-enrollment period, covered Employees and their covered Dependents will be able to change health plans based on which benefits and coverages are right for them. Employees and their Dependents who choose to enroll in an available HMO plan during this re-enrollment period will be subject to any restrictions imposed by the HMO (as announced during the re-enrollment period).

Benefit choices made during the re-enrollment period will become effective January 1st, and remain in effect until the next January 1st. Employees/Retirees and their covered dependents switching to the Clark County Self-Funded Program during the annual re-enrollment period may be subject to the new employee pre-existing limitations as outlined on page 23 of this document.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverage.

Plan Participants will receive detailed information regarding re-enrollment from their Employer.

Retirees that reinstate coverage through a County sponsored HMO benefit plan, due to a HIPAA qualified event, may switch to the Clark County Self-Funded Program during the annual re-enrollment period subject to any applicable pre-existing limitation.

Employees and/or Dependents Enrolling as Late Participants

Employees who have previously waived their group health insurance may elect to enroll during the annual re-enrollment period for the following calendar year. Those employees previously not enrolled with one of the health benefit plans, and selecting the Self-Funded Program may be subject to $2,000.00 maximum payable for any pre-existing condition treated during the first 12 months of coverage under this Plan.

Dependents may be added during the annual re-enrollment period. However, any dependents added during the annual re-enrollment period may be limited to $2,000.00 maximum payable for any pre-existing condition treated during the first 12 months of coverage under this Plan.

A Pre-Existing Condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within 90 days of the person's Effective Date under this Plan. Genetic information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

Additional Dental Coverage Limitations for Late Participants: In the case of an employee enrolled during the annual re-enrollment period, a dependent who was added during the annual re-enrollment period (excluding employees and dependents switching plans), or an employee, retiree or dependent who enrolls due to involuntary loss of other coverage, the covered services will be limited to no benefit payment during the first three months of coverage for Class A Services, no benefit payment for six months for Class B Services, and no benefit payment for Class C and Class D Services for two years.

RETIREE REINSTATEMENT

Unless dictated by State Law, only retirees that have terminated coverage as a retiree may apply for re-instatement of benefits with a Clark County & Affiliated Entity sponsored benefit program January of an even numbered year, pursuant to NRS 287.0205. The following enrollment process must be completed and documentation received by Risk Management no later than January 31st, of an even numbered year.

(1) Completion of Health Benefit Enrollment form. If retiree requests reinstatement of previously covered dependents, a copy of the certified marriage certificate for the spouse, and copy of the certified copy of the birth certificate for each child being reinstated will be required.

(2) Coverage will be effective March first of an even numbered year following completion and receipt of the Plan approved enrollment form, and any applicable dependent records. PERS will be notified regarding applicable premium deduction from the retiree's monthly retirement check.

Retirees may not participate as the subscriber in both the Public Employees Benefit Plan, and a Clark County & Affiliated Entity sponsored benefit program.

Additional note regarding Pre-existing limitations for Medical and Dental:

Once coverage is in effect, unless the retiree provides a valid HIPAA Certificate of Creditable Coverage, all retiree applicants will be limited to $2,000.00 maximum payable for any pre-existing condition treated during the first 12 months of coverage under this Plan. A pre-existing condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within 12 months prior to the effective date of the retiree applicant. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account the medical advice, diagnosis, care or treatment must have been recommended by, or received from a Physician. Dental benefits will also be limited to no benefit payment during the first three months of coverage for Class A services, no benefit payment for six months for Class B services, and no benefit payment for Class C and Class D services for two years.

4. SCHEDULE OF BENEFITS

Verification of Eligibility

Eligibility for benefits under the plan is verified by the Claims Administrator. Call them at the telephone number shown on your identification card to verify eligibility for Plan benefits before a charge is incurred.

A. MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Participating Provider Plan (PPO)

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Participating Providers because these Participating Providers have agreed to charge reduced fees to persons covered under the Plan. It is the Covered Person's choice as to which Provider to use.

Additional information about this option, as well as a list of Participating Providers will be given to covered Employees and updated as needed.

Deductibles/Co-payments/Coinsurance payable by Plan Participants

Deductibles, coinsurance and co-payments are dollar amounts that the Covered Person must pay before the Plan pays.

Typically, a deductible is an amount of money that is paid once a calendar year per covered person, or per hospital confinement if a non-contracted provider is utilized. The calendar year deductible amount must be paid before any money is paid by the Plan for any covered services. Each January 1st, a new calendar year deductible amount is required. A separate hospital emergency room deductible may apply each time you visit a hospital emergency room. Deductibles do not count toward the 100% maximum out-of-pocket payment. Deductibles are not required when you use Participating Providers.

A co-payment is an amount of money that is paid each time to a participating provider for a particular service. Typically, there may be co-payments on some services and other services will not have any co-payments.

Coinsurance is the amount paid to non-contracted providers.

OUT OF POCKET MAXIMUM

The Plan will pay the designated percentage of covered charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.

The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%:

Deductible(s)
Outpatient mental health treatment charges
Inpatient mental health treatment charges
Pharmacy Co-payments

SCHEDULE OF BENEFITS

CALENDAR YEAR DEDUCTIBLE	PARTICIPATING PROVIDERS		NON-PARTICIPATING PROVIDER
	Primary Care Physician	Specialist Physician	
Per Covered Person	$0	$0	$275
Per Family Unit	$0	$0	$550
Calendar year deductible is waived for the following covered charges: All accidental injuries.			

HOSPITAL SERVICES	PPO HOSPITAL	CONTRACTED HOSPITALS*	NON-CONTRACTED HOSPITALS*
CO-PAYMENTS, PER CALENDAR YEAR	University Medical Center of So. Nevada	CCSF Contracted Hospitals	All Other Hospitals
Inpatient Hospital Services	-0-	20% + $275 Calendar year deductible	40% + $550 per confinement deductible+ $275 calendar year deductible
Emergency Room	10%	20% + $275+ $55 ER Deductible	40% + $275 + $55 ER Deductible
Out-Patient Hospital Services (Outpatient Surgery Done In a Hospital Surgery Center)	-0-	$275 Calendar Year Deductible + 20%	$275 Calendar Year Deductible + 40%
Lab & X-Ray	-0-	$275 Calendar Year Deductible + 20%	$275 Calendar Year Deductible + 40%

Emergency room deductible is waived if the treatment is for an accidental injury.

The utilization review administrator must be notified (see ID card) within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.

The $550 per non-contracted hospital confinement deductible will not apply to emergency hospital admissions, admissions incurred as a result of accidental injury, or to any members living more than 100 miles outside of Clark County that utilize the services of a hospital outside of Clark County.

The 60% reimbursement for non-participating providers will revert to 80% reimbursement of usual and customary in the following circumstances:

Members living more than 100 miles outside of Clark County and utilizing the services of a provider outside of Clark County.

Emergency treatment for accidental injury provided outside of Clark County, or emergency treatment of an illness outside the service area if the treatment is for the sudden or unexpected onset of a condition that was severe enough to require immediate treatment and certified as such by our utilization review company.

$275 Calendar Year Deductible will be waived for inpatient hospital facility charges when a member is forced to go to another contracted facility when documentation demonstrates University Medical Center (UMC) is on divert status.

*** Subject to Usual and Reasonable Charge requirements and Deductible(s)**

PHYSICIAN SERVICES	Participating Providers Primary Care Physicians	Participating Providers Specialists	Non-Participating Physician*
Inpatient surgery (including surgeon, assistant surgeon and anesthesiologist)	$100/Surgery including all procedures performed in one day	20% per specialist service	40%
Outpatient Surgery: Hospital/Surgical Center Office	$60.00/per surgical session $10.00/procedure	20% 20%	40% 40%
Obstetrics	$100/Pregnancy	20%	40%
Sterilization: Tubal Ligation Vasectomy	$200 $100	20% 20%	40% 40%
Inpatient Hospital/Skilled Nursing Facility Visits	None	20%	40%
Office/Home Visits	$20/Visit	20%	40%
Consultations	$20/Consultation	20%	40%
Physical Therapy	$10/Visit	20%	40%
Radiology	20%	20%	40%
Pathology	20%	20%	40%
Allergy Testing	$50/Case	20%	40%
Allergy Injections	$10/Injection	20%	40%
Other Therapeutic Injections	None	20%	40%
Home IV Therapy & Supplies	N/A	20%	40%
Surgical Centers (Facility) (Non-Hospital/Free Standing)	N/A	20%	40%
Urgent Care	UMC Quick Care Only $-0- copay	20%	All Other Urgent Care Centers 40%

As referred to in this schedule, primary care physicians refers to general and family practitioners, internists, pediatricians, obstetricians and gynecologists. Specialists refer to all other physicians

The 60% reimbursement for non-participating providers will revert to 80% reimbursement of usual and customary in the following circumstances:

Members living more than 100 miles outside of Clark County and utilizing the services of a provider outside of Clark County.

Emergency treatment for accidental injury provided outside of Clark County, or emergency treatment of an illness outside the service area if the treatment is for the sudden or unexpected onset of a condition that was severe enough to require immediate treatment and certified as such by our utilization review company.

*** Subject to Usual and Reasonable Charge requirements and Calendar Year Deductible**

OTHER COVERED SERVICES	PARTICIPATING PROVIDERS	NON-PARTICIPATING/NON-CONTRACTED PROVIDER*
Skilled Nursing Facility	20% of One-half Hospital average semiprivate room rate of previous facility; 120 days Calendar Year maximum*	40% of One-half Hospital average semiprivate room rate of previous facility; 120 days Calendar Year maximum*
Inpatient Physical Rehabilitation Benefit	20% co-payment 60 day Calendar Year maximum	40% after deductible 60 day Calendar Year maximum
Home Health Care	20% co-payment 60 visits Calendar Year maximum	40% after deductible 60 visits Calendar Year maximum*
Outpatient Private Duty Nursing	20% co-payment	40% after deductible
Hospice Care	20% co-payment	40% after deductible
Local Ambulance Service	N/A	40% after deductible
Jaw Joint/TMJ	20% co-payment	40% after deductible
Occupational Therapy	20% co-payment	40% after deductible
Speech Therapy	20% co-payment	40% after deductible
Durable Medical Equipment	20% co-payment $25,000 Lifetime maximum	40% after deductible $25,000 Lifetime maximum
Prosthetics	20% co-payment	40% after deductible
Spinal Manipulation	20% co-payment; 20 visits/Calendar Year max	40% after deductible; 20 visits/Calendar Year max
Acupuncture Treatments	20% co-payment 20 visits/Calendar Year max	40% after deductible; 20 visits/Calendar Year max
Organ Transplants	20% co-payment	40% after deductible
Autism Treatment Behavior Analysis Treatment	20% co-payment Annual Maximum payable $36,000	40% after deductible Annual Maximum payable $36,000

Preventive Care	Primary Care Physician	Specialist Physician	Non-Participating Physician
Age 18 and older, Annual cytological screening test and CA125 screening	$20 co-payment for office visit 20% co-payment for laboratory	20% co-payment	40% after deductible
Ages 35 - 39, single baseline mammogram	20% co-payment for x-ray	20% co-payment	40% after deductible
Ages 40 and over, annually	20% co-payment for x-ray	20% co-payment	40% after deductible
Diabetic Education	20% co-payment		40% after deductible
Routine Well Child Care through age 6	20% co-payment		40% after deductible
Age 40 & over, Annual PSA (Prostate Specific Antigen)	20% co-payment		40% after deductible

As referred to in this schedule, primary care physicians refers to general and family practitioners, internists, pediatricians, obstetricians and gynecologists. Specialists refer to all other physicians

The 60% reimbursement for non-participating providers will revert to 80% reimbursement of usual and customary in the following circumstances: Members living more than 100 miles outside of Clark County and utilizing the services of a provider outside of Clark County. Emergency treatment for accidental injury provided outside of Clark County, or emergency treatment of an illness outside the service area if the treatment is for the sudden or unexpected onset of a condition that was severe enough to require immediate treatment and certified as such by our utilization review company.

*** Subject to Usual and Reasonable Charge requirements and Deductibles**

MENTAL HEALTH DISORDERS	PARTICIPATING PROVIDERS	NON-PARTICIPATING/NON-CONTRACTED PROVIDER*
Inpatient	20% after deductible 30 days Calendar Year max	40% after deductible; 30 days Calendar Year max **
Outpatient	50% co-payment per visit	50% after deductible; maximum $100 covered charge per visit

SUBSTANCE ABUSE	PARTICIPATING PROVIDERS	NON-PARTICIPATING/NON-CONTRACTED PROVIDER*
Inpatient	20% after deductible; withdrawal or treatment limited to 7 days $1,500; $10,000 Calendar Year maximum	40% after deductible; withdrawal or treatment limited to 7 days $1,500; $10,000 Calendar Year maximum **
Outpatient	20% co-payment; $2,500 Calendar Year maximum	40% after deductible; $2,500 Calendar Year maximum
Inpatient / Outpatient Combined	20% co-payment; 3 courses of treatment or $39,000 Lifetime maximum	40% after deductible; 3 courses of treatment or $39,000 Lifetime maximum

** Plus $550 Per Confinement Deductible

The 60% reimbursement for non-participating providers will revert to 80% reimbursement of usual and customary in the following circumstances:

Members living more than 100 miles outside of Clark County and utilizing the services of a provider outside of Clark County.

Emergency treatment for accidental injury provided outside of Clark County, or emergency treatment of an illness outside the service area if the treatment is for the sudden or unexpected onset of a condition that was severe enough to require immediate treatment and certified as such by our utilization review company.

*** Subject to Usual and Reasonable Charge Requirements and Deductible**

PRESCRIPTION DRUGS	Contracted In-Network Pharmacy Preferred Medications	Contracted In-Network Pharmacy Non-Preferred Medications
Retail 30 Day Supply	$6 co-payment for each Preferred Generic prescription; $ 35 co-payment for each Preferred Brand prescription	50% co-payment for all non-preferred prescriptions; Maximum co-payment per prescription $ 200*
Mail Order 90 Day Supply Maintenance Drugs Defined Disease State	$12 co-payment for Preferred Generic prescription; $ 70 co-payment for Preferred Brand prescription	N/A

	PARTICIPATING PROVIDERS		NON-PARTICIPATING PROVIDER
	Primary Care Physician	Specialist Physician	
MAXIMUM ANNUAL BENEFIT AMOUNT PER COVERED PERSON	$2,000,000.00 (Including Participating Provider Plan)		

B. DENTAL BENEFITS

Calendar Year Deductible

Per Person	$50
Per Family Unit	$100

The deductible applies to these Classes of Service:

Class B Services - Basic
Class C Services - Major
Class D Services - Orthodontia (treatment plans that began prior to January 1, 2003)

Dental Percentage Payable*

Class A Services - Preventive	100%
Class B Services - Basic	80%
Class C Services - Major	80%
Class D Services - Orthodontia (Lifetime Maximum per qualified dependent child)....	$3,000

Maximum Benefit Amount (For Classes A, B and C Services)

Per Person First Calendar Year of Coverage

Individual	$1,500
Family	$3,000

Per Person Second Calendar Year of Coverage

Individual	$1,750
Family	$3,500

Per Person Third and Subsequent Calendar Year of Coverage

Individual	$2,000
Family	$4,000

**** Subject to Usual and Reasonable Charge requirements and Deductible***

5. MEDICAL BENEFITS

Medical Benefits apply when covered, medically necessary charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

A. DEDUCTIBLE

Deductible Amount. This is an amount of covered charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

This amount will not accrue toward the 100% maximum out-of-pocket payment.

Family Unit Limit. When the dollar amount shown in the Schedule of Benefits has been incurred by two or more members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

B. BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the covered charges of a Covered Person that are in excess of the deductible. Payment will be made at the rate shown under Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

C. OUT-OF-POCKET MAXIMUM

Covered services are payable at the percentages shown in the schedule of benefits until $11,000 in covered charges per calendar year has been reached. Then, the covered charges incurred by a covered person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

The following charges do not apply toward the out-of-pocket maximum:

- Deductible(s)
- Outpatient mental health treatment charges
- Inpatient mental health treatment charges
- Pharmacy co-payments
- UMC Inpatient Charges

In the event that a Covered Person has reached the out-of-pocket limit at the time that the services for which a co-payment is required are rendered by a Participating Provider, the Plan will reimburse the co-payment to the Covered Person (excluding any Pharmacy co-payments).

D. MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all covered charges incurred by a Covered Person.

E. COVERED CHARGES

Covered charges are the medically necessary, Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions (including those requiring Cost Management Services) of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at 90% of the average private room rate.

(2) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility;

(b) the confinement starts within 15 days of a Hospital confinement of at least 3 days;

(c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(d) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered charges for a Covered Person's care in a skilled nursing facility is limited to 120 days per calendar year.

(3) **Inpatient Medical Rehabilitation Care.** The inpatient rehabilitation services in a licensed acute care hospital rehabilitation unit, or skilled nursing facility for short term, active, progressive rehabilitation services, that cannot be provided in an outpatient or home setting. The maximum allowable for this type of care is 60 days in a calendar year.

(4) **Physician Care.** The professional services of a Physician provided in their office, or in a hospital, for surgical services, medical services, x-ray or pathology services.

(a) Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:

(i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed each additional procedure performed during the same operative session. Any procedure that would be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure and limited in total to 150% of the combined total; and

(iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:

(a) Inpatient Nursing Care. Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is full or the Hospital has no Intensive Care Unit.

(b) Outpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a shift-basis is not covered.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility

confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

(8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) Ambulance. Local Medically Necessary professional ground transportation ambulance service(within 100 miles). A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided. In accordance with NRS 689B.047, reimbursement for this service must be made directly to the provider if that provider does not receive reimbursement from any other source. Air ambulance to the nearest facility where necessary treatment is available is covered if no emergency ground transportation is available or suitable, and the patient's condition warrants immediate evacuation.

(b) Amniocentesis. Prenatal diagnostic study to detect genetic and biochemical abnormalities, maternal-fetal blood incompatibility subject to approval by the utilization review organization for medical necessity.

(c) Acupuncture. The insertion of needles into the human body by piercing the skin of the body to control and regulate the flow and balance of energy in the body and to cure any ailment or disease of the mind or body; or any wound, bodily injury or deformity performed by a doctor of acupuncture or doctor of oriental medicine, licensed by the state, practicing under the scope of their state license. Acupuncture treatment is limited to 20 visits per calendar year.

(d) Anesthetic. Oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(e) Bariatric Surgery. Surgical intervention to alter the path of digestion or the volume of food intake in order to surgically reduce the member's caloric intake, to include but not limited to, restrictive procedures such as gastric banding or gastric stapling; malabsorptive procedures such as biliopancreatic diversion; combination restrictive/malabsorptive procedures such as gastric bypass (Roux-en-Y). Coverage of this type of surgery shall be limited to one per member's lifetime, and remains subject to all other Plan provisions.

(f) BRCA1 & BRCA2 Genetic tests for individuals already diagnosed with breast and/or ovarian cancer where results may affect the course of treatment.

(g) Cardiac rehabilitation as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(h) Chemotherapy. Radiation or chemotherapy and treatment with radioactive substances. The materials and services of technicians are included.

(i) Diabetic Education/Training. The diabetic training and education provided after the member is initially diagnosed with diabetes, which is medically necessary for the care and management of diabetes, including, without limitation, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes. Also, the training and education which is medically necessary as a result of a subsequent diagnosis that indicates a significant change in the symptoms or condition of the member which requires modification of the program of self-management of diabetes.

(j) Rental of **(durable) medical equipment** (or purchase and fitting of such equipment when purchase is more cost effective for the Plan than rental) such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness that occurred while covered under the Plan. Maximum lifetime payable $25,000.00.

(k) Medically Necessary services for care and treatment of **jaw joint conditions**, including Temporomandibular Joint syndrome (excluding Orthognathic surgery).

(l) **Laboratory studies**.

(m) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness that occurred while covered under the Plan and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy. Occupational therapy will be limited to 30 visits per calendar year, subject to utilization review for additional visits.

(n) **Orthotics.** Custom molded devices for the feet, lifetime maximum payable of $500.00.

(o) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and to improve a body function. Physical therapy will be limited to 30 visits per calendar year, subject to utilization review for additional visits.

(p) The purchase and fitting of fitted **prosthetic devices** which replace body parts provided that the loss occurred while covered under the Plan.

(q) **Radial Keratotomy** or other eye surgery to correct near-sightedness when visual acuity could not have been corrected to 20/50 with eyeglasses or contact lenses prior to surgery.

(r) **Speech therapy** by a qualified speech therapist, other than a close relative, to restore or rehabilitate any speech loss or impairment caused by injury or sickness, (except a mental, psychoneurotic or personality disorder) or by surgery for that injury or sickness, and includes speech therapy undertaken for correction of physical bodily function, i.e. swallowing. Speech therapy undertaken for correction of stuttering is not an eligible charge. In the case of congenital defect, speech therapy expenses will be considered only if incurred after corrective surgery for the defect. Speech therapy will be limited to 30 visits per calendar year, subject to utilization review for additional visits.

(s) **Spinal Manipulation/Related Modalities** by a licensed M.D., D.O. or D.C.

(t) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(u) Diagnostic **x-rays**.

F. INJURY TO OR CARE OF MOUTH, TEETH AND GUMS

Charges for injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under Medical Benefits only if that care is for the following oral surgical and dental procedures:

(1) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

(2) Emergency repair due to Injury to sound natural teeth. This repair must be made within 12 months from the date of an accident and the accident must have occurred while the person was covered under the Plan.

(3) Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth when the Injuries occurred while covered under the Plan.

(4) Excision of benign bony growths of the jaw and hard palate.

(5) External incision and drainage of cellulitis.

(6) Incision of sensory sinuses, salivary glands or ducts.

(7) Removal of impacted teeth. (Only covered under medical when dental benefits exhausted.)

(8) Dental services when need for such service is directly related to another medical condition for which treatment is covered under the Plan. This coverage becomes effective only after the member has exhausted benefits available under the Dental Services portion of the Plan, and is limited to those services excluding dental implants. Medical documentation must be provided indicating medical condition warranting the necessity of such dental services, and approved by the utilization review organization. Cosmetic dental services are not a covered expense.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

G. TREATMENT OF MENTAL DISORDERS AND SUBSTANCE ABUSE

Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

(1) All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

(2) Psychiatrists (M.D.), psychologists (Ph.D.), or counselors (LCSW, LMFT, & LADC) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

(3) No benefits will be provided for charges from any residential treatment facilities.

H. ORGAN TRANSPLANT COVERAGE LIMITS

Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

(1) The transplant must be performed to replace an organ or tissue of the Covered Person.

(2) There is no coverage under the Plan for charges or services incurred in obtaining donor organs if such charges or services are covered under any group or individual coverage of the donor.

(3) The transplant must be performed at a Plan designated or contracted organ transplant facility to receive the maximum benefits.

I. ROUTINE PREVENTIVE CARE

Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

Charges for Routine Well Adult Care. Routine well adult care includes the following cytological screening tests and mammograms:

An annual cytological screening test and CA125 for women 18 years of age or older;
The human papillomavirus vaccine, as recommended by the Food and Drug Administration or manufacturer;
A baseline mammogram for women between the ages of 35 and 40;
An annual mammogram for women 40 years of age or older;
An annual dexascan for members over the age of 50; and
An annual PSA (Prostate specific antigen) screening test for men 40 years of age or older.

Charges for Routine Well Child Care. Routine well child care includes routine physical exams and immunizations by a Physician, from birth through age 6, that is not for an Injury or Sickness. Routine Well Child Care does not include charges for routine laboratory testing.

Charges for Routine Newborn Physician Care. The benefit is limited to the Usual and Reasonable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Charges for Obstetrical Care. The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness. Coverage for a Hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the mother (if a Covered Person) and the newborn child. Coverage for a Hospital stay in connection with childbirth following a Cesarean section may not be limited to less than 96 hours for both the mother (if a Covered Person) and the newborn child. The mother and Physician may jointly agree to stays shorter than these limits.

Charges for Routine Screening for Colorectal Cancer. The benefit for these screenings will be covered in accordance with Nevada Revised Statute. The benefits will be limited to the usual & reasonable allowance.

Charges for the Human Papillomavirus (HPV) Immunization. This service will be covered in accordance with Nevada Revised Statute, and as approved by the Food and Drug Administration. The benefit will be limited to the usual & reasonable allowance.

J. WELLNESS BENEFITS

The Plan provides a wellness benefit up to $150.00 per calendar year for the following routine services for each covered employee/retiree and covered spouse, and covered dependent child from the age of 7 through 18. Co-payments for any routine services covered elsewhere under this plan are not eligible for reimbursement under this benefit. This benefit may not be accumulated from year to year, if the benefit is not used each year. An itemized statement must be submitted in order to receive this benefit. For the submission of medications for smoking cessation or weight loss, the medication must be recognized and approved by the FDA for the treatment of smoking cessation or weight loss, receipts must be from a pharmacy and include the name of the drug, patient's name, date dispensed, and amount of purchase.

(1) Check-ups (including routine physical examination, laboratory tests and x-rays)
(2) Immunizations
(3) Eyeglasses or contact lenses (not covered by vision plan)
(4) Hearing aids or evaluation to determine the need for a hearing aid
(5) Programs to stop smoking as approved or prescribed by a physician
(6) Weight loss program as approved or prescribed by a physician
(7) Minor outpatient surgical procedures

K. AUTISM SPECTRUM DISORDER COVERAGE EFFECTIVE JULY 1, 2011

Covered charges include medically necessary services that are generally recognized and accepted procedures for screening, diagnosing and treating Autism Spectrum Disorders for children under the age of 18 or, if enrolled in high school, until such Member reaches the age of 22. Covered Services must be provided by a duly licensed physician, psychologist or Behavior Analyst (including an Assistant Behavior Analyst and/or Certified Autism Behavior Interventionist) and are subject to utilization review, as outlined in Section 6 of this Plan.

Covered Services for the treatment of Autism Spectrum Disorder do not include services provided by:

- an early intervention agency or school for services delivered through early intervention, or
- school services.

The following terms apply to the coverage for Autism:

(a) "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior,

including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

(b) "Autism spectrum disorders" means a neurobiological medical condition including, without limitation, Autistic Disorder, Asperger's Disorder and Pervasive Development Disorder Not Otherwise Specified.

(c) "Behavioral therapy" means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or certified autism behavior interventionist.

(d) "Certified autism behavior interventionist" means a person who is certified as an autism behavior interventionist by the Board of Psychological Examiners and who provides behavior therapy under the supervision of:

(1) A licensed psychologist;
(2) A licensed behavior analyst; or
(3) A licensed assistant behavior analyst.

(e) "Evidence-based research" means research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.

(f) "Habilitative or rehabilitative care" means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.

(g) "Licensed assistant behavior analyst" means a person who holds current certification or meets the standards to be certified as a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Board of Psychological Examiners and who provides behavior therapy under the supervision of a licensed behavior analyst or psychologist.

(h) "Licensed behavior analyst" means a person who holds current certification or meets the standards to be certified as a board certified behavior analyst or a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and who is licensed as a behavior analyst by the Board of Psychological Examiners.

(i) "Prescription care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

(j) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

(k) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

(l) "Screening for autism spectrum disorders" means all medically appropriate assessments, evaluations or tests to diagnose whether a person has an autism spectrum disorder.

(m) "Therapeutic care" means services provided by licensed or certified speech pathologists, occupational therapists and physical therapists.

(n) "Treatment plan" means a plan to treat an autism spectrum disorder that is prescribed by a licensed physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst.

L. PRE-EXISTING CONDITIONS

Pre-Existing Condition is a condition for which medical advice, diagnosis, care or treatment was recommended or

received within 90 days of the person's Enrollment Date under this Plan. Genetic information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

Benefits payable will be limited to a maximum of $2,000 for expenses incurred for a Pre-Existing Condition until no medical advice, diagnosis, care or treatment is recommended or received for the Pre-Existing Condition for 90 days of continuous coverage or

(1) In the case of an Employee, the end of 6 continuous months immediately following the Employee's Effective Date, and

(2) In the case of a Dependent, the end of 12 continuous months immediately following the Dependent's Effective Date, whichever is earlier.

This pre-existing condition limitation does not apply to newly enrolled children under the age of 19.

In the case of an Employee and Dependents of the Employee who are covered under the Plan immediately prior to the date the Employee terminates employment with an Employer, who, within 31 days of such termination, become covered individuals with another Employer, the date of coverage for purposes of this provision shall be the date such individual became covered with the Employer who first provided him or her with coverage.

The Pre-Existing Condition does not apply to pregnancy, to a newborn child who is covered under this Plan within 60 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 60-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption. The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

Credit for Previous Coverage
A certification of the period of creditable coverage under any other health care plan or insurance policy must be submitted in order to prove entitlement to credit for the time covered under that other plan or policy. The proof of prior or other coverage will reduce the maximum period of exclusion of coverage for this Plan's pre-existing conditions, verifying there has been no break in coverage.

A "break in coverage" means a period of 63 consecutive days or more between the date coverage ended under the other health care plan or insurance policy, and the effective date of this coverage. A previous employer, or insurer is required by federal law to provide such a certification upon request. If there **has been** a break in coverage, no such credit will be provided for any periods of coverage prior to the break in coverage. If there has been **no** break in coverage, the maximum period of exclusion of coverage for pre-existing conditions described in this section will be reduced by the period of time that the individual was covered under any health insurance policy or plan that provides reimbursement for hospital and medical expenses or provides hospital and medical services. This includes COBRA Continuation Coverage, or any group healthcare plan or insurance policy (whether or not it is employer-sponsored), any individual health insurance policy or program, Medicare, Medicaid, military-sponsored health care, Tricare/Champus, CHIP, program of the Indian Health Service, state health benefits risk pool, the federal employees health benefit program, a public health plan, and/or any health benefit plan provided under the Peace Corps.

Additional Dental Coverage Limitations for Late Participants: In the case of an individual whose Dental Benefits start more than 31 days after that individual becomes eligible, the covered services will be limited to no benefit payment during the first three months of coverage for Class A Services, no benefit payment for six months for Class B Services, and no benefit payment for Class C and Class D Services for two years.

6. COST MANAGEMENT SERVICES

Read the following carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid. See your ID card for more details and the phone number you will need.

A. UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

(1) Hospitalizations, and
(2) Outpatient tests and procedures expected to exceed $400.00, and the following services:
(a) All durable medical equipment
(b) Dexascan for members under the age of 50
(c) Hospice Care
(d) Home Health Care
(e) Obstetrical Ultrasounds
(f) Outpatient MRI/MRA/CAT/PET Scans
(g) Outpatient surgery and/or office surgery (if charges are expected to exceed $400 per session)
(h) Rehabilitative Services – speech therapy, physical therapy, occupational therapy after 6th visit

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what is medically appropriate. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or expects to have outpatient tests and procedures exceeding $400, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by you when your physician recommends hospitalization or outpatient tests and procedures exceeding $400. You must inform your physician of the Plan's participation in utilization review. Your identification card shows the utilization review administrator's name and phone number for your doctor to call.

Authorization is given by telephone, followed by written confirmation to the patient, the Physician, the hospital and the Plan's Claim Administrator.

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator (see ID card) **within 48 hours** of the first business day after the admission or as soon as possible. This requirement does not apply for obstetrical care or when Medicare is the primary payor with the exception of rental or purchase of durable medical equipment, which still requires prior authorization.

The Utilization Review Organization will comply with the external review process of adverse determinations as outlined in the Nevada Revised Statute.

The utilization review administrator will determine the number of days of Medical Care Facility confinement authorized for payment. **Failure to obtain inpatient prior authorization will reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the admitting Physician and hospital allowable expenses for inpatient hospitalizations will be reduced to 75% of the covered charges.
Example
If the hospital bill is $4,000 and the hospitalization was not authorized, the eligible charges are reduced by 25%, to $3,000 and the Plan will pay benefits on $3,000.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days and receive proper authorization.

B. PRE-ADMISSION TESTING SERVICE

The Medical Benefits percentage will be at 100% for diagnostic lab tests and x-ray exams performed by the PPO Hospital or contracted hospitals when:

(1) performed on an outpatient basis within five days before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

The major medical deductible (if applicable) will apply for these tests.

C. CASE MANAGEMENT

When a catastrophic condition, such as a spinal cord injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps lifetime care. After the person's condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting—even to his or her home.

Case Management is a program whereby a case manager monitors these patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;

- monitoring Hospital or nursing home care;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs in the following situations:

(1) The catastrophic Injury or Sickness must have occurred while the patient was Covered and the Injury or Sickness must have been Covered under the Plan.

(2) An alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

7. DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Accidental Injury means a traumatic injury caused by sudden, unexpected or violent external force.

Active Employee is an Employee who performs all of the duties of his or her job with the Employer on a permanent full-time basis.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Baseline shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means January 1st through December 31st of the same year.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance is the stated percentage of covered charges you must pay to a non-participating provider after you have met any applicable deductible as listed in the schedule of benefits. The Plan will base this percentage on either the billed charge or the usual and customary charge, whichever is less.

Co-payment is the stated amount the Plan requires you to pay for a covered service provided by a participating or contracted provider.

Cosmetic Surgery means medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurements.

Covered Person is an Employee, Retiree or Dependent who is covered under this Plan.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication, which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Domestic Partner means a person who, with an Employee as defined herein has: 1) a registered, valid domestic partnership pursuant to NRS 122A.100; and 2) has not terminated that domestic partnership pursuant to NRS 122A.300; and 3) is a person of the same gender as the Employee.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Effective Date means January 1, 2013. The provisions of the Plan as in effect on the date of service shall remain applicable with respect to covered persons on the date of service, and with respect to the Plan coverage available at the time the expenses were incurred.

Emergency Admission means a hospital admission due to the sudden or unexpected onset of a condition or an injury that is severe enough to require immediate confinement as inpatient in an acute care hospital.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship, excluding provisional, temporary, or seasonal Employees. Employee shall also include certain individuals described in Appendix A for the limited purposes described in Appendix A

Employer means the following public agencies: Clark County, Nevada; Clark County Water Reclamation District; University Medical Center of Southern Nevada; Henderson District Public Library, Southern Nevada Health District, the Las Vegas Convention & Visitors Authority; the Las Vegas Valley Water District; and the Regional Transportation Commission of Southern Nevada.

Enrollment Date is the first day of coverage or, if there is a waiting period, the first day of the waiting period.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The Plan Administrator will be guided by the following principles:

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

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan. If the lawful spouse of a covered employee is also covered as an employee by this Plan, that individual will also be considered part of the family unit.

Group Health Committee means the committee established by the Plan Administrator in accordance with Appendix B

Generic Drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly

designated by the pharmacist as being generic.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Health Benefit Plan means a benefit plan that provides coverage for the reimbursement of inpatient or outpatient hospital services, physician services, diagnostic x-rays, and laboratory services, as well as dental coverage if available.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the home health care is in place of Hospital confinement; and it must specify the type and extent of home health care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

* A facility operating legally as a licensed psychiatric Hospital.

* A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Immunizations. The administration of a vaccine to provide immunity and resistance to certain diseases, by stimulating the body's own immune system to protect the individual against subsequent infection or disease.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of

the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Legal Custody means a court order awarding legal custody to a person (other than a parent, legal guardian or government organization). For purposes of this Plan coverage, an award of legal custody must place financial responsibility for the minor child upon the person to whom custody is awarded.

Legal Guardian means a court appointed person having the duty of taking care of the person of and managing the property and rights of a minor child.

Licensed Behavior Analyst means a person who holds current certification or meets the standards to be certified as a board certified Behavior Analyst issued by the Behavior Analyst Certification Board, Inc., and whom the Board of Psychological Examiners licenses as a Behavior Analyst.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Limiting Age for covered children is to the end of the month in which the child reaches age 26.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition and restores a bodily function; is not performed mainly for the convenience of the patient or provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Group Health Committee has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Member is an employee who is currently employed by one of the covered employers participating in this benefit plan and is covered by the Plan, or a retired employee formerly employed by one of the covered employers, and is currently covered by the Plan.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent Metropolitan Life Insurance Co. tables (or similar actuarial tables) for a person of the same height, age and mobility as the Covered Person.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient Care is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Pharmacy Benefit Manager (PBM) means an organization that has contracted with the Plan to provide covered prescription drugs through a comprehensive network of pharmacies.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Acupuncturist, Licensed Professional Counselor, Registered Professional Physical Therapist, Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Self-Funded Group Medical and Dental Benefit Plan, which is a benefits plan for certain employees of Clark County, Nevada and is described in this document.

Plan Participant is any Employee, Retiree or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on the Effective Date of the Plan.

Pre-Existing Condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within 90 days of the person's Enrollment Date under this Plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to pregnancy, to a newborn child who is covered under this Plan within 60 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 60-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

Preferred Brand Name Prescription Drug means a brand name prescription drug currently listed on the Pharmacy Benefit Manager's formulary as a preferred brand drug.

Preferred Generic Prescription Drug means a generic prescription drug currently listed on the Pharmacy Benefit Manager's formulary as a preferred generic drug.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drugs must be Medically Necessary in the treatment of a Sickness or Injury.

Prophylactic Surgery or Treatment means surgical services or medical treatment performed for the purpose of avoiding the possibility or risk of an illness, disease, physical or mental disorder. This includes treatment or services based on genetic information or genetic testing, or the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder.

Retired Employee is a Former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer, receiving retirement benefits under the Nevada Public Employees Retirement Act (NRS Chapter 286) or the Las Vegas Valley Water District Retirement Plan, and elects to continue coverage on a contributory basis.

Sickness is: For all covered persons: Illness, disease or Pregnancy.

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

Special Enrollee means an eligible employee, eligible family member, or retired employee who applies for coverage during a Special Enrollment Period following a Special Enrollment Event.

Special Enrollment Period means either a thirty-one (31) or sixty (60) day period following a Special Enrollment Event, as defined below:

Special Enrollment Event means an opportunity for a Special Enrollee to enroll for coverage:
Within sixty (60) days of the following events:
A change in marital status, or
An addition of a newborn, adopted or eligible minor dependent child.
Within thirty-one (31) days of the following events:
A change in Active Employee status to Retiree status, or
Involuntary loss of eligibility with another group healthcare coverage.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Surviving Spouse is a spouse of a Retired employee who is deceased, and was a covered dependent at the time of the covered Retiree's death.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include physical therapy, surgery, and any appliance that is attached to or rests on the teeth. Orthodontia treatment is not covered.

Totally Disabled means an employee who is unable to perform the duties of his or her own occupation and is confined to home or hospital due to illness or injury. In the case of a dependent or Retiree, totally disabled is defined as an individual who is unable to perform the daily activities of life and is confined to home or hospital due to illness or injury.

Totally Disabled Child means a child who is incapable of self-sustaining employment by reason of mental retardation or physical disability, and is primarily dependent upon the covered employee for support and maintenance.

Usual and Reasonable Charge is the usual charge made by the provider for a like service in the absence of the coverage, but not more than the prevailing charges, as determined by the County, for medical care of a comparable nature, made by providers of similar training and experience, within the area in which the service is actually provided.

"Area" means the municipality (*or in the case of a large city, the subdivision thereof)* in which the service is actually provided or such greater area as is necessary to obtain a representative cross section of charges for a like service. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will reimburse at the applicable coinsurance rate the actual charge billed if it is lesser than the Usual and Reasonable Charge.

8. PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

Note: All exclusions related to Dental are shown in the Dental Plan.

For all Medical Benefits shown in the Schedule of Benefits, any charges incurred for or in connection with the following are not covered:

(1) **Abortion.** Which is not medically necessary.

(2) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan.

(3) **Cosmetic services.** Care and treatment provided for cosmetic reasons. This exclusion will not apply if the care and treatment is for repair of damage from an Accidental Injury that occurred while the person was covered under the Plan; or is for correction of abnormal congenital condition in a child born while covered under the Plan.

Reconstructive mammoplasty will be covered after a medically necessary mastectomy. Coverage will include reconstructive surgery of the breast on which a mastectomy, partial mastectomy or lumpectomy has been performed, and reconstruction of the other breast to produce a symmetrical appearance, and prostheses. Treatment of physical complications for all stages of mastectomy, including lymphedemas, will also be covered.

(4) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(5) **Educational or vocational testing.** Services for educational or vocational testing or training. With the exception of Diabetic Training.

(6) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(7) **Exercise programs.** Exercise programs for treatment of any condition.

(8) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental or Investigational or not Medically Necessary. Charges for experimental services are covered to the extent as provided by Nevada Revised Statutes.

(9) **Eye care.** Radial keratotomy or other eye surgery to correct near-sightedness (except as provided elsewhere in the Plan). Also, routine eye examinations, including refractive errors, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

(10) **Genetic Testing** and Counseling. Expenses for genetic testing and counseling, except as where otherwise indicated in this document as a covered expense.

(11) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(12) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

(13) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting.

(14) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(15) **Immunizations.** Expenses for the administration of a vaccine to provide immunity and resistance to certain diseases, except as otherwise provided in this document.

(16) **Infertility.** Services provided to assist with artificial means of conception, including but not limited to artificial insemination, embryo transplants, in vitro fertilizations, and low tubal transfers, including prescriptions and any medical treatments to assist with any of these services Reversal of surgically performed sterilizations or subsequent re-sterilization.

(17) **Marriage and family counseling**. Behavioral therapy addressing marital and family relationship issues.

(18) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(19) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(20) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(21) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(22) **Not specified as covered.** Services, treatments and supplies not specified as covered under this Plan.

(23) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Medically Necessary charges for Morbid Obesity will be covered.

(24) **Occupational.** Care and treatment of an Accidental Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment, or is otherwise deemed by Statute to be care or treatment compensable under the Nevada Industrial Insurance Act commencing at NRS Chapter 616A et seq

(25) **Orthognathic surgery.** The surgical correction of a skeletal anomaly or malformation of the jaw involving the mandible or maxillary joint.

(26) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, vehicular wheel chair lifts, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(27) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(28) **Prophylactic Services.** Surgical services or treatment performed for the purpose of avoiding the risk of an illness, disease, physical or mental disorder or condition based on genetic information or genetic testing.

Prophylactic mastectomy performed on individuals who have tested positive for the BRCA 1 or BRCA 2 mutations, and have positive findings of malignancy in one breast, will be covered.

(29) **Relative giving services.** Professional services performed for nursing care or speech therapy by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(30) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(31) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Accidental Injury, Sickness or pregnancy-related condition which is known or

reasonably suspected, unless such care is specifically covered in the Schedule of Benefits. Family history of an illness alone does not constitute justification for diagnostic testing as a payable benefit.

(32) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan or after coverage ceased under this Plan.

(33) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

(34) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

(35) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches.

(36) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.

9. PRESCRIPTION DRUG BENEFITS

A. PRESCRIPTION DRUG PROGRAM

Pharmacy Drug Charge

The Plan has contracted with a Pharmacy Benefit Manager to provide a comprehensive preferred formulary pharmacy benefit program. Coverage is provided only for those preferred formulary medications approved by the U.S. Food and Drug Administration (FDA) as requiring a prescription and FDA approved for the condition, dose, duration and frequency as prescribed by a Physician. Covered Persons will be responsible for the applicable co-payments for covered Prescription Drugs.

Retail Co-payment

The retail co-payment is applied to each covered formulary prescription drug charge, which is shown in the Schedule of Benefits. The co-payment amount is not a covered charge under the Medical Plan. Formulary prescription coverage is available at any in-network retail pharmacy. The location of the in-network pharmacies is available through the Pharmacy Benefit Manager. Any one prescription is limited to a maximum of a 30-day supply.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for up to a 90-day supply of non-emergency, extended use maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, etc.). Not all medications are available through the mail order program. The list of covered mail order medications is available through the Pharmacy Benefit Manager. The mail order service is the easiest and least expensive way to obtain covered maintenance medications.

Mail Order Co-payment

The co-payment is applied to each covered formulary mail order prescription charge, and is shown in the Schedule of Benefits. It is not a covered charge under the Medical Plan. Any one covered prescription is limited to a maximum of a 90-day supply.

Covered Prescription Drugs

(1) All formulary drugs prescribed by a Physician that require a prescription either by federal or state law, and are in treatment of an illness or injury.

(2) All formulary compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin when prescribed by a Physician.

(4) Injectable medications when prescribed by a physician, and as authorized through the Drug Utilization Review Program.

(5) Covered Prescription Drugs will be dispensed in accordance with the Pharmacy Benefit Manager preferred drug formulary or approved preferred generic substitution when permissible. Preferred Generic Prescription Drugs will be dispensed if: (a) the generic has been approved by the Food and Drug Administration (FDA), (b) the particular generic substitution has been manufactured by an FDA approved manufacturer, and (c) the generic substitution has been shown, through bioequivalent studies, to be equivalent to the name brand products in terms of bioavailability and therapeutic effectiveness.

(6) Oral Contraceptives, injectable contraceptive drugs, an implanted contraceptive devises prescribed for birth control or hormone replacement therapy purposes; which are lawfully prescribed or ordered and which have been approved by the Food and Drug Administration.

Coverage for Injectable Medications

All covered injectable medications, with the exception of insulin, require prior authorization through the Pharmacy Benefit Manger. Covered injectable medications listed on the preferred formulary include injectable drugs which are an accepted standard of care for self-administration. Covered injectables may be purchased through a contracted retail pharmacy participating in the pharmacy program **only** if prior authorized through the Pharmacy Benefit Manager.

Please contact the Pharmacy Benefit Manager to determine how your injectable medication will be covered.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

(3) The usual and customary allowance as determined by the Pharmacy Benefit Manger.

(4) If a prescription is written for a Brand medication which has a generic equivalent and the prescribing physician does not specify "dispense as written" (DAW) the prescription will be filled with the generic equivalent. If the member requests the Brand medication, the member will be responsible for the Brand co-payment plus the difference in cost between the Brand and generic medication.

(5) If a covered dependent has pharmacy benefits through their primary health benefit plan, they must utilize the benefits of the primary pharmacy benefit first. This pharmacy benefit does not coordinate with the primary pharmacy benefit plan.

Use of Out of Network Pharmacy

This benefit applies only when a Covered Person incurs a covered prescription drug charge at a non-contracted pharmacy. The itemized pharmacy receipt may be submitted to the Pharmacy Benefit Manager for processing under the Direct Member Reimbursement (DMR) process. DMR forms may be obtained from the Pharmacy Benefit Manager, and must accompany the prescription receipt, which must contain the member's name, date the medication was dispensed, pharmacy NDC code, cost and name of the medication. Once all properly prepared paperwork has been received by the Pharmacy Benefit Manager, the Pharmacy Benefit Manager will process the eligible claim according to the terms and conditions of the Plan, including, but not limited to the Pharmacy Benefit Manager's preferred formulary pricing, Plan co-payment, duplication of therapies, early refill stipulations, etc.

B. EXPENSES NOT COVERED

Prescription Drug Benefits will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug (applies only to the Prescription Drug Program).

(2) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed (applies only to the Prescription Drug Program).

(3) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(4) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

(5) **FDA.** Any drug not approved by the Food and Drug Administration.

(6) **Health and Beauty Aids.** A charge for cosmetics, hair growth aids, dietary supplements and vitamins.

(7) **Immunization.** Immunization agents or biological sera.

(8) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to Investigational use".

(9) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(10) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(11) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

(12) **Smoking cessation.** A charge for Prescription Drugs for smoking cessation (i.e., nicotine gum).

(13) **Smoking deterrent patches.** A charge for smoking deterrent patches.

(14) **Weight Loss.** A charge for Prescription Drugs for weight loss.

10. DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

A. DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

B. BENEFIT PAYMENT

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

C. MAXIMUM BENEFIT AMOUNT

The Maximum Dental Benefit Amount is shown in the Schedule of Benefits.

D. DENTAL CHARGES

Dental charges are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Administrator will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Class A Services - Preventive and Diagnostic Dental Procedures

Visits & Examinations

Office visits during regular office hours, for periodic oral examination (limited to twice per calendar year). Office visits during regular office hours for treatment and observation of injuries to teeth and supporting structure (other than for routine operative procedures).

Prophylaxis for children under age 14 (limited to twice per calendar year).

Prophylaxis for individuals age 14 and over, treatments to include scaling and polishing (limited to twice per calendar year).

Topical applications of sodium fluoride, including prophylaxis (limited to one treatment per year and to children under age 18).

Emergency palliative treatment per visit

Sealants for dependent children under age 14 (lifetime maximum payable $150.00)

X-Rays

Bitewing films (not more than twice per year).

2 films.

4 films.

Class B Services - Basic Dental Procedures

Visits & Examinations

Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater).

Professional visit during regular office hours – Problem focused.

Special consultation by a specialist for case presentation when diagnostic procedures have been performed by a general dentist.

X-Rays & Pathology

Single film

Additional films (up to 12), each.

Entire denture series consisting of at least 14 films, including bitewings, if necessary (limited to once every 12 months).

Intra-oral, occlusal view, maxillary or mandibular, each.

Upper or lower jaw, extra-oral, one file.

Upper or lower jaw, extra-oral, one films.

Panoramic survey, maxillary and mandibular, single film (considered an entire denture series).

Biopsy and examination of oral tissue.

Study models.

Microscopic examinations.

Oral Surgery

Includes local anesthesia and routine postoperative care.

Extractions

Uncomplicated (single)

Each additional tooth.

Surgical removal of erupted tooth.

Postoperative visit (sutures and complications) after multiple extractions and impaction.

Impacted Teeth

Removal of tooth (soft tissue).

Removal of tooth (partially bony).

Removal of tooth (completely bony).

Alveolar or Gingival Reconstructions

Alveolectomy (edentulous) per quadrant.

Alveolectomy (in addition to removal of teeth) per quadrant.

Alveolectomy with ridge extension, per arch.

Removal of palatal torus.

Removal of mandibular tori, per quadrant.

Excision of hyperplastic tissue, per arch.

Excision of pericoronal gingiva.

Cysts & Neoplasms

Incision and drainage of abscess.

Removal of cyst or tumor up to ½".

Removal of cyst or tumor over to ½".

Other Surgical Procedures

Sialolithomy (removal of salivary calculus).

Closure of salivary fistula.

Dilation of salivary duct.

Transportation of tooth or tooth bud.

Removal of foreign body from bone (independent procedure).

Maxillary sinusotomy for removal of tooth fragment or foreign body.

Closure of oral fistula of maxillary sinus.

Sequestrectomy for osteomyelitis or bone abscess, superficial.

Condylectomy of temporomandibular joint.

Meniscectomy of temporomandibular joint.

Radical resection of mandible with bone graft.

Crown exposure for orthodontia.

Removal of foreign body from soft tissue.

Frenectomy.

Suture of soft tissue injury.

Injection of sclerosing agent into temporomandibular joint.

Treatment of trigeminal neuralgia by injection into second and third divisions.

Anesthesia

General, only when provided in conjunction with a surgical procedure.

Nitrous Oxide for dependent children under the age of six.

Periodontics

Periodontic prophy (limited to one treatment every three months).

Emergency treatment (periodontal abscess, acute periodontitis, etc.).

Subgingival curettage, root planing, scaling per quadrant (not prohlaxis).

Correction of occlusion related to periodontal problems per quadrant.

Gingivectomy (including post-surgical visits) per quadrant.

Gingivectomy, osseous or muco-gingival surgery (including post-surgical visits) per quadrant.

Gingivectomy, treatment per tooth (fewer than 6 teeth).

Localized delivery of therapeutic agent via controlled vehicle into diseased crevicular tissue.

Endodontics

Unless otherwise indicated, the limit shown is for one tooth.

Pulp capping

Therapeutic pulpotomy (in addition to restoration).

Vital pulpotomy.

Remineralization (Calcium Hydroxide, temporary restoration) as a separate procedure only.

Root Canals - includes necessary x-rays and cultures but excludes final restoration.

Single rooted canal therapy (Traditional method).

Single rooted canal therapy (Sargenti method).

Bi-rooted canal therapy (Traditional method).

Bi-rooted canal therapy (Sargenti method).

Tri-rooted canal therapy (Traditional method).

Tri-rooted canal therapy (Sargenti method).

Endodontic retreatment.

Apicoectomy (including filling of root canal).

Apicoectomy (separate procedure).

Restorative Dentistry

Excludes inlays, crowns (other than stainless steel) and bridges. Multiple restorations in one surface will be considered as a single restoration.

Amalgam Restorations - Primary Teeth

Cavities involving one surface.

Cavities involving two surfaces.

Cavities involving three or more surfaces.

Amalgam Restorations - Permanent Teeth

Cavities involving one surface.

Cavities involving two surfaces.

Cavities involving three or more surfaces.

Synthetic Restorations

Silicate cement filling.

Plastic filling.

Composite filling involving one surface.

Composite filling involving two surfaces.

Composite filling involving three or more surfaces.

Pins

Pin (Retention) when part of the restoration used instead of gold or crown restoration.

Core buildup including any pins; prefabricated cast post and core in addition to crown.

Crowns

Stainless steel (when tooth cannot be restored with a filling material).

Full & Partial Denture Repairs

Broken dentures, no teeth involved.

Partial denture repairs (metal).

Replacing missing or broken teeth, each tooth.

Adding Teeth to Partial Denture to Replace Extracted Natural Teeth

First tooth.

First tooth with clasp.

Each additional tooth and clasp.

Recementation

Inlay.

Crown.

Bridge.

Repairs Crowns & Bridges

Repairs

Relining or rebasing of dentures (limited to once every 36 months).

Restorative

Gold restoration and crowns are covered only when teeth cannot be restored with a filling material.

Inlays

One surface.

Two surfaces.

Three or more surfaces.

Onlay, in addition to inlay allowance.

Crowns

Acrylic.

Acrylic with gold.

Acrylic with non-precious metal.

Porcelain.

Porcelain with gold.

Porcelain with non-precious metal.

Non-precious metal (full cast).

Gold (full cast).

Gold (3/4 cast).

Gold dowel pin.

Space Maintainers

Includes all adjustments within 6 months after installation.

Fixed space maintainer (band type).

Removal acrylic with round wire rest only.

Stainless steel clasps and/or activating wires, in addition to basic allowances, per wire or clasp.

Removal inhibiting appliance to correct thumb sucking.

Fixed or cemented inhibiting appliance to correct thumb sucking.

Occlusal guard

CLASS C SERVICES - MAJOR DENTAL PROCEDURES

Prosthodontics

Bridge Abutments (see Inlays & Crowns under Class B Services).

Pontics

Cast Gold (sanitary).

Cast non-precious metal.

Slotted facing (Steele's).

Slotted pontic (True Pontic type).

Porcelain fused to gold.

Porcelain fused to non-precious metal.

Plastic processed to gold,

Plastic processed to non-precious metal.

Removal Bridge (Unilateral)

One piece casting, gold or chrome cobalt alloy clasp attachment (all types), per unit including pontics.

Dentures and Partial

Fees for dentures and partial dentures include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.

Complete upper denture.

Complete lower denture.

Partial acrylic upper or lower with gold or chrome cobalt alloy clasps, base, up to 4 teeth and 2 clasps.

Each additional tooth or clasp.

Partial lower or upper with chrome cobalt alloy lingual or palatal bar and acrylic saddles, base, up to 4 teeth and 2 clasps.

Simple stress breakers, extra.

Stayplate, base.

Each additional tooth or clasp.

Special tissue conditioning, per denture.

Denture duplication (jump case), per denture.

Adjustment to denture more than 6 months after installation.

Dental Implants

Surgical placement of endosteal implant

Surgical placement of eposteal implant

Surgical placement of transosteal implant

CLASS D SERVICES - ORTHODONTIA TREATMENT AND APPLIANCES

This is treatment to move teeth by means of appliances to correct a handicapping malocclusion of the mouth if required by an overbite of at least four millimeters, crossbite, or protrusive or retrusive relationships to at least one cusp.

For treatment plans that begin prior to January 1, 2003, the orthodontic benefit will be as follows:

These services are available for covered Dependent children starting treatment between ages 8-18, and include preliminary study, including x-rays, diagnostic casts and treatment plan, active treatments and retention appliance.

Payments for comprehensive full-banded orthodontic treatments are made in installments.

For treatment plans that begin after January 1, 2003, the orthodontic benefit will be as follows:

These services are available for covered dependent children under age 19. Orthodontia benefits terminate when a dependent child turns 19. Orthodontia treatment will include preliminary study, including x-ray, diagnostic casts, active treatment and retention appliance. The plan will pay a lifetime maximum of $3,000.00 per covered dependent child.

The benefits for orthodontic charges will be paid as follows:

$750 - For Banding, or removable, fixed or cemented appliance for tooth guidance

$125 per month for monthly adjustments.

Participant will be responsible for any orthodontic care that exceeds this payment schedule. In no event will benefits be payable for services incurred after termination of coverage.

E. PREDETERMINATION OF BENEFITS

Before starting a dental treatment for which the charge is expected to be $300 or more, it is recommended that a predetermination of benefits form be submitted in order to remove any misunderstanding between you and your Dentist on benefits payable.

A regular dental claim form is used for the predetermination of benefits. The covered Employee fills out the Employee section of the form and then gives the form to the Dentist.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form.

The Dentist should send the form to the Claims Administrator at this address shown on the back of this booklet.

The Claims Administrator will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

F. ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

If a dental service is performed that is not on the list of dental services, but the list contains one or more other services that under customary dental practices are suitable for the condition being treated, then for the purpose of the coverage, the listed service that the Plan determines would produce a professionally satisfactory result will be considered to have been performed.

G. EXCLUSIONS

A charge for the following is not covered:

(1) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.

(2) **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions.

(3) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.

(4) **Medical services.** Services that, to any extent, are payable under any medical expense benefits of the Plan.

(5) **No listing.** Services which are not included in the list of covered dental services.

(6) **Orthognathic surgery.** The surgical correction of a skeletal anomaly or malformation of the jaw involving the mandible or maxillary joint.

(7) **Personalization.** Personalization of dentures.

(8) **Replacement.** Replacement of lost or stolen appliances and dentures.

(9) **Not Reasonably Necessary.** A service not reasonably necessary or not customarily performed for the Dental and Orthodontia care of a covered individual.

(10) **Service Not Furnished.** A service not furnished by a Dentist, except x-rays ordered by a Dentist and services by a licensed Dental Hygienist under the Dentist's supervision.

(11) **U.S. Government.** Services (a) furnished by or on behalf of the U.S. Government, or any other government, unless as to such government payment is legally required, or (b) to the extent to which any benefit in connection with such a service or charge is provided under any law or governmental program under which the individual is, or could be, covered.

(12) **Prior Service.** A service to a covered individual which is (a) an appliance, or modification of an appliance, for which an impression was made before the person became a covered individual, or (b) a crown, bridge or gold restoration for which a tooth was prepared before the person became a covered individual, (c) root canal therapy, for which the pulp chamber was opened before the person became a covered individual, or (d) an orthodontic procedure in connection with which an active appliance has been installed prior to the first day on which the person became a covered individual.

(13) **Prior 5 Years.** A partial or full removable denture or fixed bridgework, or for the addition of teeth thereto, or for a crown or gold restoration, if involving a replacement or modification of a denture, bridgework, crown or gold restoration which was installed during the immediately preceding five years.

(14) **Prior Extractions.** A partial or full removable denture or fixed bridgework if involving replacement of one or more natural teeth extracted prior to the person's becoming a covered individual under this Coverage, unless the denture of fixed bridgework also includes replacement of a natural tooth which (a) is extracted while the person is such a covered individual and (b) was not an abutment to a partial denture or fixed bridge installed within the immediately preceding five years.

(15) **Occupational.** Care and treatment of an Accidental Injury or Sickness that is occupational – that is, arises from work for wage or profit including self-employment.

(16) **Restorations.** Restorations for the purpose of splinting, or to increase vertical dimension or restore occlusion.

(17) **Cosmetic.** Services for cosmetic purposes unless made necessary by an Accidental Injury occurring while covered, or dental care of a congenital or developmental malformation. Facings on molar crowns or pontics are always considered cosmetic.

(18) **Appointments.** Charges for failure to keep a scheduled appointment with a Dentist and/or completion of claim forms.

(19) **Reasonable and Customary.** The portion of any charge for any service in excess of the reasonable and customary dental charge. The reasonable and customary charge is the usual charge made by the provider for a like service in the absence of the coverage, but not more than the prevailing charges, as determined by the County, for dental care of a comparable nature, made by providers of similar training and experience, within the area in which the service is

actually provided."Area" means the municipality *(or in the case of a large city, the subdivision thereof)* in which the service is actually provided or such greater area as is necessary to obtain a representative cross section of charges for a like service.

(20) **Prior Orthodontics.** Charges for an orthodontic procedure for which an active appliance was installed before the patient was covered, or installed before the patient was covered for two consecutive years, if the coverage started more than 31 days after the patient was eligible.

H. EXTENSION OF BENEFITS

If coverage terminates for a covered individual while receiving treatment for which benefits would have been paid had coverage remained in effect, dental benefits will be extended to cover dental care received within 31 days after the date of termination. This extension is subject to all conditions and limitations of the Plan. This does not apply to orthodontic treatment.

11. HOW TO SUBMIT A CLAIM

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

(1) Obtain a claim form from the Benefits Office.

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

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

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

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

(5) Send the above to the Claims Administrator at the address on the back cover.

A. WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 60 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

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

(2) the claim is submitted within two years from the date incurred.

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

When the nature of an injury giving rise to a claim for benefits, by a Covered Person, is such that it appears the injury may have been the result of the act of a third party, prior to the payment of benefits the Plan will deliver to the Covered Person a form requiring acknowledgement of the assignment provisions of the Plan as set forth herein, and requiring the member to affirmatively inform the Plan of any intent to seek recovery from a third-party or insurer as a result of the injury. The assignment acknowledgement form must be executed by the Covered Person, or the employee/retired member if the Covered Person is a dependent of an eligible employee/retiree, and returned to the Plan or its third-party administrator, **prior to** the Plan payment of any claims for benefits related to the injury. Claims subject to the provision will not be paid, and will be pended until the executed form is returned, for up to 60 days, and then denied if the form has not been received.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a written notice of this denial. This request will be processed within 10 working days after receipt of the claim. If not approved in whole or part, written notice will be provided which contains the following information:

(1) the specific reason or reasons for the denial;

(2) specific reference to those Plan provisions on which the denial is based;

(3) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

(4) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

A Plan Participant will be notified within 10 days of receipt of the claim as to the acceptance or denial of a claim. If special circumstances require an extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

B. CLAIMS REVIEW PROCEDURE

In cases where a claim for benefits payment is denied in whole or in part, the Plan Participant may appeal the denial by writing to the Group Health Committee at the Clark County Risk Management Office. This appeal provision will allow the Plan Participant to:

(1) Request from the Plan Administrator a review of any claim for benefits. Such request must be filed within two years from the date of service and include: the name of the Employee, his or her Plan identification number and the name of the patient.

(2) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim, and the applicable Plan Document provision. The appeal should not exceed twenty-five (25) pages.

(3) Be notified of the time and place of the hearing.

(4) Appear, testify and present evidence before the Plan Administrator.

At the close of the hearing, the Group Health Committee will make a decision based upon the evidence presented and the provisions of the Plan. The Plan Participant will be notified in writing of the Committee's decision.

C. CLAIM OVERPAYMENTS

An Employee shall be responsible for repaying to the Plan any overpayments made to the Employee, his or her Dependents and to any providers directly. Failure to make such repayments (or agree to terms acceptable to the Plan Administrator) after written notice from the Plan Administrator requesting a repayment shall result in the reduction of future claim payments which would otherwise be payable to the Employee and/or his or her Dependents, or to a service provider on behalf of the participant or his /her dependents. In the event the Plan Administrator should be required to institute litigation to enforce this provision of the Plan, then the Plan Administrator upon prevailing will be entitled to recover pre-judgment interest and reasonable attorneys' fees in addition to any other relief provided by law.

12. COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed either the actual charge for the service, or 100% of the allowable or reasonable and customary charge for the service or supply, whichever is less, but never more than would be payable in the absence of double coverage.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes Medicare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered by one of the Group Plans covering the person for whom the claim is made. In the case of a contracted provider, the Plan will allow up to the Clark County Self Funded contracted rate. When this Plan is the secondary Plan, this Plan will allow for the reimbursement of the primary carrier's preferred provider co-payment, not to exceed this Plan's contracted rate when applicable, or the usual and reasonable allowable, excluding services provided at University Medical Center in Las Vegas.

In the case of HMO (Health Maintenance Organization) plans: This Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Also, when an HMO pays its benefits first, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Automobile Limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit Plan Payment Order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits by these rules up to the allowable charge.

(3) Plans with a coordination provision will pay their benefits by the following rules, up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member, subscriber or retiree) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

Special Rule. If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay before Plan A.

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those benefits of a benefit plan which covers that person as a laid-off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(d) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(e) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

(f) When a child's parents are divorced or legally separated or were never married, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(g) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first.

(h) When the coordination of benefits provisions of the plan are valid under the applicable law and conflict with the coordination of benefits provisions of this Plan, then the benefits payable under this Plan will be reduced to the amount which would be paid in equal proportion by each plan (50/50 compromise). Benefits will be further reduced to the extent necessary so that the sum of such benefits will not exceed the total allowable expenses

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) If a Plan Participant is covered as retired member by this Plan and as a retired member by another plan, the plan that covered the member as a retiree the longest will pay first.

Claims Determination Period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to Receive or Release Necessary Information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of Payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of Recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Requirement for spousal enrollment in other group insurance. If a spouse is covered as a dependent of an employee or retiree covered by the Clark County Self Funded Health Benefit Plan, and the spouse is employed by a company that offers an employee health benefit plan, or a retiree health benefit plan as a retiree of another company, and he/she is eligible for any such (non-HMO) coverage at a monthly cost equal to or less than the current Clark County employee and spouse employee premium deduction rounded to the next lowest $5.00 increment for employee only, the spouse is required to enroll in such other employer sponsored program. If the spouse declines any other employer-sponsored coverage, the Clark County Self Funded Benefit Plan will provide coverage to the spouse at 20% of the Plan allowable, either the contracted rate or the usual and reasonable allowable when the contracted rate is not available, instead of the normal benefit payable for such service covered by the Clark County Self Funded Plan.

If the dependent spouse of an employee misses his/her employer's open enrollment period for the calendar year for which the employee is enrolling the newly eligible dependent spouse in this coverage, the above benefit limitation will be waived for the first year of the dependent spouse's coverage, but not to exceed 12 months from the effective date of the dependent spouse's coverage with this Plan.

INTEGRATION WITH MEDICARE

Entitlement to Medicare Coverage: Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income Benefits is also entitled to Medicare coverage after a waiting period.

Medicare Participants May Retain or Cancel Coverage Under This Plan: If you, your covered Spouse or Dependent Child becomes covered by Medicare, whether because of end-stage renal disease (ESRD), disability or age, you may either retain or cancel your coverage under this Plan. If you and/or any of your Dependents are covered by both this Plan and by Medicare, as long as you remain actively employed, your medical expense coverage will continue to provide the same benefits and your contributions for that coverage will remain the same with the exception of members who are eligible for Medicare due to ESRD. Active members who are eligible for Medicare due to Social Security disability or reaching age 65, this Plan pays first and Medicare pays second. If you are covered as a retiree under this Plan and entitled to Medicare, Medicare coverage will pay first and this Plan will pay second.

If you are covered by Medicare and you cancel your coverage under this Plan, coverage of your Spouse and/or your Dependent Child(ren) will terminate, but they may be entitled to COBRA Continuation Coverage. See the COBRA chapter for further information about COBRA Continuation Coverage. If any of your Dependents are covered by Medicare and you cancel that Dependent's coverage under this Plan, that Dependent will **not** be entitled to COBRA Continuation Coverage.

Coverage Under Medicare and This Plan When You Are Totally Disabled: If you become Totally Disabled and entitled to Medicare because of your disability, you will no longer be considered to remain actively employed. As a result, once you become entitled to Medicare because of your disability, Medicare pays first and this Plan pays second.

Coverage Under Medicare and This Plan When You Have End-Stage Renal Disease: If while you are actively employed, you or any of your covered Dependents become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the **earlier** of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second. Once a member becomes eligible for Medicare coverage as a result of ESRD, the member is required to retain such coverage. If the member fails to retain Medicare coverage, the Plan will estimate the Medicare benefits and pay as secondary beginning the first day of the 31st month.

How Much This Plan Pays When It is Secondary to Medicare:

- **When the Plan Participant is Covered by Medicare Parts A and B:** When the Plan participant is covered by Medicare Parts A and B and this Plan is secondary to Medicare, the Plan pays benefits according to the following: In the case of Medicare Assigned claims, this plan will pay the 20% of the Medicare approved amount, and the Medicare Part A or Part B deductibles, provided there is sufficient Self-Funded benefit available with respect to that claim. In the case of non-covered Medicare unassigned claims, the payment of benefits will be based on the Clark County Self Funded allowable and plan provisions. In no event will benefits exceed the benefits provided to active employees.

- **When a Plan Participant is Covered by Medicare + Choice (Part C):** This Plan provides benefits that supplement the benefits you receive from Medicare Part A and B coverage. If a Plan participant is covered by a Medicare + Choice (Part C of Medicare) and obtains medical services or supplies in compliance with the rules of that program (including, without limitation, obtaining all services In-Network when the Medicare Part C requires it), this Plan will reimburse all applicable co-payments.

  However, if the Plan Participant doesn't comply with the rules of the Medicare Part C program, including without limitation, approved referral, preauthorization, or case management requirements, this plan will NOT provide any health care services or supplies or pay any benefits for any services or supplies that the Plan Participant receives.

- **When the Plan Participant is Not Covered by Medicare:** You are responsible, to enroll for Medicare coverage for which you are eligible. This Plan will pay as primary if you are on Medicare but not eligible for Medicare Part A. However, this Plan will always be secondary to Medicare Part B, whether or not you have enrolled, this Plan will estimate Medicare's benefit.

- **When the Plan Participant Enters Into a Medicare Private Contract:** Under the law, a Medicare Participant is entitled to enter into a Medicare private contract with certain Health Care Practitioners under which he or she agrees that NO claims will be submitted to or paid by Medicare for health care services and/or supplies furnished by the Health Care Practitioner. If a Medicare participant enters into such a contract, this Plan will NOT pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to it.

13. THIRD PARTY RECOVERY PROVISION

ASSIGNMENT OF PROCEEDS AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to injuries which may be caused by the act or omission of a third party or a third party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that third party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any proceeds the Covered Person may recover from a third party or insurer in an amount equal to the payments made to, or on the behalf of, the Covered Person. This assignment shall apply to any amount recovered by the covered Person whether or not designated as payment for medical expenses.

The covered Person automatically assigns to the Plan, proceeds received from the third party or insurer when this provision applies, and must repay to the Plan the benefits paid on his or her behalf, out of the recovery made from the third party or insurer, in the event such proceeds come into the possession of the Covered Person, or his or her agent.

When the nature of an injury giving rise to a claim for benefits by a Covered Person is such that it appears the injury may have been the result of the act of a third party, prior to the payment of benefits the Plan will deliver to the Covered Person a form requiring acknowledgement of the assignment provisions of the Plan as set forth herein, and requiring the member to affirmatively inform the Plan of any intent to seek recovery from a third-party or insurer as a result of the injury. The assignment acknowledgement form must be executed by the Covered Person, or the employee/retired member if the Covered Person is a dependent of an eligible employee/retiree, and returned to the Plan or its third-party administrator, **prior to** the Plan payment of any claims for benefits related to the injury. Claims subject to the provision will not be paid, and will be pended until the executed form is returned, for up to 60 days, and then denied if the form has not been received.

This provision shall not apply if the Covered Person elects not to accept benefits from the Plan in the event of injuries caused by a third party.

Amount subject to the assignment or refund. The Covered Person agrees to recognize the Plan's right to assignment and reimbursement. These rights provide the Plan with a priority over any funds paid by a third party or insurer to a Covered Person relative to the Injury or Sickness, including priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. The Plan shall have no obligation to compromise its recovery for any reason. The Plan's right of assignment and refund are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the plan.

When a right of recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of assignment and refund as a condition to having the Plan make payments. It shall be the obligation of the Covered Person to obtain the signature of any attorney, or other individual acting on behalf of the Covered Person, for any instrument acknowledging the Plan's right of assignment and refund. Immediately upon receipt by the covered person, or his or her agent, of proceeds covered by the assignment, the Covered Person shall notify the Plan, in writing, of the amount and location of the proceeds. The Plan shall then notify the Covered Person, or his or her agent, of the amount of proceeds assigned, which sum shall then be promptly paid to the Plan. In addition, the Covered Person will do nothing to prejudice the right of the Plan to assignment and recovery.

Defined terms: "Recovery" means monies paid to, or on behalf of, the covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injuries or Sickness whether or not said losses reflect medical or dental charges covered by the Plan.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

Recovery from another plan under which the Covered Person is covered. This right of refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

14. COBRA CONTINUATION OPTIONS

Federal law gives certain persons the right to continue their health care benefits beyond the date that they might otherwise terminate. The entire cost (plus the administration fee allowed by law) must be paid by the continuing person. Coverage will end if the covered individual fails to make timely payment of contributions or premiums (within a maximum of 45 days during initial premium/contribution and 30 days thereafter). This law is referred to as "COBRA", which stands for the Consolidated Omnibus Budget Reconciliation Act of 1985.

Complete instructions on COBRA will be provided by the Plan Administrator to Plan Participants who become qualified beneficiaries under COBRA.

Plan Administrator - The plan administrator is CLARK COUNTY RISK MANAGEMENT; P.O. Box 551711, Las Vegas, NV 89155-1711; (702) 455-4544. The Plan Administrator is responsible for administering COBRA continuation coverage.

For notification purposes, employees should contact their individual Employer/Affiliate as listed on the back cover of this plan document.

Under federal COBRA law, should you lose your group health insurance because of one of the below listed qualifying events, covered employees and covered family members (called qualified beneficiaries) will be offered the opportunity for a temporary extension of health coverage (called "Continuation Coverage) at group rates which you will be required to pay. This notice is intended to inform all plan participants, in a summary fashion of your potential future options and obligations under the continuation coverage provisions of federal law. Should an actual qualifying event occur in the future, the plan administrator will send you additional information and the appropriate election notice at that time. **Please take special note, however, of your notification obligations and procedures which are highlighted in this description!**

Qualifying Events For Covered Employee * - If you are the covered employee, you will become a qualified beneficiary and have the right to elect this health plan continuation coverage if you lose your group health coverage because of a termination of your employment (for reasons other than gross misconduct on your part) or a reduction in your hours of employment.

Qualifying Events For Covered Spouse * - If you are the covered spouse of an employee, you will become a qualified beneficiary and have the right to elect this health plan continuation coverage for yourself if you lose group health coverage because of any of the following reasons:

1) A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
2) The death of your spouse;
3) Divorce or, if applicable, legally separate from your spouse; or
4) Your spouse becomes enrolled in Medicare (Part A, Part B, or both).

Qualifying Events For Covered Dependent Children * - If you are the covered dependent child of an employee, you will become a qualified beneficiary and have the right to elect continuation coverage for yourself if you lose group health coverage because of any of the following reasons:

1) A termination of the parent-employee's employment (for reasons other than gross misconduct) or reduction in the parent-employee's hours of employment;
2) The death of the parent-employee;
3) Parent's divorce or, if applicable, legally separate;
4) The parent-employee becomes enrolled in Medicare (Part A, Part B, or both); or
5) You cease to eligible for coverage as a "dependent child" under the terms of the health plan.

*Rights similar to those described above may apply to covered retirees, and their covered spouses, and dependents if the Clark County and/or Affiliated Entities commences a bankruptcy proceeding under title 11 of the United States code and these individuals lose coverage within one year of or one year after the bankruptcy filing.

PROTECT YOUR GROUP HEALTH INSURANCECONTINUATION COVERAGE RIGHTS!

EMPLOYEE/QUALIFIED BENEFICIARY 60 DAY NOTIFICATION REQUIREMENT!

Under group health plan rules and COBRA law, the employee, spouse, or other family member has the responsibility to notify the benefits department of their own employer/affiliate of a divorce, legal separation, or a child losing dependent status under the plan. Please read Chapter 2, Section H of this document for specific information on when a dependent ceases to be a dependent under the terms of the plan. To protect your continuation coverage rights in these two situations, this notification must be made within 60 days from whichever date is later, the date of the event or the date on which health plan coverage would be lost under the terms of the insurance contract because of the event. Procedures for making proper and timely notice are as outlined on pages 3 – 5 of this plan document.

If this notification is not completed according to the outlined procedures and within the required 60 day notification period, then rights to continuation coverage will be forfeited. In addition, keeping an individual covered by the health plan beyond what is allowed by the plan may be considered insurance fraud on the part of the employee.

If the qualifying event is a termination of employment, reduction in hours, death, enrollment in Medicare (Part A, Part B, or both), or if retiree coverage is provided, a commencement of a bankruptcy proceeding, the employer will notify the Plan Administrator within 30 days following the date coverage ends.

Election Period And Coverage - Once the plan administrator learns a qualifying event has occurred, the plan administrator will notify qualified beneficiaries of their rights to elect continuation coverage. Each qualified beneficiary has independent election rights and will have 60 days to elect continuation coverage. The 60 day election window is measured from the later of the date health plan coverage is lost due to the event or from the date of notification. This is the maximum period allowed to elect continuation coverage as the plan does not provide an extension of the election period beyond what is required by law. For each qualified beneficiary who elects group health insurance continuation coverage, coverage will begin on the date that coverage under the plan would be lost because of the event. If a qualified beneficiary does not elect continuation coverage within this election period, then rights to continue health insurance will end and they cease to be a qualified beneficiary.

If a qualified beneficiary elects continuation coverage, they will be required to pay the entire cost for the health insurance, plus a 2% administration fee. Clark County is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the plan to similarly situated non COBRA participants and/or covered dependents. Should coverage change or be modified for non COBRA participants, then the change and/or modification will be made to your coverage as well.

Length Of Continuation Coverage - 18 Months. If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, then each qualified beneficiary will have the opportunity to continue coverage for 18 months from the date of the qualifying event. Exception: If you are participating in a health flexible spending account at the time of the qualifying event, you will only be allowed to continue the health flexible spending account until the end of the current plan year in which the qualifying event occurs.

Social Security Disability Extension - The 18 months of continuation coverage can be extended for an additional 11 months of coverage, to a maximum of 29 months, for all qualified beneficiaries if the Social Security Administration determines a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act on the date of the qualifying event or at any time during the first 60 days of continuation coverage. In the case of a new born or adopted child that is added to a covered employee's continuation coverage, then the first 60 days of continuation coverage for the new born or adopted child is measured from the date of the birth or the date of the adoption. It is the qualified beneficiaries responsibility to obtain this disability determination from the Social Security Administration and provide a copy of the determination to Clark County, Nevada according to the below listed notification procedures within 60 days after the date of determination and before the original 18 months expire. In general, if coverage is extended due to a Social Security Disability, premium rates will be raised to 150% of the applicable rate.

Secondary Event Extension - Another extension of the 18 or above mentioned 29 month continuation period can occur, if during the 18 or 29 months of continuation coverage, a second qualifying event takes place such as a divorce, legal separation, death, Medicare entitlement, or a dependent child ceasing to be a dependent. If a second event occurs, during the original 18 or 29 months of continuation coverage, coverage will be extended to 36 months from the date of the original qualifying event date for eligible dependent qualified beneficiaries. It is the qualified beneficiaries responsibility to notify Clark County, Nevada according to the below listed notification procedures within 60 days of the

second event and within the original 18 or 29 month continuation timeline. In no event, however, will continuation coverage last beyond three years from the date of the event that originally made the qualified beneficiary eligible for continuation coverage. A reduction in hours followed by a termination of employment is not a second event.

Social Security Disability/Second Qualifying Event Notification Procedures
See prior paragraph.

Length Of Continuation Coverage - 36 Months. If the original event causing the loss of coverage was the death of the employee, divorce, legal separation, Medicare entitlement, or a dependent child ceasing to be a dependent child under the elected plan, then each dependent qualified beneficiary will have the opportunity to continue coverage for 36 months from the date of the qualifying event.

Eligibility, Premiums, And Potential Conversion Rights - A qualified beneficiary does not have to show they are insurable to elect continuation coverage, however, they must have been actually covered by the plan on the day before the event to be eligible for continuation coverage. An exception to this rule is if while on continuation coverage a baby is born to or adopted by a covered employee qualified beneficiary. If this occurs, the new born or adopted child can be added to the plan and will gain the rights of all other qualified beneficiaries. The COBRA timeline for the new born or adopted child is measured from the date of the original qualifying event. Procedures and timelines for adding these individuals can be found in your benefits booklets and must be followed. The plan administrator reserves the right to verify continuation eligibility status and terminate continuation coverage retroactively if a qualified beneficiary is determined to be ineligible or if there has been a material misrepresentation of the facts.

A qualified beneficiary will have to pay all of the applicable premium plus a 2% administration charge for continuation coverage. These premiums will be adjusted during the continuation period if the applicable premium amount changes. In addition, if continuation coverage is extended from 18 months to 29 months due to a Social Security disability, Clark County can charge up to 150% of the applicable premium during the extended coverage period. Qualified beneficiaries will be allowed to pay on a monthly basis. In addition there will be a maximum grace period of (30) days for the regularly scheduled monthly premiums. At the end of the 18, 29, or 36 months of continuation coverage, a qualified beneficiary will be allowed to enroll in an individual conversion health plan provided, if an individual conversion plan is available at that time.

Cancellation Of Continuation Coverage - The law provides that if elected and paid for, your continuation coverage will end prior to the maximum continuation period for any of the following reasons:

1) CLARK COUNTY and/or AFFILIATES ceases to provide any group health plan to any of its employees;
2) Any required premium for continuation coverage is not paid in a timely manner;
3) A qualified beneficiary first becomes, after the date of COBRA election, covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary other than such an exclusion or limitation which does not apply to or is satisfied by such beneficiary by reason of the Health Insurance Portability and Accountability Act;
4) A qualified beneficiary first becomes, after the date of COBRA election, entitled to Medicare;
5) A qualified beneficiary extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled;
6) A qualified beneficiary notifies The Plan Administrator they wish to cancel continuation coverage.
7) For cause, on the same basis that the plan terminates the coverage of similarly situated non -COBRA participants.

Should continuation coverage be terminated for one of the above reasons, a notice will be sent to you at that time outlining any available health coverage options that may be available to you.

Notification Of Address Change - In order to protect your group health insurance continuation coverage rights and to insure all covered individuals receive information properly and efficiently, you are required to notify Clark County or your employer's benefits office of any address change as soon as possible. Failure on your part to do so will result in delayed notifications or a loss of continuation coverage options. If any of your covered dependents do not live at your same address, please notify your benefits office immediately.

Should an actual qualifying event occur and it is determined that you are eligible for continuation, you will be notified of all your actual rights at that time. Should you have any questions regarding the information contained in this notice, you should contact Clark County Risk Management or your employer's benefit office, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at www.dol.gov/ebsa.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

TERMINATION OF THE PLAN

The Plan shall continue in full force and effect unless terminated, modified, altered or amended by the Plan Administrator as provided in this section.

Although the Plan Administrator has established the Plan with the bona fide intention and expectation that it will be able to make contributions indefinitely, nevertheless the County is not and shall not be under any obligation or liability whatsoever to continue its contributions or to maintain the Plan for any given length of time. The Plan Administrator may, in its sole and absolute discretion, on 30 days notice, discontinue such contributions to terminate the Plan in accordance with its provisions at any time without liability whatsoever for such discontinuance or termination. In the event that the Plan is terminated, the Plan will, to the extent of funds available, continue to pay all benefits then due and payable to the Covered Individual.

15. RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Clark County, Nevada is the Plan Administrator of the Self-Funded Group Medical and Dental Benefit Plan. The Plan Administrator may delegate to others one or more of its duties.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

The Plan Administrator shall also have the additional responsibilities described in Appendix B.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator subject to the provisions of any applicable collective bargaining agreement. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction or withheld from Retiree's pension check.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

16. EXEMPTIONS FROM HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA)

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, as amended, group health plans must generally comply with the requirements listed below. However, the law also permits State and local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. Clark County and Affiliated entities have elected to exempt The Clark County Self-Funded from #1 through #2 of the following requirements:

(1) Parity in the application of certain limits to mental health benefits. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

(2) Coverage of dependent students on medically necessary leave of absence. Group health plans are required to continue coverage for up to one year for a dependent child, covered as a dependent under the plan based on student status, who takes a medically necessary leave of absence from a postsecondary educational institution.

The exemption from these Federal requirements will be in effect for the 2013 Plan Year, for one year, beginning January 1, 2013 and ending December 31, 2013. The election may be renewed for subsequent plan years.

The Plan provides in accordance with Federal Law the following:

(3) Limitations on preexisting condition exclusion periods. A preexisting condition exclusion period generally may not exceed 12 months, and generally must be reduced by prior health coverage an individual has had. Also, a plan may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition, nor, under certain conditions, with respect to newborns or children adopted or placed for adoption.

(4) Special enrollment periods. Group health plans are required to provide special enrollment periods for individuals who do not enroll in the plan because they have other coverage, but subsequently lose that coverage. Also, if a plan provides dependent coverage, the plan must provide a special enrollment period for new dependents (and the employee if not already enrolled) within 30 days after a marriage, birth, adoption or placement for adoption. A 60-day special enrollment period applies to eligible individuals who lose eligibility for Medicaid coverage or coverage under a State child health plan, or become eligible under Medicaid or a State child health plan for group health plan premium assistance.

(5) Prohibitions against discriminating against individual participants and beneficiaries based on health status. A group health plan may not discriminate in enrollment rules or in the amount of premiums or contributions it requires an individual to pay based on certain health status-related factors: health status, medical condition (physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

(6) Standards relating to benefits for mothers and newborns. Group health plans offering health coverage for hospital stays in connection with the birth of a child generally may not restrict benefits for the stay to less than 48 hours for a vaginal delivery, and 96 hours for a cesarean section.

(7) Required coverage for reconstructive surgery following mastectomies. Group health plans that provide medical and surgical benefits for a mastectomy must provide certain benefits in connection with breast reconstruction as well as certain other related benefits. This Plan will comply with the Women's Health and Cancer Rights Act.

HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

Effective Date: April 14, 2003

17. DISCLOSURE OF MEDICAL INFORMATION UNDER THE CLARK COUNTY SELF-FUNDED PLAN

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact Clark County's HIPAA Compliance Office.

Who Will Follow This Notice:
This Notice describes the privacy policies of the Clark County Self-Funded Group Medical, Wellness, Vision, Prescription Drug, and Dental Benefit Plan (the "Plan"), which is sponsored by Clark County ("County"). Please note that each insurer of an insured program provided under the Plan will provide a separate notice of its privacy practices.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal, and we are committed to protecting it. We create a record of the care and benefits that you receive under the Plan. This notice applies to all of those records of your care and benefits.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Provide you this Notice of our legal duties and privacy practices regarding your medical information; and
- Follow the terms of the Notice that are currently in effect. We may change the terms of our Notice at any time without advance notice to you. The new Notice will be effective for all medical information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may obtain a copy of the Notice by contacting Clark County's HIPAA Compliance Office at (702) 383-3854. The current version of this Notice may also be found on Clark County's website at: http://www.clarkcountynv.gov/depts/internal_audit/pages/hipaa_pmo.aspx

How We May Use And Disclose Medical Information About You:

The following categories describe ways that we use and disclose medical information. Examples of each category are included. Not every use or disclosure in each category is listed; however, all of the ways we are permitted to use and disclose information fall into one of these categories:

- ***For Treatment:*** We may use medical information about you to coordinate or manage medical treatment or services as Plan benefits. For example, we may disclose medical information about you to physicians or health care providers who are or will be involved in taking care of you. Your medical information may also be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to provide treatment.
- ***For Payment:*** We may use your medical information to pay for your health care benefits under the Plan. These activities may include making benefit determinations and paying claims. 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.
- ***For Healthcare Operations:*** We may use or disclose, as needed, your medical information in order to support the business activities of the Plan. These activities include, but are not limited to, quality assessment and improvement, reviewing the competence or qualifications of health care professionals, disease management, case management, conducting or arranging for medical review, business planning and development, legal services and auditing functions (including fraud and abuse compliance programs) and general administrative activities. For example, the Plan may use information about your claims to project

future benefit costs or audit the accuracy of its claims processing functions. We may also use or disclose your medical information, as necessary, to contact you to remind you of an appointment.

We may share your medical information with third party "business associates" that perform various activities (*e.g.*, claims administration and eligibility status inquiries) for the Plan. Whenever an arrangement between the Plan and a business associate involves the use or disclosure of your medical information, we will have a written contract that contains terms to protect the privacy of your medical information.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your medical information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose medical information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your location, general condition or death. Finally, we may use or disclose your medical information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Disclosures to Plan Sponsor: The Plan also will disclose your medical information to Clark County, the Plan's sponsor, for administrative purposes permitted by law and related to treatment, payment or health care operations. The County has amended its plan documents to protect your medical information as required by federal law.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your medical information in the following situations without your authorization. These situations include:

Required By Law: We may use or disclose your medical information to the extent that the law requires the use or disclosure, including requested disclosures to the Secretary of the Department of Health and Human Services to determine our compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Public Health: We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report the abuse or neglect of children, elders and dependent adults;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight: We may disclose medical information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws. For example, we may disclose medical information to a licensing board to investigate a complaint against a provider.

Legal Proceedings: We may disclose medical information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful legal process, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct on County premises; or
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Nevada Attorney General and Grand Jury Investigations: We may release medical information if asked to do so by an investigator for the Nevada Attorney General, or a grand jury, investigating an alleged violation of Nevada laws prohibiting patient neglect, elder abuse or submission of false claims to the Medicaid program. We may also release medical information to an investigator for the Nevada Attorney General investigating an alleged violation of Nevada workers' compensation laws.

Workers' Compensation: We may disclose your medical information as authorized to comply with workers' compensation laws and other similar legally established programs. These programs provide benefits for work-related injuries or illness.

For Specific Government Functions: We may disclose your medical information for the following specific government functions: (1) health information of military personnel, as required by military authorities; (2) health information of inmates, to a correctional institution or law enforcement official; and (3) for national security purposes.

YOUR RIGHTS

The following is a statement of your rights with respect to your medical information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your medical information.

You may inspect and obtain a copy of medical information about you that is contained in a designated record set for as long as we maintain the medical information. A "designated record set" contains medical and billing records and any other records that the Plan uses to make decisions regarding your health care services or benefits. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

Under federal law, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and medical information that is subject to a law that prohibits access to medical information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to appeal this decision.

If you wish to make a request for access, you should make your request to the applicable business associates named at the end of this Notice. You may also make a written request to our Privacy Officer with respect to designated records sets, if any, held by the County or any business associate not named at the end of this Notice.

You have the right to request a restriction of your medical information.

You may ask us not to use or disclose any part of your medical information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your medical information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse).

The Plan is not required to agree to a restriction that you may request. If the Plan believes it is in your best interest to permit use and disclosure of your medical information, your medical information will not be restricted. If the Plan does agree to the requested restriction, we may not use or disclose your medical information in violation of that restriction

unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your caregiver.

If you wish to make a request to restrict uses and disclosures of your medical information, you should make your request to the applicable business associates named at the end of this Notice. You may also make a written request to Clark County's HIPAA Compliance Office with respect to uses and disclosures by the County or any business associate not named at the end of this Notice.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Your request must specify how or where you wish to be contacted.

If you wish to make a request for communications by alternative means, you should make your request to the applicable business associates named at the end of this Notice. You may also make a written request to Clark County's HIPAA Compliance Office with respect to uses and disclosures by the County or any business associate not named at the end of this Notice.

You may have the right to have us amend your medical information.

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You may request an amendment of medical information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

If you wish to make a request to amend your medical information, you should make your request to the applicable business associates named at the end of this Notice. You may also make a written request to Clark County's HIPAA Compliance Office with respect to designated records sets, if any, held by the County or any business associate not named at the end of this Notice.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the Plan;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

You have the right to receive an accounting of certain disclosures we have made, if any, of your medical information.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations, as described in this Notice. The right to receive this information is subject to certain exceptions, restrictions and limitations.

If you wish to make a request for an accounting, you should make your request to the applicable business associates named at the end of this Notice. You may also make a written request to Clark County's HIPAA Compliance Office with respect to disclosures, if any, by the County or any business associate not named at the end of this Notice.

Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing

the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

You have the right to receive a paper copy of this Notice.

You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice upon request.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. The Notice will contain on the first page, in the top right-hand comer, the effective date.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services (HHS) if you believe your privacy rights have been violated by us. To file a complaint with HHS, send a letter to:

Office of Civil Rights
Medical Privacy, Complaint Division,
U.S. Department of Health and Human Services
200 Independence Avenue, SW, HHH Building, Room 509H
Washington, D.C. 20201
866-627-7748 or for the hearing impaired call 886-788-4989

To file a complaint with the Plan, submit your complaint in writing and address it to:

Clark County HIPAA Compliance Program Management Office
P.O. Box 551120
Las Vegas, NV 89155.

You may also call (702) 383-3854 for further information about the complaint process.

We will not retaliate against you for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose medical information about you by signing an authorization, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

CONTACT INFORMATION

If you wish to exercise one or more of the rights listed in this Notice, contact the representative listed for the appropriate program(s) in which you participate:

Privacy Officer for the Benefits Administrator

Clark County HIPAA Compliance Program Management Office
P.O. Box 551120
Las Vegas, NV 89155
(702) 383-3854

Medical Plan

American Benefit Plan Administrator
9121 W. Russell Road, Suite 219
Las Vegas, NV 89148

Vision Plan

Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670

APPENDIX A – SPECIAL PROVISIONS

SPECIAL PROVISIONS CONCERNING ELECTED OFFICIALS

The following provisions shall apply concerning benefits for Elected Officials.

(1) **Elected Officials.** Individuals who are elected to county office shall be considered Employees for purposes of this Plan during the term of their elected position.

(2) **Waiting Period.** Elected Officials are not required to serve a waiting period.

(3) **Effective Date.** Elected Officials and their eligible Dependents will be covered under this Plan as of the date they take the oath of office and satisfy the Plan's Enrollment Requirements.

SPECIAL PROVISIONS CONCERNING FIREFIGHTERS TRANSFERRING TO M-PLAN

The following provisions shall apply concerning benefits for Employees who are Firefighters including Battalion Chiefs transferring to an M-Plan Position:

(1) **Waiting Period.** A Firefighter described above is not required to serve a waiting period.

(2) **Actively at Work.** A Firefighter described above and his or her Dependents must satisfy the Plan's requirements concerning actively at work and enrollment.

(3) **Partial Year Coverage.** A Firefighter described above and his or her Dependents will be credited with expenses incurred during the partial calendar year prior to becoming covered under this Plan for purposes of the Plan's deductible requirements as if they had been covered under this Plan when such expenses were incurred.

(4) **Pre-Existing Conditions.** A Firefighter described above and his or her Dependents will be credited with employment with an Employer prior to becoming covered under this Plan for purposes of the Plan's pre-existing condition requirement as if they had been covered under this Plan.

SPECIAL PROVISIONS CONCERNING EMPLOYEES TRANSFERRING TO CLARK COUNTY FROM THE DIVISION OF CHILD & FAMILY SERVICES WITH THE STATE OF NEVADA DEPARTMENT OF HUMAN RESOURCES

The following provisions shall apply concerning benefits for Employees who transfer from the Division of Child & Family Services with the State of Nevada, pursuant to Assembly Bill number one, who transfer to a position covered by Clark County.

(1) **Actively at Work.** A Child & Family Services worker described above and his or her dependents must satisfy the Plan's requirements concerning actively at work and enrollment.

(2) **Pre-Existing Conditions.** For the purposes of this Plan's pre-existing condition requirement, the length of the pre-existing condition limitation may be reduced or eliminated based on the Child & Family Services worker's coverage as provided by the Public Employees Benefit Plan just prior to becoming covered under this Plan.

SPECIAL PROVISIONS CONCERNING PREVENTIVE SCREENING

WHEREAS, the Southern Nevada Health District has determined that unsafe medical practices have been occurring at several Las Vegas-area medical clinics; and

WHEREAS, those unsafe medical practices identified by the Southern Nevada Health District may have exposed Plan

participants to hepatitis B, hepatitis C, and HIV.

Plan participants who had potential exposure to hepatitis B, hepatitis C, and HIV, due to unsafe medical practices in Las Vegas area medical clinics, and who have received written notification from the Southern Nevada Health District recommending laboratory screening for the participant, or meet other eligibility requirements, shall be eligible for laboratory screenings for these three tests. Eligibility requirements will be determined by the Plan Administrator. Testing will be subject to all Plan provisions.

SPECIAL PROVISIONS CONCERNING EMPLOYEES OF THE SOUTHERN NEVADA HEALTH DISTRICT

The following provisions shall apply concerning benefits for Employees of the Southern Nevada Health District and their covered dependents effective August 1, 2009, who were covered by the Public Employee's Benefit Plan (PEBP) on July 31, 2009.

(1) **Waiting Period.** A Southern Nevada Health District employee/retiree described above and his or her dependents are not required to serve a waiting period.

(2) **Actively at Work.** A Southern Nevada Health District employee described above and his or her covered dependents must satisfy the Plan's requirements concerning actively at work and enrollment.

(3) **Pre-Existing Conditions.** A Southern Nevada Health District employee/retiree described above and his or her dependents will not be subject to the Plan's medical pre-existing condition requirement.

(4) **Maximum Lifetime Benefit Amount per Covered Person.** A Southern Nevada Health District employee/retiree described above and his or her dependents will be credited with the lesser of the remaining Public Employee's Benefit Plan's Lifetime Maximum as if they had been covered under this Plan when such expenses were incurred, available under the PEBP, or $1,500,000.00.

SPECIAL PROVISIONS CONCERNING STATUTORY MANDATES

It is the intent of the Plan to comply with any law or clarifying regulation which applies to it. Therefore, the Plan will be administered in conformity with any applicable federal or state law, including regulations issued under such law. Any provision which conflicts with such law or regulation will not be enforced.

This Plan Document and Summary Plan Description will be amended from time to time to reflect any such statutory mandates and will be made available to all participants for future reference.

APPENDIX B - PLAN ADMINISTRATION

ADDITIONAL RESPONSIBILITIES OF PLAN ADMINISTRATOR

In addition to the Plan Administrator duties set forth previously, the Plan Administrator shall have the following duties.

(1) **Contracting.** Contracting and administering all agreements necessary or incidental to the operation of the Group Plan. The agreements which the Plan Administrator is authorized to enter into on behalf of the Group Plan include, but are not limited to, agreements for claims administration, preferred providers, excess and aggregate insurance, and utilization review.

(2) **Trust Fund.** Administration of the expendable trust fund established for the deposit of contributions and the payment of expenses necessary for the operation of the Group Plan. The Plan Administrator's responsibilities regarding the trust fund shall include the collection of payments and contributions to the fund and making payments and transfer from the fund as required to effect the provisions of the Group Plan.

(3) **Executive Board.** The Plan Administrator shall establish an Executive Board not to exceed seven members which shall consist of representatives from management appointed from the governmental agencies participating in the Plan.

The Chief Administrative Officer for the Plan Administrator shall appoint the members of the Board and designate a Chairman and Vice-Chairman who will act in the absence or disability of the Chairman.

The duties of the Executive Board shall include monitoring the financial performance of the Plan including the administration of periodic independent actuarial studies, the evaluation and recommendation of contractors to the Plan Administrator, and the negotiation of Plan changes with the Nevada Service Employees Union subject to the approval of the governing bodies.

The Board shall meet at a mutually agreed upon time at least once every other month and may hold such other meetings as circumstances may require or render desirable for the performance of its function and discharge of its duties and responsibilities.

(4) **Group Health Committee.** The Plan Administrator shall establish a seven-member committee which shall consist of representatives from both labor and management appointed from the governmental agencies participating in the Plan. Effective January 1, 1990, the committee shall be increased to nine members. Effective January 1, 1995, the committee shall be increased to ten members. The committee shall meet to resolve disputes and appeals from determinations made by the Claim Administrator, and make Plan change recommendations to the Executive Board.

The Clark County Manager or his designee shall appoint the members of the committee and designate a Chairman and a Vice-Chairman who will act in the absence or disability of the Chairman.

The committee shall meet at a regularly appointed time at least once every other month and may hold such other meetings as circumstances may require or render desirable for the performance of its function and the discharge of its duties and responsibilities. A majority of the members shall constitute a quorum for all purposes. Action taken by the committee shall require a majority affirmative vote. Appeals from determinations made by the Claims Administrator will be resolved according to the following procedure. Only a Covered Individual may submit a written appeal to the Clark County Risk Management Office. The Risk Management Office will then schedule a hearing on the appeal before the Group Plan Committee. The Covered Individual will be notified of the time and place of the hearing and will have the right to appear, testify and present evidence. At the close of the hearing, the Group Plan Committee will make a decision based upon the evidence presented and the provisions of the Plan. The Covered Individual will be notified in writing of the Group Plan Committee's decision.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded health plan and the administration is provided through a third party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

Self-Funded Group Medical and Dental Benefit Plan

PLAN EFFECTIVE DATE: January 1, 2013

PLAN YEAR ENDS: December 31st

EMPLOYER INFORMATION

Clark County, Nevada
PO Box 551711
Las Vegas, Nevada 89155-1711
(702) 455-4544

ADDITIONAL PARTICIPATING EMPLOYERS	
Clark County Water Reclamation District 668-8066	University Medical Center of Southern Nevada 383-2230
Las Vegas Convention & Visitors Authority 892-7527	Las Vegas Valley Water District 258-3115
Regional Transportation Commission of Southern Nevada 676-1500	Clark County Regional Flood Control District 685-0000
Southern Nevada Health District 759-1101	Henderson District Public Libraries 207-4278

PLAN ADMINISTRATOR

Clark County, Nevada
PO Box 551711
Las Vegas, Nevada 89155-1711
(702) 455-4544

CLAIMS ADMINISTRATOR

American Benefit Plan Administrator
9121 W. Russell Road, Suite 219
Las Vegas, NV 89148