TO: SOUTHERN NEVADA DISTRICT BOARD OF HEALTH DATE: September 22, 2022

RE: *Approve the amendment to the Self-Funded Group Medical and Dental Benefits Preferred Provider Organization (PPO) Plan among Clark County, the Clark County Water Reclamation District, the University Medical Center of Southern Nevada, the Las Vegas Convention and Visitors Authority, the Las Vegas Valley Water District, the Clark County Regional Flood Control District, the Regional Transportation Commission of Southern Nevada, the Southern Nevada Health District, the Henderson District Public Libraries, the Mount Charleston Fire Protection District, the Las Vegas Metropolitan Police Department and the Moapa Valley Fire Protection District adopting an amended Self-Funded Group Medical and Dental Benefits PPO Plan, effective January 1, 2022. (Also sitting as the Clark County Water Reclamation District Board of Trustees, the University Medical Center of Southern Nevada Board of Hospital Trustees, the Mount Charleston Fire Protection District Board of Fire Commissioners and the Moapa Valley Fire Protection District Board of Fire Commissioners)*

PETITION #10-23

That the Southern Nevada District Board of Health *Approve the amendment to the Self-Funded Group Medical and Dental Benefits Preferred Provider Organization (PPO) Plan among Clark County, the Clark County Water Reclamation District, the University Medical Center of Southern Nevada, the Las Vegas Convention and Visitors Authority, the Las Vegas Valley Water District, the Clark County Regional Flood Control District, the Regional Transportation Commission of Southern Nevada, the Southern Nevada Health District, the Henderson District Public Libraries, the Mount Charleston Fire Protection District, the Las Vegas Metropolitan Police Department and the Moapa Valley Fire Protection District adopting an amended Self-Funded Group Medical and Dental Benefits PPO Plan, effective January 1, 2022. (Also sitting as the Clark County Water Reclamation District Board of Trustees, the University Medical Center of Southern Nevada Board of Hospital Trustees, the Mount Charleston Fire Protection District Board of Fire Commissioners and the Moapa Valley Fire Protection District Board of Fire Commissioners)*

PETITIONERS:

Sherhonda Brathwaite, *Director of Human Resources*
Fermin Leguen, MD, MPH, *District Health Officer*

DISCUSSION:

The Self-Funded Group Medical and Dental Benefits PPO Plan (the Plan) was established in 1984 to provide group medical and dental benefits to the employees of Clark County and affiliated entities.

Annually, the Plan is put before the Board of County Commissioners for approval.

On September 21, 2021, the Board approved an amended Plan for the upcoming Plan Year, effective January 1, 2022. Due to the implementation of the Clark County Self-Funded Group Medical and Dental Benefits Exclusive Provider Organization (EPO) Plan, it was determined further clarification was required for certain benefits. Following are the proposed additional modifications for the upcoming Plan Year, effective January 1, 2022:

• The addition of Continuity of Care provisions.
• Updating the lifetime maximum benefit for various services so that benefits paid while covered by any County plan will apply toward the lifetime maximum.

The above noted changes have been discussed with represented members, as required by governing bargaining agreements.

FUNDING:

Previous Board action on March 24, 2022 provided authorization for funding the employer portion of the premiums based on the labor agreements through FY23

ATTACHMENTS:

- Clark County Board of Commissioners Agenda Item
- 2022 CCSF PPO Plan Document
- EPO Plan Document 2022 12.14.2021 Final.pdf

CLARK COUNTY BOARD OF COMMISSIONERS
AGENDA ITEM

Petitioner: Les Lee Shell, Chief Administrative Officer
Jessica L. Colvin, Chief Financial Officer

Recommendation:

Approve and authorize the Chair to sign an amendment to the Self-Funded Group Medical and Dental Benefits Preferred Provider Organization (PPO) Plan among Clark County, the Clark County Water Reclamation District, the University Medical Center of Southern Nevada, the Las Vegas Convention and Visitors Authority, the Las Vegas Valley Water District, the Clark County Regional Flood Control District, the Regional Transportation Commission of Southern Nevada, the Southern Nevada Health District, the Henderson District Public Libraries, the Mount Charleston Fire Protection District, the Las Vegas Metropolitan Police Department and the Moapa Valley Fire Protection District adopting an amended Self-Funded Group Medical and Dental Benefits PPO Plan, effective January 1, 2022. (Also sitting as the Clark County Water Reclamation District Board of Trustees, the University Medical Center of Southern Nevada Board of Hospital Trustees, the Mount Charleston Fire Protection District Board of Fire Commissioners and the Moapa Valley Fire Protection District Board of Fire Commissioners) (For possible action)

FISCAL IMPACT:

Fund #:	6520.000	Fund Name:	Self-Funded Group Insurance
Fund Center:	1020520000	Funded PGM/Grant:	N/A
Amount:	No Estimated Cost		
Description:	Self-Funded Group Medical and Dental Benefits PPO Plan Changes		
Additional Comments:	N/A		

BACKGROUND:

The Self-Funded Group Medical and Dental Benefits PPO Plan (the Plan) was established in 1984 to provide group medical and dental benefits to the employees of Clark County and affiliated entities. Annually, the Plan is put before the Board of County Commissioners for approval.

On September 21, 2021, the Board approved an amended Plan for the upcoming Plan Year, effective January 1, 2022. Due to the implementation of the Clark County Self-Funded Group Medical and Dental Benefits Exclusive Provider Organization (EPO) Plan, it was determined further clarification was required for certain benefits. Following are the proposed additional modifications for the upcoming Plan Year, effective January 1, 2022:

• The addition of Continuity of Care provisions.
• Updating the lifetime maximum benefit for various services so that benefits paid while covered by any County plan will apply toward the lifetime maximum.

Cleared for Agenda

12/21/2021

File ID#

21-1796

The above noted changes have been discussed with represented members, as required by governing bargaining agreements.

CLARK COUNTY
SELF-FUNDED GROUP MEDICAL AND DENTAL BENEFITS PLAN

Plan Document
Effective January 1, 2022

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INTRODUCTION

This Plan Document describes the medical and dental benefits available to Plan Participants who are eligible to participate in the Clark County Self-Funded Group Medical and Dental Benefits Plan, as effective January 1, 2022. Coverage under the Plan will take effect for a Plan Participant when applicable waiting periods are satisfied, and eligibility requirements are met.

No oral interpretations can change this Plan. The Plan Administrator 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. Changes in the Plan may occur in any or all parts of the Plan including but not limited to benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, and eligibility.

Plan Participants enrolling in medical will automatically be enrolled in dental and vision. However, upon request Plan Participants may opt out of dental and/or vision. This document summarizes the Plan rights and benefits for Plan Participants who are expected to read the Plan Document to understand the plan, what is required, how to become eligible for benefits, and what steps to take to ensure receipt of those benefits.

Plan Participants will be provided a listing of the participating hospitals and physicians of the Preferred Provider Organization (PPO). At the time of service, it is the Plan Participant's responsibility to confirm with the medical provider and/or facility that they continue to participate in the PPO. A telephone number is provided on your Identification Card to contact the network to assist you with locating providers in your area. Additionally, The Clark County website, http://www.clarkcountynv.gov/finance/risk-management/Pages/default.aspx contains links to many online provider directories under the *Self-Funded PPO Network (Clark County Employees and Retirees Only)* option. Printed provider directories are also available to you free of charge; however, due to changes the printed directories become obsolete quickly.

The use of the PPO network and providers provides a higher level of benefits to Plan Participants. These participating hospitals and physicians of the network have agreed to extend a discount to Plan Participants who utilize their facilities. When claims for hospital services are processed, the amount of the discount will be shown on the Explanation of Benefits (EOB). This, of course, helps reduce the Plan Participant's liability for the cost of the services.

One of the advantages of a PPO network is the determination of what charge amounts are acceptable for benefit payment. As defined later in this document, *covered expenses* will be considered only up to the reasonable and customary charge for the geographic area in which the service is rendered. This means that if a PPO network physician bills an amount in excess of the reasonable and customary amount, Plan Participants cannot be billed for the excess charge.

In addition, the Plan provides an Out-of-Area benefit at the level shown in the Schedule of Medical Benefits to the following Plan Participants only in the event the Plan Participant uses a PPO network provider outside the State of Nevada, subject to prior approval:

- Plan Participants who reside outside the State of Nevada
- Plan Participants who reside within the State of Nevada, subject to prior approval
- Emergent services

All other Plan Participants will receive benefits at the Out-of-Network benefit when using a provider outside of the State of Nevada.

However, an out of network physician who bills an amount in excess of the reasonable and customary amount can bill Plan Participants for the excess charge. It is therefore to your benefit to use our PPO network. Excess charges will not be paid by the Plan. Excess charges paid by a Plan Participant are not considered towards annual deductibles and /or maximum out of pocket limits.

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.

Continuity Of Care

You or your Dependents have the option of requesting extended care from your current health care provider or facility if the provider or facility is no longer working with your health Plan and is no longer considered In-Network.

The In-Network benefit level may continue for up to 90 days or until you no longer meet the criteria below, whichever is earlier, despite the fact that these expenses are no longer considered In-Network due to provider or facility termination from the Network. In order to be eligible, you or your Dependents must have been, and must continue to be, under a treatment plan by a provider or facility who was a member of the participating Network. You must also be one of the following:

- An individual undergoing a course of treatment for a serious and complex condition that is either:
  - An acute Illness, meaning a condition serious enough to require specialized medical care to avoid the reasonable possibility of death or permanent harm.
  - A chronic Illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time.
- An individual undergoing Inpatient or institutional care.
- An individual scheduled for non-elective surgical care, including necessary postoperative care.
- An individual who is pregnant and being treated.
- An individual who is terminally ill and receiving treatment for such Illness by a provider or facility.

To obtain a Continuity of Care form that you and your provider will need to complete for the request to be considered, call the number on the back of Your ID card or access the benefit portal.

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

The Self-Funded Group Medical and Dental Benefits Plan continues to maintain an exemption from selected sections of the Health Insurance Portability and Accountability Act of 1996. See page 85 for additional details.

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

ELIGIBILITY PROVISIONS

Eligible Classes of Employees.
All Active and Retired Employees of the Employer who meet the eligibility requirements set forth herein.

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 is:

1. A Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if the employee routinely works in a position which is eligible for employer sponsored pension contribution, and the employee is on the regular payroll of the Employer for that work; and
2. Continuously employed for a period of sixty days as an Active Employee; or
3. A Retired Employee of the Employer who was covered on the Plan at the time they separated from active employment with the Employer; or
4. 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. 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. 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 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 timeframe to Clark County Risk Management: or

   Recalled, after a reduction in force or layoff, for employment by an Employer, as defined by the Plan, as a full-time employee, and who has remained continuously covered by the Plan as a COBRA participant; or
7. A person is eligible for Employee Medical coverage if mandated by the Affordable Care Act. Employees who, at the time of hire, are classified as full-time employees who can reasonably be expected to work 30 hours per week or more will be eligible to enroll in a Medical plan as of their date of hire.

   Employees whose hours cannot be determined to be 30 hours per week or more will be classified as a Variable Hour Employee and have their hours tracked during an "Initial Measurement Period". That period will be the first 12 months of employment beginning the 1st of the month following their date of hire. If the employee averages at least 30 hours per week during the 12-month Initial Measurement Period, the employee will be offered Medical coverage for a 12-month period beginning the 1st of the month following 30 days after the end of the Initial Measurement Period. The employee must enroll in coverage according to Clark County requirements for coverage to become effective.

   Employees who have gone through an Initial Measurement Period will also have their hours averaged during the Standard Measurement Period. Hours will be calculated following the Standard Measurement Period and if an employee is determined to have worked 30 or more hours per week on average, they will be offered Medical coverage. The Office of Risk Management will notify these employees of their eligibility. Coverage will begin on January 1st following the Standard Measurement Period, providing the employee enrolls in coverage according to Clark County requirements. This 12-month period of coverage is referred to as the Standard Stability Period.

   Coverage will remain in effect for the entire 12-month Stability Period, providing the employee pays their portion of the premium, regardless of the number of hours the employee works during the subsequent Standard Measurement Period. Coverage will remain in effect for each Standard

Stability Period providing the employee works a minimum of 30 hours per week on average during each Standard Measurement Period and pays the appropriate contribution.

The Plan Administrator may extend Plan coverage to employees who have been furloughed by a participating entity as a result of a decline in the economy or workload. The responsible entity shall continue to remit the full cost of the premium to the Plan for the period of time the member is furloughed. A member is eligible for continued coverage for a period not to exceed 24-months as a result of his/her furlough status. A member is considered in furlough status when he/she is in an continuous unpaid status for a specified period.

Special Provisions for 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 effective on the date the official takes the oath of office, so long as the Elected Official complies with the Plan's Enrollment Requirements within 31 days of the date the oath of office is taken.

Special Provisions for Firefighters Transferring to an 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.

A person eligible for Employee coverage must timely comply with all enrollment requirements in order to be covered by the Plan.

Dependent Eligibility

A Dependent is any one of the following persons:

1. A covered Employee's Spouse. The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the marriage was performed (celebrated). 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 employment of the Employer.
2. 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 grandfathered Domestic Partner, or children for whom a court has ordered coverage through a National Qualified Medical Child Support Order.

The Plan Administrator, at the administrator's discretion, may require documentation such as certified marriage certificates, grandfathered domestic partner registrations, divorce decrees, social security identification, tax returns, certified birth certificates, adoption decrees, or copies of certified court orders.

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 Benefits 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 Benefits Plan will provide coverage to the spouse at 20% of the Plan allowable, either the contracted rate or the reasonable and customary 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.

Guardianship/Legal Custody Children
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.

Subject to the foregoing limitation, if a covered Employee or spouse is the court appointed Legal Guardian or has court ordered Legal Custody of a minor child or minor children, these children may be enrolled in this Plan as covered dependents 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 transcript from the Internal Revenue Service verifying the continued dependency of the minor child covered by this Plan through court appointed guardianship/custody.

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.
OR
Child(ren) who are a covered dependent(s) of the Plan due to their relationship with a covered employee who later become a benefit eligible employee must obtain primary coverage from the Plan and drop their dependent status.

A covered Dependent child who is Totally Disabled, incapable of self-sustaining employment by reason of mental challenge or incapacitation 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 or coverage will be terminated. 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.

Ineligible for Dependent Coverage
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;
- An Employee's Domestic Partner regardless of gender. Domestic Partners enrolled in the plan prior to January 1, 2018 will remain eligible;
- Parents of any Employee;
- Any person including employee and/or their dependent(s) who ~~is on~~are active duty in any military service of any country;

- Any person who is covered or eligible for coverage under the Plan as an Employee;
- An Employee's spouse who is not a United States Citizen, unless the individual is a lawful resident actively seeking permanent residency in the United States; or
- Persons legally present in the United States on a temporary basis, including those on a temporary visa, are not eligible for dependent coverage on the Plan.

A spouse/grandfathered domestic partner or child of a covered dependent child will not be eligible for coverage under this Plan.

The phrase **child placed with a covered employee in anticipation of adoption** refers to a child whom the employee intends to adopt, whether the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such employee of legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

The term **Legal Guardianship** is a relationship established by Court Order giving the Employee or Employee's spouse/grandfathered domestic partner the legal authority, and the corresponding duty, to care for the personal interests of a minor child, called a ward.

NOTE: Keeping an ineligible dependent *(spouse/grandfathered domestic partner or child)* enrolled is considered fraudulent eligibility. Such fraudulent eligibility would permit the Plan to dis-enroll the ineligible dependent from the Plan retroactively to the date the dependent became ineligible. In addition, the Plan retains the right to seek recovery, from the Employee or Retiree, of any amounts paid for claims made on behalf of the ineligible dependent and may seek other corrective and/or legal actions as deemed appropriate. An ineligible dependent is not eligible for COBRA upon disenrollment.

ENROLLMENT

An Employee must enroll for coverage by completing and signing an approved enrollment application. The covered Employee is also required to enroll for Dependent coverage.

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 Open Enrollment period.

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 all the enrollment and eligibility 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 affirmatively enrolled as a Dependent in the plan by completing and submitting an approved enrollment change form by the end of the 60th day following the date of birth.** Additionally, the employee will be required to submit a certified copy of the birth certificate and social security card/number, 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 by the end of the 60th day following the date of birth, enrollment can only take place as provided in the Open Enrollment provisions and will be subject to the Plan's open enrollment limitations.

Enrollment Requirements for Newly Eligible Dependents

When an employee acquires eligible dependents through marriage, birth, adoption, or placement for adoption, they may add these dependents to their coverage by affirmatively requesting enrollment by the end of the 60th day following acquisition 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, certified birth certificate, etc. A copy of the individuals social security card, or proof you have filed for it, is also required).

Enrollment is required regardless of whether you change enrollment tiers. If you are already enrolled in family coverage adding a child does not change your coverage tier, however, the new child must be affirmatively enrolled before coverage will be effective.

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 by the end of the 60th day following the event, enrollment can only take place as provided in the Open Enrollment Provisions and will be subject to the Plan's Open Enrollment limitations.

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

Members shall provide a new enrollment form and accompanying documentation to the Plan upon a dependent's change in status from legal guardianship to adoption within the time frames set forth above.

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., certified marriage certificate, certified 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 Open Enrollment Provisions.

Effective Dates for Special Enrollments

The effective date for dependents enrolled due to the events described above will be as follows:

1. In the case of marriage, the first of the month following the date the employee requests coverage for the spouse (signature date);
2. In the case of a Dependent's birth, as of the date of birth;
3. 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
4. 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.

Medicaid or State Child Health Insurance Plan (SCHIP)

An employee may change his or her election under the Plan if:

1. The employee's or dependent's Medicaid or State Child Health Insurance Plan (SCHIP) coverage is terminated as a result of loss of eligibility; or
2. The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or SCHIP.

An individual must request special enrollment within 60 days of a qualifying event involving Medicaid or SCHIP (loss of eligibility or premium assistance eligibility).

Enrollment Requirements for Retired Employees and Surviving Spouses of Retired Employees.

Employees who retire from participating Employers under the Plan, and the Retired Employee's dependents, are eligible to continue Plan coverage at the time of Retiree's retirement, on a contributory basis. To retain coverage upon retirement the Retiring Employee, or the Employee's spouse if the Employee is physically incapacitated, must make written application for continued Plan coverage within 31 days of retirement. Failure to make written application within 31 days of retirement will cause coverage to terminate.

Employees who retire from participating Employers under the Plan, and who did not elect to continue Plan coverage at the time of retirement, or the surviving spouse of such a Retired Employee who is deceased, may re-enroll in Plan coverage in January of any even numbered year as provided by Nevada Revised Statute 287.0205. Only a surviving spouse, who was a Plan Participant under the Plan at some point during the Retired Employee's lifetime, is eligible for enrollment under this provision.

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.

Required Documentation for covered Employees and their covered Dependents

Covered Employees who wish to switch medical plans or add an eligible Dependent during annual open enrollment or due to a qualifying event shall have 90 days from the date of the Plan's receipt of the enrollment request, to provide a copy of the certified birth certificate, certified marriage certificate, or

other necessary dependent documentation, as required by the Administrator, to verify dependent eligibility. A copy of the Dependent's Social Security card, or proof you have filed for it, is also required.

Covered Employees who gain an eligible Dependent mid-year must add Dependents to their coverage by affirmatively requesting enrollment by the end of the 60th day following acquisition by completing and submitting an approved enrollment form. Additionally, the covered Employee will be required to submit a copy of the applicable documentation (i.e., certified marriage certificate, certified adoption orders, certified birth certificate, etc. A copy of the Dependent's Social Security card, or proof you have filed for it, is also required).

The mid-year 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 by the end of the 60th day following the event, enrollment can only take place as provided in the annual open enrollment Provisions and will be subject to the Plan's annual open enrollment limitations. Covered Employees shall have 90 days from the date of the Plan's receipt of the enrollment request, to provide a copy of the certified birth certificate, certified marriage certificate, or other necessary dependent documentation, as required by the Administrator, to verify dependent eligibility.

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 by the end of the 60th day following 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.

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. The member's failure to timely notify the Employer as required by this section may result in disenrollment of the member. The member will be responsible for all expenditures incurred by both the Plan and their Employer as a consequence of the member's failure to provide the timely notification required by the Plan. These changes include, but are not limited to:

1. Date of death of spouse;
2. Effective date of the dissolution of marriage or final divorce decree;
3. Date of legal separation;
4. Guardianship/legal custody children who are no longer legally or financially dependent on the employee;
5. Retiree or covered dependent of Retiree that becomes eligible or ineligible for Medicare; or
6. Employee changes family status (i.e., no eligible Dependents, eligible Spouse only, eligible Spouse and Children only, and eligible Children only).
7. Dependent is no longer an eligible dependent as defined by the plan.

Dual Choice of Health 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 Open 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 Open Enrollment periods, (b) the first of the month following your move out of the HMO service area, and (c) upon the HMO ceasing operation.

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 the following:

1. The Eligibility Requirement;
2. The Enrollment Requirements of the Plan; and,
3. The appropriate premium has been paid

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.

If the employee or dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a special enrollment right.

Open Enrollment Period
During the annual open enrollment period, covered Employees and their covered Dependents will be able to change health plans based on which benefits and coverage is right for them.

Benefit choices made during open enrollment period will become effective January 1st and remain in effect until the next January 1st.

A Plan Participant who switches health plans during open enrollment or due to a qualifying event must confirm their dependents meet the Self-Funded Plans definition of dependent eligibility. A copy of the certified birth certificate, certified marriage certificate, or other necessary dependent documentation, as required by the Administrator, must be provided to verify dependent eligibility. A copy of the Dependent's Social Security card, or proof you have filed for it, is also required.

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 from their Employer.

Retirees who reinstate coverage through a County sponsored HMO benefit plan, may switch to the Clark County Self-Funded Program during the annual Open Enrollment period, or due to a HIPAA qualified event.

Employees and/or Dependents Enrolling as Late Participants
Employees who have previously waived their group health insurance may elect to enroll during the annual open enrollment period for the following calendar year.

Retiree Reinstatement
Retirees of a Plan Participant Employer are eligible to re-instate coverage with this Plan in January of an even numbered year, as provided by NRS 287.0205, so long as:

1. The retiree was covered by the Plan on the last day of his or her active employment with the Participant Employer;
2. The Participant Employer was the retiree's last public employer;
3. The retiree has retired into a defined benefit retirement plan, sponsored by the Participant Employer, including but not limited to PERS; and
4. The retiree complies with the requirements of NRS 287.0205 to seek reinstatement.

This provision shall be interpreted and applied in harmony with NRS 287.0205 and where NRS 287.0205 is in conflict with this provision, NRS 287.0205 will control, being interpreted to extend to the retirees of the Non-PERS participating Employers who are Participant Employers under this Plan.

Retiree/Dependent Reinstatement Enrollment:
The following enrollment process must be completed, and documentation received by Clark County 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 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. Non-PERS participating Employers shall collect retiree premiums on behalf of the Plan and deliver the premium payments to the Plan on behalf of the Non-PERS retirees.

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

Section 125 Tax Regulations on This Plan

The Plan Administrator has chosen to administer this Plan in accordance with Section 125 regulations of the Internal Revenue Code. Per this regulation, by electing a pre-tax benefit, the Participant agrees to pretax salary reduction put toward the cost of his or her benefits.

Coverage Elections: Per Section 125 regulations, Participants are generally allowed to enroll for or change coverage only during each annual enrollment period. However, exceptions are allowed if the Plan Administrator agrees, and the Participant enrolls for or changes coverage within 31 days (unless otherwise stated below) of the date the Participant meets the criteria shown below. The change must be consistent with the event.

Change of Status: A change in status is defined as:

- Change in legal marital status due to marriage, death of a spouse, or divorce; *
- Change in employment status of employee, spouse or dependent due to termination or start of employment, strike, lockout, beginning or end of unpaid leave of absence, including under the Family and Medical Leave Act (FMLA), or change in worksite;
- Changes in employment status of employee, spouse or dependent resulting in eligibility or ineligibility for coverage;
- Changes which cause a dependent to become eligible or ineligible for coverage; and*
- Change in residence from the network coverage area.

**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. Refer to Enrollment section for details.*

Court Order: A change in coverage due to and consistent with a court order of the employee or other person to cover a dependent.

Change in Cost of Coverage: If the cost of benefits increases or decreases during a benefit period, the Plan Administrator may, in accordance with plan terms, automatically change the Participant's elective contribution.

When the change in cost is significant, the Participant may either increase his or her contribution or elect less-costly coverage. When a significant overall reduction is made to the benefit option the Participant has elected, the Participant may elect another available benefit option. When a new benefit option is added, the Participant may change his or her election to the new benefit option.

Changes in Coverage of Spouse or Dependent Under Another Employer's Plan: The Participant may make a coverage election change if the plan of the Participant's Spouse or Dependent: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to Special

Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or (c) this Plan, and the other plan have different periods of Coverage or open enrollment periods.

Revocation Due to Reduction in Hours: The Participant may revoke coverage under this Plan if he or she experiences a change in employment status so that the Participant is reasonably expected to average less than 30 hours of service per week, even if such a change does not cause the Participant to be ineligible, and the revocation of the election of coverage corresponds to the intended enrollment of the Participant and his or her dependents in another plan that provides minimum essential coverage with an effective date no later than the first day of the second month following the date coverage under this Plan is revoked.

Revocation Due to Enrollment in a Qualified Health Plan: The Participant may revoke coverage under this Plan if he or she is eligible for a Special Enrollment Period in a Qualified Health Plan through a Marketplace or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period and the revocation of the election of coverage corresponds to the intended enrollment of the Participant and his or her dependents in a Qualified Health Plan through a Marketplace for new coverage with an effective date no later than the day immediately following the last day of coverage under this Plan.

There may be additional situations that qualify for a special enrollment opportunity. Contact the Plan Administrator for additional details.

TERMINATION OF BENEFITS

When Employee Coverage Terminates

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

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 Continuation of Coverage section)
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.

Good Faith Reliance upon Information Provided

The Employer has issued coverage in reliance upon the truth and accuracy of all information furnished to the Employer and to the Plan Administrator by the employee/retiree and their claimed dependents. In the event any such information is determined to have been untrue, inaccurate, or incomplete, the Plan Administrator shall have the right to declare coverage for the employee/retiree or their claimed dependents null and void as of the original effective date of coverage. Any misuse of a Plan Participant's identification, membership information, or misrepresentation of information deemed by the Plan Administrator to be material to Plan coverage or payment, whether the misrepresentation is by omission or commission, will be grounds for dis-enrollment of the employee/retiree and their claimed dependents from this coverage. The member will be responsible for full reimbursement to the Plan and to their Employer for any expenditure made by the Plan o r the Employer in reliance upon such misrepresentations. Said reimbursement must be made within 31 days of the member's receipt of notification of the amount of the expenditure owed. Failure to make timely reimbursement will be further grounds for dis-enrollment and may result in a civil action or referral for criminal prosecution. If dis-enrolled under this provision of the Plan the employee and the employee's dependents may not be eligible for future Open Enrollment.

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:

1. ***For disability leave only*:** the date the Employer ends the continuance.
2. ***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.

Rehiring a Terminated Employee

A terminated Employee who is rehired within 30 days of termination will have their previous elections reinstated. If the rehire date is after 30 days from the date of termination, the rehired employee will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

When Dependent Coverage Terminates

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

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 Continuation of Coverage section.)

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 Continuation of Coverage section.)
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 certified birth certificates, certified 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.

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.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) provides leaves of absence up to 12 weeks for the birth or adoption of a child, care of an immediate family member with a serious health condition, or because of the employee's inability to perform the functions of his or her job due to the employee's own serious health condition. Health coverage benefits during your approved leave of absence under The Family and Medical Leave Act will continue as long as you pay any required contributions. If you do not return to work at the end of an approved leave, you will be required to reimburse the employer the difference between any required contributions and the total monthly premium.

It is the employee's responsibility to request leave under the FMLA and to comply with all requests for information, such as medical certifications, made by your employer. When the need for leave is foreseeable, the employee must provide reasonable prior notice and make efforts to schedule leave so as not to disrupt company operations. If you have any questions concerning your rights under the Family and Medical Leave Act, or your employer's responsibilities under the Act, please contact the Office of Risk Management.

***Service Member Family Leave*:** An eligible employee who is the spouse, son, daughter, parent, or next of kin of a service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to 26 weeks of leave in a single 12-month period to care for the service member. This leave is available during a "single 12-month period" during which an eligible employee is entitled to a combined total of 26 weeks of all types of FMLA Leave combined.

Military Leave of Absence

(The Uniformed Services Employment and Reemployment Rights Act of 1994)

In the event an employee is called to active duty, he may elect to continue Plan coverage for up to 24 months, beginning on the date the employee's absence starts. The employee may be required to pay up to 102% of the full premium cost for continuation coverage, except a person on active duty for 30 days or less will not be required to pay more than the employee's share, if any, for the coverage. These rights apply only to employees and their dependents covered under the Plan before leaving for military service. If you have any questions regarding military leave of absence, continuation of coverage, the cost of continued coverage or the maximum period of such coverage, please contact the Office of Risk Management.

If your participation in this Plan is terminated by reason of service in the uniformed services, your coverage will be reinstated upon re-employment without any exclusions or waiting periods that would not have applied if coverage had not been terminated. However, applicable exclusions may be imposed with respect to coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during service in the military.

Uniformed services means the Armed Forces; the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty; the commissioned corps of the Public Health Service; and any other category of person designated by the President in time of war or national emergency. Military fitness examinations also are considered service in the uniformed services. ROTC members are in uniformed services.

CONTINUATION OF COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that continuation of employer-sponsored health care coverage be made available to formerly covered employees and dependents for a specified period of time at their own expense.

The COBRA regulations 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 premiums.

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 A 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 A 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.

PROTECT YOUR GROUP HEALTH INSURANCE CONTINUATION 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 the Termination of Benefits section of this document for specific information on when a dependent cease 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 in the Eligibility and Enrollment sections 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, 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. *Initial premium is due no later than 45 days after electing COBRA coverage. Subsequent premium payments are due on the 1st of each month and will be considered late if not received or post-marked by the 30th day after the due date. Payment is considered not received if a check is returned for insufficient funds.*

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. 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 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 the case of a newborn or adopted child that is added to a covered employee's continuation coverage, then the first 60 days of continuation coverage for the newborn or adopted child is measured from the date of the birth or the date of the adoption. In no event, however, will continuation coverage last beyond three years (36 months) 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 and Premiums - 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 newborn or adopted child can be added to the plan and will gain the rights of all other qualified beneficiaries. The COBRA timeline for the newborn 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 monthly. In addition, there will be a maximum grace period of 30 days for the regularly scheduled monthly premiums.

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 pre-existing 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 ensure 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 Centers for Medicare and Medicaid (CMS) via email at phig@cms.hhs.gov or call toll free at 1-877-267- 2323, option #4, extension 61565.

Note: Payment will not be considered made if a check is returned for non-sufficient funds.

The Plan Administrator reserves the right to terminate Plan coverage retroactively to the date the employee or covered dependent lost their eligibility under the terms of the employer-sponsored health care plan. This section of the Plan Document is a summary of a very complicated law. In the event of any inconsistency between this Notice and federal law, federal law will take precedence.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA coverage, you should contact The COBRA Administrator or you may contact the Centers for Medicare and Medicaid (CMS) via email at phig@cms.hhs.gov or call toll free at 1-877-267-2323, option #4, extension 61565.

You may also visit the COBRA section on the CMS website:

https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/cobra_fact_sheet.html

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

COORDINATION OF BENEFITS PROVISION

The purpose of this Plan is to provide you with reimbursement of your covered medical and dental expenses based on the description of coverage as outlined in the booklet. In the event that you or any of your covered dependents incur expenses for which benefits are payable under this Plan and at the same time benefits are payable under any other plan, this Plan will coordinate benefits. In coordinating benefits, this Plan will be either primary or secondary depending on the rules below.

- When this Plan is primary, it will pay the Reasonable and Customary Charge without regard to the other plan's payment.
- When this Plan is secondary, it will pay the Reasonable and Customary Charge after the other plan has paid as well as subtract the other plan's payment. In addition, this Plan will calculate the Reasonable and Customary Charge to include your cost sharing responsibility associated with the other plan's payment. If this Plan pays secondary, in no event will the Plan's calculation of the Reasonable and Customary Charge exceed the amount this Plan would have paid if it were primary.

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.

For a charge to be allowable it must be a Reasonable and Customary 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 reasonable and customary allowable, excluding services provided at University Medical Center in Las Vegas.

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

Some examples of other types of coverage with which benefits will be coordinated are:

- Any policy of insurance through an insurance company, including individual coverage.
- Any insurance or any other arrangement of benefits for individuals of a group, including coverage for students sponsored by or provided through a school or other educational institution.
- Any pre-payment coverage or any other coverage toward the costs of which any employer makes contributions or payroll deductions or any labor union makes contributions.
- Any governmental program or coverage required by statute, including Medicare.
- Liability, homeowner's, or automobile insurance, which is subject to any Motor Vehicle Financial Responsibility Law. This Plan shall have secondary liability for those medical expenses incurred as a result of a motor vehicle accident, on behalf of a Plan Participant subject to any state automobile insurance law, regardless of the terms and conditions of any specific automobile policy. Furthermore, if a Plan Participant has no personal injury protection or medical benefits coverage, in a state where such coverage is mandated, coverage under this Plan shall be reduced by the minimum coverage requirement of the state with jurisdiction. In addition to the above, for those Plan Participants subject to the law of any state which permits issuance of a state mandated motor vehicle policy with an optional high personal injury protection deductible, this Plan shall not recognize as a covered expense, the personal injury protection deductible selected by any Plan Participant. Such deductible amount shall be the direct responsibility of the Plan Participant.

Order of Benefit Determination

The following rules are used to establish the order of benefit determination for medical and/or dental claims when this plan and another plan cover the same individual. A plan that does not contain a coordination of benefits provision will automatically be the primary payer.

Non-Dependent or Dependent – The Plan covering the person other than as a dependent (for example, as an employee, subscriber, or retiree) is the primary plan, and the plan covering the person, as a dependent is the secondary plan. Medicare rules provide one exception to this rule. If the person is a Medicare beneficiary and covered as a dependent by a group health plan, then Medicare is

secondary to the plan covering the person as a dependent of an active employee.

Employee or Retiree – If an individual is covered under one plan as an employee and another plan as a retiree, the employee plan is primary. However, if an individual is covered both as a retiree under one plan and as a dependent under a spouse's employee plan, order of benefit determination is that the retiree plan pays first, and the dependent plan pays second.

Continuation Coverage (COBRA) – If an individual has continuation coverage under the federal COBRA law or state continuation laws and is covered under another group health plan as an employee or retiree, then the continuation coverage pays second.

Coverage for Employees and Dependents over the age of 65 – If you are an active employee over age 65, the Clark County Self-Funded Group Medical and Dental Benefits Plan will be the primary payer of benefits and Medicare will be secondary until retirement.

Coverage for Retirees and Dependents (including Permanently Disabled Dependents of a Retiree) – If you or your Dependents reach age 65 or become eligible to enroll in Medicare Part A or Parts A and Part B, this Plan will pay as secondary to Medicare for medical claims regardless of your or your Dependents actually enroll in Medicare Part A and/or Part B. The Plan will pay for outpatient prescription drug coverage in accordance with the Employer Group Waiver Plan (EGWP) section of the Prescription Drug Expense Benefit Provision. The specific rules establishing the order of benefit determination for a child covered under more than one plan are as follows:

Birthday Rule – The primary plan is the plan of the parent whose birthday is earlier in the year, if the parents are married or if a court order awards joint custody without specifying which parent has responsibility for providing health care coverage. 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.

Court Order – If a court order specifies that one parent is responsible for health coverage, then the plan of that parent will be the primary plan.

Parents Are Separated Or Divorced Or Deceased – In the absence of a specific court order the order of benefit determination is as follows:

- The plan of the custodial parent.
- The plan of the spouse of the custodial parent.
- The plan of the noncustodial parent.
- The plan of the spouse of the noncustodial parent.

Adult Child – If an adult child is covered as a dependent child under this plan and is married or has a grandfathered domestic partner and covered under the spouse's or grandfathered domestic partner's group health plan, the spouse/grandfathered domestic partner plan will be the primary plan.

When the above referenced rules fail to establish an order of benefit determination, the plan that has covered the person for the longer period of time is the primary payer.

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

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.

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.

Whenever payments that should have been made under this Plan were made by another plan, this Plan shall have the right, exercisable alone and at its sole discretion, to reimburse the other plan in the amount that would have been paid by this Plan. Such reimbursement shall be deemed payment for covered services and the Plan shall be fully discharged from liability.

Requirement for Spousal Enrollment in Other Group Insurance

If a spouse is covered as a dependent of an employee or retiree under the Clark County Self- Funded Health Benefit Plan and has access to a non-HMO health benefit plan through his or her own employer or former employer 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, this Plan will provide coverage to the spouse at 20% of the Plan's regular allowable, either the contracted rate or the reasonable and customary allowable when the contracted rate is not available.

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. Such waiver will not exceed 12 months from the effective date of the dependent spouse's coverage with this Plan.

Coordination 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):*** If a Plan Participant is covered by a Medicare + Choice plan (Part C of Medicare) all medical services or supplies are provided 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 not reimburse the retiree for any out-of-pocket expenses. Retirees should not enroll in both a Medicare + Choice plan and the Self-Funded plan.
- ***When the Plan Participant is Not Covered by Medicare***: You are responsible to enroll for all 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 you have enrolled; this Plan will estimate Medicare's benefit and this Plan will only pay up to 20% of the Plan's allowable.

***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 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.

Please Note: If a member seeks services from a provider that accepts Medicare, benefits will be coordinated based on in-network cost sharing, however, if the provider does not accept Medicare, benefits will be coordinated based on whether the provider is considered in-network or out-of -network based on the County's provider network hierarchy.

IMPORTANT HIGHLIGHTS

Clark County believes this plan is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act).

Questions regarding what might cause a plan to change from grandfathered health plan status can be directed to Clark County Risk Management Department. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

(1) **MANDATORY PRE-AUTHORIZATION**

You must obtain *Pre-Authorization* for certain health procedures. Refer to the applicable Care Management Program Section of this Plan Document. See pages 36 & 37 for a list of procedures requiring pre-authorization.

(2) **BILLS SHOULD BE SUBMITTED FOR PAYMENT ON A TIMELY BASIS**

Claims filed more than 12 months after the date of service will not be eligible for payment.

A Plan Document/SPD is intended to summarize the features of your Self-Funded Group Medical and Dental Benefits Plan in clear, understandable, and informal languages. The terms under which the plan administers benefits are contained in this booklet.

The Clark County Self-Funded Group Medical and Dental Benefits Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care provide http://www.clarkcountynv.gov/finance/risk- management/Pages/default.aspx.

You do not need prior authorization from The Clark County Self-Funded Group Medical and Dental Benefits Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre- approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the claims administrator at the number on the back of the ID card, or at http://www.clarkcountynv.gov/finance/risk- management/Pages/default.aspx.

(3) **PRESCRIPTION DRUGS. -** Prescription drugs are subject to a formulary. Also step therapy, pre-authorization and other programs may apply.

GENERAL PROVISIONS

Administration – This plan of benefits is administered through Clark County's Risk Management Department. Clark County as the Plan Administrator shall have the discretionary power and authority to: determine eligibility for benefits; interpret or construe the terms of the Plan and any other writing affecting the establishment or operation of the Plan; determine questions of fact which arise in connection with the Plan; and decide all matters arising under the Plan, based on the applicable facts and circumstances.

Assignment of Benefits – In the event a Plan Participant has executed an Assignment of Benefits, the Plan shall direct amounts payable under the terms of this Plan to the provider of service. If the Plan receives notification from a provider that the provider has the Plan Participant's authorization to assign benefits on file, then that shall be acceptable notice to the Plan that an Assignment of Benefits has been executed. Benefits may not, however, be assigned to anyone other than the provider of service without the approval of Clark County.

Funding – 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.

Plan Amendment or Termination – Clark County reserves the full, absolute, and discretionary right to amend, modify, suspend, withdraw, discontinue, or terminate the Plan in whole or in part at any time for any and all Plan Participants of the Plan by formal action taken by the Board of Directors, or by the execution of a written amendment by the Plan Administrator. If the Plan is amended, modified, suspended, withdrawn, discontinued, or terminated, covered employees and covered dependents will be entitled to benefits for claims incurred prior to the date of such action. Such changes may include, but are not limited to, the right to (1) change or eliminate benefits, (2) increase or decrease participant contributions, (3) increase or decrease deductibles and/or copayments, and (4) change the class(es) of employees or dependents covered by the Plan.

Medical Care Decision – The benefits under the Plan provide solely for the payment of certain health care expenses. All decisions regarding health care are solely the responsibility of each Plan Participant in consultation with the health care providers selected. The Plan contains rules for determining the percentage of allowable health care expenses that will be reimbursed, and whether treatments or health care expenses are eligible for reimbursement. Any decision with respect to the level of health care reimbursements, or the coverage of a particular health care expense, may be disputed by the Plan Participant in accordance with the Plan's claim procedures. Each Plan Participant may use any source of care for health treatment and health coverage as selected, and neither the Plan nor the employer shall have any obligation for the cost or legal liability for the outcome of such care, or as a result of a decision by a Plan Participant not to seek or obtain such care, other than the liability of the Plan for the payments of benefits as outlined herein.

Assignment, Reimbursement & Third-Party Recovery

1. **Coverage for Injuries Caused by a Third-Party** - The Plan Participant may incur medical, dental, or other expenses due to injuries which were or may have been caused by the act or omission of third-party. In such circumstances, the Plan Participant may have a claim against such third-party, for reimbursement of, or contribution toward the expense and damage associated with the injury. Benefits advanced, or to be advanced by the Plan related to such an injury will be paid only **f** the Plan Participant fully cooperates with the terms and conditions of the Plan, specifically including the terms of this provision of the plan

2. **Assignment** - A Plan Participant who claims and receives Plan benefits on account of an injury caused by the act or omission of a third-party, automatically assigns to the Plan any proceeds the Plan Participant may recover from a third-party or insurer on account of said injury. This automatic assignment is in an amount equal to the payments made by the Plan on behalf of the Plan Participant as a consequence of the third-party caused injury. This assignment applies to ALL recovery that the Plan Participant, his heirs, guardians, executors, agents, or other representatives may obtain as a result of injury to the Plan Participant, whether or not the recovery is designated as payment for medical expenses.

3. **Plan Participant's Assignment Obligations** - A Plan Participant who claims and receives Plan benefits on account of an injury caused by the act or omission of a third-party, must execute an Assignment Acknowledgment at the time the first claim is submitted. This document acknowledges this assignment provision of the Plan and acknowledges the Plan Participant's obligation to promptly reimburse the Plan for benefits paid by the Plan, out of any monies recovered from any source as compensation for the injury and any damage associated therewith, whether said monies are received as judgment, award, settlement or otherwise.

The Assignment Acknowledgment requires the Plan Participant to affirmatively inform the Plan of any intent to seek recovery from a third-party or insurer as a result of the injury. The Acknowledgement must be completed and executed by the Plan Participant AND by the Employee or Retiree Plan member if the Plan Participant is a dependent of an eligible Employee/Retiree. The Acknowledgment must be returned to the Plan or its third-party claims administrator prior to Plan payment of any claims for benefits related to the injury.

It shall be the obligation of the Plan Participant to obtain the signature of any attorney, or other individual acting on behalf of the Plan Participant, on any requested document acknowledging the Plan's right of assignment and refund.

As a condition to having the Plan advance benefits, the Plan Participant will execute and deliver to the Plan all required documents and will assist the Plan as necessary to secure the Plan's right of assignment. Failure or refusal to execute such documents, or to furnish information as requested by the Plan, does not preclude the Plan from exercising its right to assignment, or from obtaining full reimbursement of Plan benefits expended as a consequence of a third-party injury to a Plan Participant. The Plan Participant, Employee or Retiree if the Plan Participant is a dependent, will do nothing to prejudice the right of the Plan to assignment and recovery.

Immediately upon receipt by the Plan Participant, or his or her agent, of proceeds covered by this assignment, the Plan Participant shall notify the Plan, in writing, of the amount and location of the proceeds. The Plan shall then notify the Plan Participant, or his or her agent, of the amount of proceeds assigned, which sum shall then be promptly paid to the Plan.

4. **Plan Participant's Failure to Comply with this Assignment Provision** - Claims subject to this provision will not be paid and will be pended until the executed assignment Acknowledgment is returned. Claims will be pended for up to 60 days from the date the Acknowledgment form is provided to the Plan Participant. If the completed and executed Acknowledgment form is not received by the Plan within that 60 days, claims related to the third-party caused injury will be denied.

If the Plan Participant fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any recovery or reimbursement to or on behalf of the Plan Participant, the Plan Participant will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant.

The Plan Participant's failure to reimburse the Plan as called for herein, or failure to notify the Plan that claims being made are the result of a third-party caused injury, may result in denial of Plan payment for future claims on behalf of the Plan Participant, or on behalf of the Employee or Retiree if the Plan Participant is covered as a dependent of an Employee or Retiree, until the Plan is reimbursed in accordance with the Plan terms.

5. **Plan Rights Under this Assignment Provision** - Any settlement or recovery made to or on behalf of the Plan Participant shall first be deemed for reimbursement of medical expenses paid by the Plan, and the Plan has a lien on any

amount recovered by the Plan Participant whether or not recovered amounts are designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Plan has a right to assignment and reimbursement from the first dollars recovered. The Plan's assignment has priority over any and all funds paid by any party to or on behalf of a Plan Participant relative to the third-party caused injury, including a priority over any claim for non-medical or dental charges, attorneys' fees, other costs, or expenses, whether or not the Plan Participant is made whole.

The Plan has a right to pursue any claim which the Plan Participant has or may have against any third-party or insurer, whether or not the Plan Participant chooses to pursue that claim.

The Plan shall have no obligation to compromise its recovery for any reason. The Plan's right of assignment and refund are limited solely 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.

If any provision of this Assignment Provision is adjudged by a court to be unenforceable, that determination shall not affect the validity and enforceability of any other term or condition of this Assignment Provision.

6. **Plan Participant Minors** - If the injured Plan Participant is a minor, any amount recovered by the minor, or on behalf of the minor by the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of whether the minor's representative has access to or control of any recovered funds. If the injury or condition giving rise to this assignment involves wrongful death of a Plan Participant who was a minor, this provision applies to the parent, guardian or the executor, agent of other personal representative of the estate.

7. **Defined terms:**

"Injury" – physical or mental hurt, pain, illness, impairment, disfigurement, or damage caused by the wrongful act or omission of a third-party person or entity, other than the Plan Participant.

"Insurer" – Includes but is not limited to any loss coverage, contractual or otherwise, in the nature of liability coverage, no-fault coverage, homeowner's plan, renter's plan, uninsured or underinsured motorist coverage, contractual medical payment provisions or other insurance coverage of any nature whatsoever, from which the Plan Participant may seek or receive recovery in relation to an injury.

"Recovery" – monies paid to, or on behalf of, the Plan Participant by way of judgment, settlement, expense waiver, or otherwise to compensate for all losses and/or damages caused by the injuries or illness, whether or not said losses/damages reflect medical or dental charges covered by the Plan.

"Refund" or "Reimbursement" – repayment to the Plan for medical or dental benefit expenses paid by the Plan toward care and treatment of injury.

"Third-Party" – Any person, corporation, or entity other than the Plan Participant.

8. **Caveats:**

This Assignment provision shall not apply if the Plan Participant elects NOT to accept benefits from the Plan for services related to injuries caused by a third party.

This Assignment provision in all its terms and conditions applies whether or not the Plan Participant executes and returns the assignment Acknowledgment.

The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of this Plan Document.

MEDICAL EXPENSE BENEFIT PROVISION

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.

The Clark County Self-Funded Group Medical and Dental Benefits Plan (the "Plan") has been designed to provide all eligible employees and covered eligible dependents with a program of health care protection. The benefit plan is based on the calendar year.

Coinsurance: Coinsurance is the percentage of eligible medical expenses that the covered member(s) will pay after any required deductible has been satisfied.

Co-pay: Is an amount the Plan Participant must pay to providers at the time the service/supply is rendered. The balance of the eligible expense will be paid by the Plan, unless a lesser percentage is shown. Co-pays do not apply toward any deductible requirements.

Deductible: A deductible is the amount of covered expenses, which must be paid each calendar year by Plan Participants before the Plan will consider expenses for reimbursement. The individual deductible applies separately to each Plan Participant. The family deductible applies collectively to all Plan Participants in the same family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of the calendar year. Deductibles are calculated based on eligible expenses incurred during the 12 months of each calendar year. Each January 1st a new deductible amount is required.

Out-of-Pocket Maximum: An out-of-pocket maximum is the amount of covered expenses that must be paid during a calendar year. The individual out-of-pocket maximum applies separately to each Plan Participant. When a Plan Participant reaches the annual out-of-pocket maximum, the Plan will pay 100% of allowed charges (except for the excluded charges) for the individual during the remainder of the calendar year.

The family out-of-pocket maximum applies collectively to all Plan Participants in the same family. When the annual family out-of-pocket maximum is satisfied, the Plan will pay 100% of allowed charges (except for the excluded charges) for any covered family member during the remainder of the calendar year.

The 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.

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

Premiums
Balance-billed charges
Expenses for non-covered services
Charges in excess of Reasonable & Customary
Charges in excess of annual maximum benefits

SCHEDULE OF MEDICAL BENEFITS

	Preferred Network (University Medical Center)	In-Network	Out-of-Network
Calendar Year Deductible:			
• Per Plan Participant	$0	$250	$1,500
• Per Family	$0	$750	$3,000
	The In-Network and Out-of-Network accumulations do not cross-apply.		
Benefit Percentage: *(except as stated otherwise)*			
• Medical Plan Pays	90%	80%	60%
• Plan Participant Pays	10%	20%	40%
Out of Area *(if authorized)*			
• Medical Plan Pays	N/A	80%	N/A
• Plan Participant Pays	N/A	20%	N/A
Calendar Year Medical Out-of-Pocket Maximum:			
• Per Plan Participant	$3,750		$11,500
• Per Family	$7,750		$23,000
	The In-Network and Out-of-Network accumulations do not cross-apply. The Out-of-Pocket Maximum excludes premiums, non-covered charges, balance-billed charges, amounts in excess of Reasonable & Customary fees and annual maximum benefits.		
Maximum Lifetime Benefit: *(except as stated otherwise)*	Unlimited		

Benefits and Services	Preferred Network (University Medical Center)	In-Network	Out-of-Network
Hospital Services			
• Inpatient	10% coinsurance *(Deductible not applicable)*	20% coinsurance after $100 co-pay *(Deductible applies)*	40% coinsurance after $750 co-pay *(Deductible applies)*
• Outpatient	10% coinsurance *(Deductible not applicable)*	20% coinsurance after $100 co-pay *(Deductible applies)*	40% coinsurance after $300 co-pay *(Deductible applies)*
	Precertification is required for inpatient treatment.		
Physician Office Visits			
• Primary Care Visit	$10 co-pay *(Deductible not applicable)*	$20 co-pay *(Deductible waived)*	40% coinsurance *(Deductible applies)*
• Specialist Visit	N/A	20% coinsurance *(Deductible waived)*	40% coinsurance *(Deductible applies)*
• Urgent Care	$20 co-pay (UMC Quick Care only) *(Deductible not applicable)*	20% coinsurance *(Deductible waived)*	40% coinsurance *(Deductible applies)*
• Teladoc	N/A	$10 co-pay *(Deductible waived)*	N/A
Acupuncture	N/A	20% coinsurance *(Deductible applies)*	40% coinsurance *(Deductible applies)*
	Limited to 20 visits per calendar year.		
Ambulance Service			
• Ground or Air	N/A	20% coinsurance after $100 co-pay and in-network deductible	
• Scheduled Inter-Facility	N/A	20% coinsurance after $100 co-pay and in-network deductible	
	Deductible and co-pay are waived if patient is admitted. Air ambulance is covered to the nearest facility when treatment of a life-threatening condition is required. Scheduled inter-facility air transport requires precertification and is covered when a higher level of care is medically necessary to treat a life-threatening condition from the level of care available at the patient's current facility.		

Benefits and Services	Preferred Network (University Medical Center)	In-Network	Out-of-Network
Autism Care *(ABA and Behavioral Therapy)*	Paid based upon place of service		40% coinsurance *(Deductible applies)*
	Limited to $72,000 maximum per calendar year. Inpatient and Outpatient services that do not have a primary diagnosis of autism will be paid under applicable Inpatient and Outpatient services. Group therapy for patients with primary diagnosis of autism are covered under the plan per NRS 689A.0435 – State mandated coverage for autism spectrum disorders.		
Chemotherapy	10% coinsurance *(Deductible not applicable)*	20% coinsurance *(Deductible applies)*	40% coinsurance *(Deductible applies)*
	Pre-certification is required.		
Chiropractic Care	N/A	20% coinsurance *(Deductible applies)*	40% coinsurance *(Deductible applies)*
	Limited to 20 visits per calendar year. Precertification is required after 20 visits.		
Clinical Trials	Covered as any other illness and paid based upon place of service		Not covered
	Refer to the Covered Medical Expense section for more information.		
Complex Care Management	N/A	100% covered	N/A
	Refer to the Covered Medical Expense section for more information.		
Diabetic Education	100% covered	100% covered	40% coinsurance *(Deductible applies)*
Diagnostic Lab & X-Ray	10% coinsurance on Test 100% covered for Interpretation *(Deductible not applicable)*	20% coinsurance *(Deductible waived)*	40% coinsurance *(Deductible applies)*
Durable Medical Equipment	N/A	20% coinsurance *(Deductible applies)*	40% coinsurance *(Deductible applies)*
	Precertification is required.		
Emergency Room	20% coinsurance after $100 co-pay and in-network deductible		
	Deductible is waived if the treatment is for an accidental injury. Services for treatment that does not meet the Plan's definition of Emergency Medical Condition may not be covered.		
Hearing Aids	N/A	Charges are covered up to a maximum of $3,000 every 3 years.	
Home Health Care	N/A	20% coinsurance *(Deductible applies)*	40% coinsurance *(Deductible applies)*
Home Infusion Therapy and Supplies	N/A	20% coinsurance *(Deductible waived)*	40% coinsurance *(Deductible applies)*
	Precertification is required.		
Hospice Care Services	10% coinsurance *(Deductible not applicable)*	20% coinsurance *(Deductible applies)*	40% coinsurance *(Deductible applies)*
	Precertification is required for inpatient care.		
Mental Health and Substance Abuse			
• Inpatient	10% coinsurance *(Deductible not applicable)*	20% coinsurance after $100 co-pay *(Deductible applies)*	40% coinsurance after $750 co-pay *(Deductible applies)*
• Partial Hospitalization	10% coinsurance *(Deductible not applicable)*	20% coinsurance after $100 per day co-pay *(Deductible applies)*	40% coinsurance after $750 per day co-pay *(Deductible applies))*
• Specialty Care Visit	N/A	20% coinsurance *(Deductible waived)*	40% coinsurance *(Deductible applies)*
• Urgent Care Visit	$20 co-pay *(Deductible not applicable)*	20% coinsurance *(Deductible waived)*	40% coinsurance *(Deductible applies)*

Benefits and Services	Preferred Network (University Medical Center)	In-Network	Out-of-Network
Occupational Therapy	$10 co-pay *(Deductible not applicable)*	$10 co-pay *(Deductible waived)*	40% coinsurance *(Deductible applies)*
	Limited to 30 visits per calendar year. Precertification is required after 30 visits. No charge for separate facility fee.		
Orthotics	10% coinsurance *(Deductible not applicable)*	20% coinsurance *(Deductible applies)*	40% coinsurance *(Deductible applies)*
	Precertification may be required. Limited to a lifetime maximum of $500 on all County plans.		
Outpatient Surgery • Physician • Facility	10% coinsurance *(Deductible not applicable)* N/A	20% coinsurance *(Deductible waived)* 20% coinsurance after $100 co-pay *(Deductible applies)*	40% coinsurance *(Deductible applies)* 40% coinsurance after $300 co-pay *(Deductible applies)*
	Pre-certification may be required.		
Physical Therapy	$10 co-pay *(Deductible not applicable)*	$10 co-pay *(Deductible waived)*	40% coinsurance *(Deductible applies)*
	Limited to 30 visits per calendar year. Precertification is required after 30 visits. No charge for separate facility fee.		
Pre-Admission Testing	100% covered	100% covered	40% coinsurance *(Deductible applies)*
Preventive Care	100% covered	100% covered	40% coinsurance *(Deductible applies)*
	Refer to the Covered Medical Expense section for more information.		
Prosthetics	10% coinsurance *(Deductible not applicable)*	20% coinsurance *(Deductible applies)*	40% coinsurance *(Deductible applies)*
	Precertification may be required.		
Rehabilitation Care, Inpatient	10% coinsurance *(Deductible not applicable)*	20% coinsurance after $100 co-pay *(Deductible applies)*	40% coinsurance after $750 co-pay *(Deductible applies)*
	Limited to 60 days per calendar year.		
Skilled Nursing Facility	10% coinsurance *(Deductible not applicable)*	20% coinsurance after $100 co-pay *(Deductible applies)*	40% coinsurance after $750 co-pay *(Deductible applies)*
	Precertification is required. Limited to 120 days per calendar year.		
Speech Therapy	$10 co-pay *(Deductible not applicable)*	$10 co-pay *(Deductible waived)*	40% coinsurance *(Deductible applies)*
	Precertification is required. Limited to 30 visits per calendar year. No charge for separate facility fee.		
Temporomandibular Joint Syndrome (TMJ)	10% coinsurance *(Deductible not applicable)*	20% coinsurance *(Deductible applies)*	40% coinsurance *(Deductible applies)*

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

For information on the Prescription Drug tiers as used herein please visit www.navitus.com.

	In-Network	Out-of-Network
Calendar Year Out-of-Pocket Maximum: • Per Plan Participant • Per Family	 $2,000 $4,000	
Maximum Lifetime Benefit: *(except as stated otherwise)*	Unlimited	
Retail (30-Day Supply) *		
• Tier 1	$9 co-pay	50% of allowable drug cost, then In-Network co-pay
• Tier 2	20% coinsurance ($30 minimum - $60 maximum per prescription)	50% of allowable drug cost, then In-Network co-pay
• Tier 3	30% coinsurance ($60 minimum - $120 maximum per prescription)	50% of allowable drug cost, then In-Network co-pay
Retail (90-Day Supply) *		
• Tier 1	$18 co-pay	50% of allowable drug cost, then In-Network co-pay
• Tier 2	20% coinsurance ($60 minimum - $120 maximum per prescription)	50% of allowable drug cost, then In-Network co-pay
• Tier 3	30% coinsurance ($120 minimum - $240 maximum per prescription)	50% of allowable drug cost, then In-Network co-pay
Mail Order (90-Day Supply) *		
• Tier 1	$18 co-pay	50% of allowable drug cost, then In-Network co-pay
• Tier 2	20% coinsurance ($60 minimum - $120 maximum per prescription)	50% of allowable drug cost, then In-Network co-pay
• Tier 3	30% coinsurance ($120 minimum - $240 maximum per prescription)	50% of allowable drug cost, then In-Network co-pay

*The US Preventive Task Force has compiled a list of prescription drug benefits that will be covered by this Plan with no cost sharing. Additional information can be found under this provision by visiting: *http://www.healthcare.gov*.

Note: It is advised to check this list regularly as it is subject to change without notice.

Note: Prescription drugs may cost less for Medicare retirees if the Medicare benefit coinsurance or copayment is the lesser cost.

CARE MANAGEMENT PROGRAM

Utilization review is a program designed to help ensure that all Plan Participants receive necessary and appropriate health care while avoiding unnecessary expenses.

The Case Management program consists of the following:

a. Precertification of the Medical Necessity for the following non-Emergency Services before Medical and/or Surgical services are provided:
    1. All Inpatient Admissions, and
    2. Outpatient tests, services and procedures including, but not limited to:
        a. Diagnostic Radiology - Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Myocardial Perfusion Imaging, Positron Emission Tomography (PET), Cardiac blood pool imaging and cardiac tests including Diagnostic cardiac catheterizations and Stress echocardiograms.
        b. DME - Seat lifts, TENS, pumps, wheelchairs, power operated vehicles, speech generating devices, insulin infusion pump, osteogenesis stimulators, neuromuscular stimulators;
        c. Implanted Ear Devices and Replacement Osseo integrated, cochlear or auditory brain stem implant;
        d. Injectable Medications - Immune globulin, drugs for factor deficiencies, interferon, Rituxan®, some chemotherapeutic agents, Botox;
        e. Erectile Dysfunction - Inflatable and non-inflatable prosthesis surgeries and procedures including removal or replacement, Penile implants - does not include erectile dysfunction drugs;
        f. Bariatric Surgery - Surgery for weight reduction, Gastrectomy, gastric restrictive procedures, lap sleeve, revision of stomach-bowel fusion;
        g. Oral pharynx Uvulectomy, LAUP procedures, palatopharyngoplasty (PPP), uvulopalatopharyngoplasty (UPP);
        h. Orthotics & Prosthetics - Helmets, extremity prosthetic additions, electric prosthetic joints, facial prosthesis provided by a non-physician, voice amplifiers, cranial remolding orthosis, lower extremity orthosis;
        i. Outpatient Procedures - (Potentially Cosmetic) Surgeries and procedures that may not be medically necessary - Facial reconstruction, , varicose vein treatment, breast reconstruction or reduction, blepharoplasty, rhinoplasty, Radial Keratotomy, excessive skin removal and mastectomy, and procedures related to pain management;
        j. Potential Experimental/Investigational - Keratoplasty, total disc arthroplasty, molecular pathology and gene analysis, arthrodesis, external defibrillator, biologic implant and services not approved by the FDA;
        k. Spinal Procedures Surgeries and procedures of the spine - Allograft/osteopromotive material for spine surgery, osteotomy, percutaneous vertebroplasty, arthrodesis, laminectomy, vertebral corpectomy, destruction by neurolytic agent, laminectomy, facet joint nerve destruction, spinal cord decompression;
        l. Therapeutic Radiology - Radiology treatment of tumors - Brachytherapy, proton beam therapy, radiotherapy;
        m. Transplants - Prior authorization of transplants and transplant-related services starting from the outpatient evaluation testing through and including services post-transplant. For more information, please refer to the "Utilization Management At A Glance" document -Adult or pediatric, living, or cadaveric donors for heart, heart/lung, intestinal, liver, pancreas, pancreatic islet cell, multivisceral solid organ transplants; preparation for and including allogeneic/autologous hematopoietic/bone marrow transplants;

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.

This is not a complete and inclusive list. This list may change so please contact the Utilization Review company identified on the back of the members ID card for any questions regarding precertification.

Clark County will follow the precertification guidelines that has been endorsed by the Utilization Review company's comprehensive list.

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, however, the fact that a physician may prescribe, order, recommend, or approve a service does not, of itself, make it medically necessary or make the charge a covered expense, even though it is not specifically listed as an exclusion under this Plan.

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

Here's how the program works

Precertification
Before a Plan Participant enters a Medical Care Facility on a non-emergency basis or expects to have outpatient tests and procedures that require precertification, 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 that require precertification. 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 payer 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 Plan Participant does not receive prior authorization as explained in this section, the Physician, hospital, and any related services will be reduced to only services that have been prior authorized.

Example
If the hospital bill is for 7 inpatient days and the hospitalization was authorized for 4 days, the eligible charges are reduced by 3 days and the Plan will pay benefits on the authorized 4 days.

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 Plan Participant's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Plan Participant 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 Plan Participant 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.

Preadmission 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.

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 homecare;
- determining alternative care options; and/or
- assisting in obtaining any necessary equipment and services.

Case Management occurs in the following situations:

- The catastrophic Injury or Illness must have occurred while the patient was covered, and the Injury or Illness must have been covered under the Plan.
- 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.

COVERED MEDICAL EXPENSES

Your benefit plan is designed to reimburse you for covered medical expenses you incur for treatment necessary because of an illness or an accident. All expenses must be reasonable and customary in order to be considered for benefit payment. Refer to the Schedule of Benefits for details on Deductibles, Coinsurance, Out-of-Pocket Maximums, and Limitations on benefits.

Acupuncture – Services for 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.

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 when treatment of a life-threatening condition is required is covered if no emergency ground transportation is available or suitable, and the patient's condition warrants immediate evacuation. Note, members may be subject to balance billing if the air ambulance provider is not contracted with the Plan.

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.

Autism Spectrum Disorder – 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).

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:

- *"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.
- *"Autism spectrum disorders"* means a neurobiological medical condition including, without limitation, Autistic Disorder, Asperger's Disorder and Pervasive Development Disorder Not Otherwise Specified.
- *"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.
- *"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.
- *"Evidence-based research"* means research that applies rigorous, systematic, and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.

- *"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.
- *"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.
- *"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.
- *"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.
- *"Psychiatric care"* means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
- *"Psychological care"* means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
- *"Screening for autism spectrum disorders"* means all medically appropriate assessments, evaluations, or tests to diagnose whether a person has an autism spectrum disorder.
- *"Therapeutic care"* means services provided by licensed or certified speech pathologists, occupational therapists, and physical therapists.
- "*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.

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; mal-absorptive procedures such as biliopancreatic diversion; combination restrictive/mal-absorptive procedures such as gastric bypass (Roux-en-Y).

Coverage of this type of surgery shall be limited to one per member's lifetime on all County plans and remains subject to all other Plan provisions.

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

Breast Reconstruction Following Mastectomy – In accordance with The Women's Health and Cancer Rights Act of 1998, the following coverage is offered to a Plan Participant who elects the following services in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Cardiac Rehabilitation – As deemed medically necessary provided services are rendered (1) Under the supervision of a physician; (2) In connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (3) Initiated within 12 weeks after other treatment for the medical condition ends; and (4) In a Medical care facility as defined by the Plan.

Chemotherapy – The use of chemical agents in the treatment or control of disease. High dose chemotherapy in connection with a non-covered transplant procedure is not a covered expense.

Oncology Program
This provision describes a specialty case management program designed for certain aspects of care received by cancer patients who are beneficiaries under the Plan.

Your Plan has entered an arrangement with American Health Holding, a company specializing in oncology case management, to assist you and your oncologist during cancer treatment when administered either in an outpatient setting (e.g., in the physician's office or other covered outpatient setting) or an inpatient setting. The program applies to the plan of treatment for all cancer types and stages and begins with a treatment planning phase (including drug and/or radiation treatment) and continues through active treatment and transitional care.

A Registered Nurse will be assigned to you and will contact you to provide support, education, and answer any questions you might have about your disease and your treatment plan and will remain in contact with you and your oncologist for the duration of your cancer journey.

Unless your oncologist has entered into an agreement with HealthSCOPE Benefits to accept other reimbursement rates, the payment for all drugs used in the treatment of cancer will be limited to the rate of Average Sales Price plus 10%. Average Sales Price is the price calculated by pharmaceutical manufacturers and submitted to the Centers for Medicare and Medicaid Services (CMS) on a quarterly basis.

Chiropractic Care – 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.

Clinical Trials – Routine costs to include drugs and devices for a Plan Participant who satisfies the requirements as a "*Qualified Individual*" in an "*Approved Clinical Trial*".

A *Qualified Individual* is defined as an individual who is enrolled or participating in a health plan coverage and who is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or another life-threatening disease or condition. To be a qualified individual, there is an additional requirement that a determination be made that the individual's participation in the approved clinical trial is appropriate to treat the disease or condition. That determination can be made based on the referring health care professional's conclusion or based on the provision of medical and scientific information of the individual.

Routine Costs as defined for purposes of these new federal requirements, with some important exceptions, generally include all items and services consistent with the coverage provided under the plan (or coverage) for a qualified individual (ex. for treatment of cancer or another life-threatening disease or condition) who is not enrolled in a clinical trial. However, costs associated with the following are excluded from that definition, and the plan or issuer is not required under federal law to pay for the following:

- The cost of the investigational item, device, or service.
- The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management.
- The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Approved Clinical Trial is defined in the statute as a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life- threatening disease or condition and is one of the following:

- A federally funded or approved trial.
- A clinical trial conducted under an FDA investigational new drug application.
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

With respect to an individual's right to select providers, a plan or issuer may require the individual to

participate in the approved clinical trial through a participating provider if the provider will accept the individual as a participant in the trial.

Centers of Excellence – Any Participant in need of an organ transplant or other eligible procedure may contact the Claims Administrator to initiate the pre-certification process resulting in a referral to a Center of Excellence. The Claims Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all transplant admissions taking place at a Center of Excellence.

These centers have the greatest experience in performing applicable procedures and the best survival rates. The Plan Administrator shall determine what network Centers of Excellence are to be used.

If a Plan Participant chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to covered Employees and updated as requested.

Colorectal At-Home Cancer Screening – In addition to the services covered under the Preventive Care benefit, the Plan will cover one at-home FIT-DNA colorectal screening (Cologuard) every three years for Plan Participants starting at age and continuing through age 75 years.

Complex Care Management – Plan Participants may be eligible to receive 100% coverage for certain services as part of the Plan's Complex Care Management program. This program provides access to one of the Plan's Centers of Excellence for complex care conditions, which may include one or more of the following:

- Life threatening conditions.
- Conditions that cause serious disability without necessarily being life threatening.
- Conditions associated with severe consequences.
- Conditions affecting multiple organ systems.
- Conditions requiring coordination of management by multiple specialties.
- Conditions requiring treatments that carry a risk of serious complications.

Examples of conditions that may qualify for participation in the program include: neurological disorders, gastroenterological disorders, infection diseases, pediatric disorders, Multiple Sclerosis, Inflammatory Bowel Disease, rare and unique cancers, transplants, cardiac disease, dialysis, spinal fusion, or ventricular assist devices.

Participation in the program is voluntary. The Claims Administrator may contact Plan Participants with program details. Plan Participants may also inquire about in the program by contacting the phone number on the ID card.

Eligible Participants will receive a medical record review by a Center of Excellence provider covered at 100% with no deductible to determine if an on-site evaluation would be beneficial.

If the Center of Excellence facility determines that an on-site evaluation would be beneficial, the Claims Administrator will coordinate the travel and care for the Participant, and a companion caregiver. Travel expenses will also be covered at 100% with no annual deductible in accordance with travel policies in effect.

Claims for eligible services performed at one of the Centers of Excellence included in the program are covered at 100% with no annual deductible.

To participate in the Complex Care Management program, all of the following requirements must be met:

- The Participant and designated caregiver must agree to abide by program requirements.
- The Participant must be safe to travel for medical care and must not require emergency care at the time of travel.
- The Center of Excellence at which the Participant will receive services will be determined by the geographical location of residence and indicated service.
- The Participant acknowledges that the Center of Excellence must receive necessary medical records prior to acceptance into the program.
- The Participant must identify the designated caregiver. The caregiver must agree to (and be able to) meet

caregiver requirements.

- The Participant must provide the Center of Excellence physician with contact information for a local physician who has agreed to manage follow-up care after the Participant returns home from the Center of Excellence.
- Centers of Excellence services must be preauthorized by the Claims Administrator of the program in order to be covered under the Plan.

NOTE: Services provided at facilities other than one in the Complex Care Management program, or services prior to arrival or subsequent to discharge from a Center of Excellence through coordination and approval by the Claims Administrator, will be subject to regular coverage terms under the Plan. In addition, services performed at a Center of Excellence that are not eligible services under the Complex Care Management program will be subject to regular coverage terms under the Plan.

Dental Injury – 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:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
- Emergency repair due to Injury to sound natural teeth. This repair must be made within 12 months from the date of an accident.
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor, and roof of the mouth.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands, or ducts.
- Removal of impacted teeth. (Only covered under medical when dental benefits exhausted.)
- 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.

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.

Diagnostic Services – Diagnostic laboratory and x-ray expense, including charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar diagnostic tests generally approved by physicians throughout the United States. This benefit includes professional fees from a physician, as well as facility charges for diagnostic services.

Dialysis – Charges for dialysis therapy when used for treatment of an illness or injury and rendered in accordance with a physician's written treatment plan. Dialysis equipment rental, supplies, upkeep, and the training of the covered individual, or the technician who attends him, to operate the equipment.

Durable Medical Equipment – Rental and fitting of durable basic (i.e., non luxury) medical equipment (but not to exceed the purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost-effective due to a long-term need for the equipment. Such equipment must be prescribed by a Physician and required for therapeutic use in treatment of an active Illness or Accidental Injury. Durable medical equipment includes such items as braces, crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen and dialysis equipment, seat lifts, TENS, pumps,

power operated vehicles, speech generating devices, insulin infusion pump, osteogenesis stimulators, neuromuscular stimulators, etc.

- *Brace Replacements*. Unless there is sufficient change in the Plan Participant's physical condition to make the device no longer functional, replacement of leg, arm, back, and neck braces are limited to one replacement every three years.
- *Breastfeeding Support and Supplies*
  Breast pumps purchased through a contracted Durable Medical Equipment supplier will be processed under the Preventive benefit with no cost-sharing. Breast pumps purchased from a retail outlet will be reimbursed as an Out-of-Network benefit.

Eye Correction Surgery – 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. Procedure must be performed by an ophthalmologist.

Family Planning – Charges including medical history, physical examination, related laboratory tests, medical supervision in accordance with generally accepted medical practice, information, and counseling on contraception, and after appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation. Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs) will be covered by the plan with no network cost sharing to the member.

Gender Reassignment – Charges for services related to gender reassignment will be covered in accordance with medical necessity guidelines. Benefits include pre- and post-surgical hormone therapy but does not include any cosmetic surgery. ***A candidate for gender reassignment must be 18 years of age or older, been confirmed with gender dysphoria, and actively participating in a recognized gender identity treatment program.*** *Gender reassignment will be limited to one change per lifetime.*

There is no coverage for the reversal of gender reassignment, cosmetic surgery, or travel costs.

Hearing Aids and Exams – Charges for services or supplies in connection with hearing aids including the fitting and repair of hearing aids. Charges are covered up to a maximum of $3,000 every 3 years.

Home Health Care – These are the charges made by a home health care agency, for the following services and supplies furnished to a member in his/her home in accordance with a home health care plan. The home health care must have been established in lieu of hospital or skilled nursing facility confinement.

- Part-time or intermittent nursing care by a registered graduate nurse (R.N.) or by a licensed practical nurse (L.P.N.) if the services of a registered graduate nurse (R.N.) are not available.
- Part-time or intermittent home health aide services which consist primarily of caring for the patient.
- Physical therapy, occupational therapy, respiratory therapy,
- Speech Therapy – only to restore or rehabilitate speech loss
- Medical supplies, drugs and medicines prescribed by a physician, and laboratory services provided by or on behalf of a hospital, but only to the extent that such charges would have been covered if the family member had remained in the hospital.

Each visit by a registered graduate nurse (R.N.) or licensed practical nurse (L.P.N.) to provide nursing care, by a therapist to provide physical, occupational, or speech therapy, and each visit of up to four hours of home health aide services shall be considered as one home health care visit.

Limitations

Home health care expenses will not be included as covered medical expenses if they are for:

- Services or supplies not specified in the home health care plan;
- Services of a member of your family, your spouse/grandfathered domestic partner's family, or your household;
- Services of any social worker;
- Transportation services.

Hospice Care – Hospice care of a Plan Participant with a terminal prognosis (life expectancy of 6 months or less) who has been admitted to a formal program of Hospice care. Eligible expenses include Hospice charges for:

- Hospice facility services and supplies rendered on an inpatient basis;
- Nursing care by a registered graduate nurse, a licensed practical nurse, a vocational nurse, or a public health nurse whom is under the direct supervision of a registered nurse;
- Medical supplies, including drugs and biologicals and the use of medical appliances;
- Physician services; and
- Services, supplies, and treatments deemed medically necessary and ordered by a Physician.

Hospital Services – Inpatient and outpatient hospital expenses will be eligible for coverage if they are determined to be medically necessary and appropriate for the proper treatment of the Plan Participant's condition. Inpatient hospital stays will be payable according to the average semi- private room rate. After 23 observation hours, a confinement will be considered an inpatient confinement. *Private room* allowance is the average semi-private room charge or 90% of the lowest charge by the facility for private rooms in a facility that does not provide any semi-private accommodations unless it is deemed medically necessary. Also covered under hospital services are:

- *Ambulatory Surgical Center* – Services and supplies provided by an ambulatory surgical center in connection with a covered outpatient surgery.
- *Birthing Center* – Services and supplies provided by a birthing center in connection with a covered pregnancy.
- *Blood* – Charges for whole blood or blood plasma, administration of blood, blood processing and materials and supplies of technicians. If the patient donates his own blood for himself prior to surgery the Plan will pay up to the reasonable and customary amount for processing as if the blood was donated from a donor. *Please note that the cost for blood or plasma replaced by or for the patient is not reimbursed under the Plan.*
- *Diagnostic X-ray and Laboratory* – Facility fees for diagnostic x-ray and laboratory examinations.
- *Emergency Medical Care* – The initial treatment of an Emergency Medical Condition as defined herein with acute symptoms of sufficient severity to require immediate medical attention. Outpatient Emergency Services and supplies to treat injuries caused by an accident. Please note: **Emergency Room treatment of a condition that does not meet the definition of Emergency Medical Condition ~~is~~ may not be covered and charges will be the Participant's responsibility.**
- *Intensive Care Unit* – Hospital charges for intensive care accommodation.
- *Medical Care or Supplies* – Special hospital charges for inpatient medical care or supplies received during any period room and board charges are made. This does not include personal supplies or convenience items such as slippers, toothbrushes, guest trays, etc.
- *Pre-Admission Testing* – Outpatient tests and studies required for your scheduled admission to a hospital. Pre-admission testing must is done within 5 days before a pre-scheduled hospital confinement and be related to the condition which causes the confinement.
- *Medicine* – Medicines which are dispensed and administered to a Plan Participant during an Inpatient confinement.

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. Maximum of 60 days in a calendar year.

Maternity and Newborn Care – Maternity expenses are covered to the same extent as any other illness. Coverage will NOT include expenses incurred by a surrogate mother, who is not a Plan Participant. Maternity expenses are available to a dependent child up through and including delivery. Hospital nursery services and a physician's exam provided during the birth confinement to a covered well newborn child, including a PKU test and circumcision.
Breast pumps will be covered under the Health Care Reform Mandated Preventive Services benefit level and are limited to one per pregnancy.

Newborns' and Mothers' Health Protection Act

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

Medical Supplies – Disposable medical supplies such as casts, splints, trusses, surgical dressings, colostomy bags and related supplies, and catheters.

Mental Health – For Plan purposes, shall mean any disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources, except for those conditions that are expressly excluded in the list of *Medical Limitations and Exclusions* Section. All licensed Mental Health Providers such as Psychiatrists (M.D.), psychologists (Ph.D.), counselors (LCSW, LMFT, & LADC), or any practitioner of the healing arts licensed and regulated by a State or Federal agency acting within the scope of their license may bill the plan for covered mental health services. *No benefits will be provided for residential treatment facilities.*

Midwife – Services of a registered nurse midwife when provided in conjunction with a covered pregnancy.

Occupational Therapy – Therapy provided under the direction of a physician and by a certified occupational therapist, utilizing arts, crafts, or specific training in daily living skills, to improve and maintain a patient's ability to function. Additional visits subject to review for medical necessity. Covered expenses do not include recreational programs, maintenance therapy, or supplies used in occupational therapy.

Organ Transplants – Expenses incurred by a Plan Participant who is the recipient of a human organ or tissue transplant which is not experimental or investigational in nature. 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. The transplant must be performed at a Plan designated or contracted organ transplant facility to receive the maximum benefits.

Orthotics – Custom molded devices for the feet.

Partial Hospitalization – Partial hospitalization must be a medically necessary alternative to inpatient hospitalization for mental health treatment or substance abuse treatment. This service is designed for patients who do not require 24-hour care, but who would benefit from more intensive treatment than ordinarily offered on an outpatient basis and are subject to the same limitations and conditions as mental health or substance abuse treatment.

Physical Therapy – Professional services of a licensed physical therapist, when specifically prescribed by a physician or surgeon as to type, frequency, and duration, but only to the extent that the therapy is for improvement of bodily function. Additional visits subject to review for medical necessity.

Physician Services – Medical and surgical treatment by a physician (M.D. or D.O.) including office, home or hospital visits, and consultations. Also includes Radiologists, Pathologists, and other licensed medical professionals.

- *Allergy Testing and Treatment* – Including coverage for allergy injections.
- *Hospital Visits* – Physician consultation services during your hospital confinement and expenses for inpatient visits by a physician.
- *Office Visits* – Covered services for office visits include expenses for most services and supplies provided in the physician office.

Preventive Care – The Plan will provide preventive health care services mandated through the ACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).

See https://www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html or https://www.uspreventiveservicestaskforce.org/ for more details.

Important Note: The Preventive Care services identified through this link are recommended services, not mandated services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered;

Preventive and Wellness Services for Adults and Children – In compliance with section (2713) of the Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved. With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

A description of Preventive and Wellness Services can be found at: https://www.healthcare.gov/preventive-care-benefits/.

Women's Preventive Services – With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration not otherwise addressed by the recommendations of the United States Preventive Service Task Force, which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

a. Well-woman visits;
b. Gestational diabetes screening;
c. HPV DNA testing;
d. Sexually transmitted infection counseling;
e. HIV screening and counseling;
f. FDA-approved contraception methods and contraceptive counseling;
g. Breastfeeding support, supplies, and counseling; and
h. Domestic violence screening and counseling.

A description of Women's Preventive Services can be found at: http://www.hrsa.gov/womensguidelines/ or at https://www.healthcare.gov/preventive-care-benefits/.

For information about breastfeeding support and supplies, including breast pumps, please contact the customer service number on the back of the member ID card. Breast pumps purchased from a retail outlet will be reimbursed as an Out-of-Network benefit.

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:

- *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.
- *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 outlined under Home Health Care. Outpatient private duty nursing care on a shift-basis is not covered.

Prosthetics – Artificial limbs, eyes or other prosthetic appliances required to replace natural limbs, eyes or other body parts, devices that support or correct the function of a limb or the torso while a person is covered by the Plan. May also include helmets, extremity prosthetic additions, electric prosthetic joints, facial prosthesis provided by a non-physician, voice amplifiers, cranial remolding orthosis, and lower extremity orthosis, and knee braces. Prosthetic devices necessitated by a functional birth defect in a covered Dependent child.

- *Brace Replacements.* Unless there is sufficient change in the Plan Participant's physical condition to make the device no longer functional, replacement of leg, arm, back, and neck braces are limited to one replacement every three years.

Radiation Therapy – Care and services for radium and radioactive isotope therapy.

Respiratory Therapy – Professional services of a licensed respiratory therapist, when specifically prescribed by a physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of respiratory function.

Screenings Due to Possible Exposure – The Southern Nevada Health District has determined that unsafe medical practices have been occurring at several Las Vegas-area medical clinics; and 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.

Second Surgical Opinion – A second surgical opinion consultation following a surgeon's recommendation for surgery. The Physician rendering the second opinion regarding the Medical Necessity of a proposed surgery must be qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

A third opinion consultation will also be covered if the second opinion obtained does not concur with the first Physician's recommendation. This third Physician must be qualified to render such a service and must not be affiliated in any way with the Physician who will be performing the actual surgery.

Skilled Nursing Facility – Benefits are provided for Semi-Private room and board and ancillary supplies that are provided by a skilled nursing facility, but only when:

- Confinement is for the same condition causing the preceding confinement;
- Admission to the skilled nursing facility occurs within fifteen (15) days following discharge from an accredited hospital of a confinement of at least 3 days where services were rendered for the same or related conditions;
- The attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and,
- 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.

Sleep Disorders – Care and treatment for sleep disorders when deemed Medically Necessary.

Smoking Cessation – Care and treatment for smoking cessation programs as determined by The Department of Health and Human Services (HHS). Additional information can be found by visiting *http://www.healthcare.gov.* Note: It is advised to check this list regularly as it is subject to change without notice.

Speech Therapy – 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 illness, (except a mental, psychoneurotic or

personality disorder) or by surgery for that injury or illness 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, expenses will be considered only if incurred after corrective surgery for the defect. Additional visits subject to review for medical necessity.

Substance Abuse – For Plan purposes substance abuse is physical and/or emotional dependence on drugs, narcotics, alcohol, or other addictive substances to a debilitating degree. It does NOT include tobacco dependence or dependence on ordinary drinks containing caffeine. Psychiatrists (M.D.), psychologists (Ph.D.), counselors (LCSW, LMFT, & LADC), or any other practitioner of the healing arts licensed and regulated by a State or Federal Agency may bill the Plan directly.
All licensed mental health providers acting within the scope of their license may bill the plan for covered substance abuse services. *No benefits will be provided for charges from any residential treatment facilities.*

Surgical Services – The following services you receive from a professional provider will be considered eligible expenses:

- *Anesthesia* – Anesthetics and services of a Physician or registered nurse anesthetist for the administration of anesthesia.
- *Assistant Surgeon* – the services of an assistant surgeon not to exceed 20% of the reasonable and customary charge of the primary surgeon.
- *Multiple Surgical Procedures* - Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:
    - If two or more surgical procedures are performed during the same session through the same incision, natural body orifice or operative field, the amount eligible for consideration under the Plan is the allowable for the largest amount billed for one procedure, plus 50% of the allowable for each of the additional procedures performed, unless the provider agreement states otherwise;
    - If two or more surgical procedures are performed during the same session through different incisions, natural body orifices or operative fields, the amount eligible for consideration under the Plan is the allowable for the largest amount billed for one procedure, plus 50% of the allowable for all other procedures performed, unless the provider agreement states otherwise;
    - EXCEPTION to subsections (i) and (ii) – Any procedure that includes the current procedural terminology (CPT) descriptive wording of "list separately in addition to the code for the primary procedure" will be allowed at 100%.
    - If multiple unrelated surgical procedures are performed by 2 or more surgeons on separate operative fields, benefits will be based on the contracted allowable or Reasonable and Customary Charge for each surgeon's primary procedure and limited in total to 150% of the combined total; and
    - If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Reasonable and Customary allowance.
- *Surgical Dressings* – Expenses related to surgical dressings, splints, casts, and other devices used in the reduction of fractures and dislocations.

Temporomandibular Joint (TMJ) Syndrome – The treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include but is not limited to physical therapy. Any appliance that is attached to or rests on the teeth and orthodontic services is covered under the Dental plan. *This does not include orthognathic surgery.*

Urgent Care – illness or injury that does not appear to be life threatening, but still requires care within 24 hours. Some examples include: fever or flu, cough, cold, rash, infections, sprain, strains, vomiting, diarrhea, minor broken bones (i.e., toes or fingers).

Wellness Benefit – The Plan provides a wellness benefit up to $200.00 per calendar year for the following routine services for each covered employee/retiree and covered spouse and covered dependent child through age 26. This benefit may not be accumulated from year to year if the benefit is not used each year. To receive reimbursement, Plan Participants must complete a Wellness Benefit Designation Form with substantiation 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. The wellness benefit does NOT cover Deductibles, co-

payments, coinsurance, or any amount over the Reasonable and Customary amount as determined by the Plan.

1. Check-ups (including routine physical examination, laboratory tests and x-rays) or immunizations not covered under the Preventive and Wellness Services as specified by the Affordable Care Act
2. Eyeglasses or contact lenses (not covered by vision plan; a copy of the EyeMed denial form and/or explanation of benefits MUST be attached to the claim form)
3. Programs to stop smoking as approved by a physician
4. Weight loss program as approved or prescribed by a physician
5. Wigs (cranial prosthesis) due to hair loss caused by chemotherapy treatments

Wellness claims filed more than 12 months after the date of service will not be eligible for payment

MEDICAL EXCLUSIONS AND LIMITATIONS

No payment will be made under any provision of this Plan for expenses incurred by a Plan Participant for:

Administrative Fees – Expenses for missed appointments, completion of claim forms or provided medical information to determine coverage, and/or charges for telephone consultations (not including virtual telemedicine visits, which are covered).

Batteries – Replacement batteries for wheelchairs or other durable medical equipment.

Biofeedback – Biofeedback, recreational, or educational therapy, or other forms of self-care of self- help training or any related diagnostic testing except as provided under the Autism Spectrum Disorder.

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

Cosmetic Surgery – Any surgery, service, drug, or supply designed to improve the appearance of an individual by alteration characteristic which is within the broad range of normal, but which may be considered unpleasing or unsightly, except when:

- Necessitated by a non-occupational accidental injury, disease, or infection which occurs and is treated while the patient is covered by the Plan.
- Surgery is performed to reconstruct a prior mastectomy, which was medically necessary;
- Necessary to correct a congenital abnormality in a child.

Counseling – Expenses for religious, marital, family or relationship counseling.

Court-Ordered Care – Any care, confinement, or treatment of a Plan Participant in a public or private institution as the result of a court order.

Custodial Care – Care or confinement primarily for the purpose of meeting personal needs which could be rendered at home or by person without professional skills or training. Any type of maintenance care which is not reasonably expected to improve the patient's condition, except as may be included as part of a formal Hospice care program.

Educational or Vocational Testing – Services for educational or recreational therapy; vocational testing or training; learning disabilities; behavior modification therapy; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; aquatic or pool therapies. Charges incurred for special education or training for learning disorders.

Any expense related to the services performed by a physician or other professional provider enrolled in an education or training program when such services are related to the education or training program.

Employees of Covered Facilities – Professional services billed by a physician or nurse who is an employee of a clinic, hospital or skilled nursing facility and paid by the facility for the services that they provide.

Excess Charges – The part of an expense for care and treatment of an injury or illness that is in excess of the reasonable and customary charge.

Excess Skin Removal following Bariatric Surgery – The removal of excess skin following bariatric surgery.

Exercise Program – Exercise programs, equipment or supplies made or used for physical fitness, athletic training, or general health upkeep.

Experimental or Investigational – Charges for Experimental or Investigational services, treatments, supplies, or drugs which have not been approved by the United States Food and Drug Administration. *The Affordable Care Act (ACA) along with Section 2709 of the Public Health Service Act (PHSA) limits what treatment may be considered experimental and/or investigational. Refer to Clinical Trials in the Covered Medical Expenses section for more information.*

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.

Foot Care – Expenses for routine or cosmetic foot care, such as corns, calluses, flat foot conditions, supportive devices for the foot (except custom foot orthotics as specified in the *Covered Medical Expenses* section), treatment of subluxations of the foot (except capsular or bone surgery), toenails (except surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet. Orthopedic shoes are not covered (except when permanently attached to braces).

Foreign Travel – Care, treatment or supplies out of the United States if travel is for the sole purpose of obtaining medical services.

Genetic Testing and Counseling – Unless required as part of the prior authorization process to dispense pharmaceutics or as required by the Food and Drug Administration, expenses for genetic testing and counseling, are excluded unless otherwise indicated in this document as a covered expense.

Government Coverage – Care, treatment or supplies furnished by a program or agency funded by any government for which the Plan Participant is not liable for payment. This does not apply to covered expenses rendered by a United States Veteran's Administration Hospital when services are provided for a non-service-related illness or injury, Medicaid or when otherwise prohibited by law.

Hair Loss – Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether prescribed by a physician.

Holistic or Homeopathic Medicine – Services, supplies or accommodations provided in connection with holistic or homeopathic treatment, including drugs.

Hypnosis – Services, supplies or treatment related to the use of hypnosis.

Illegal Acts – Charges for an injury or illness caused wholly, partially, directly, or indirectly by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault, or other felonious behavior; or by participating in a riot or public disturbance. In compliance with the Health Insurance Portability and Accountability Act, if an injury results from a medical condition or act of domestic violence, the plan will not deny benefits for the injury. A medical condition includes both physical and mental illnesses.

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

Infertility Treatment – Expenses for the promotion of conception including, but not limited to artificial insemination, in vitro fertilization, GIFT (Gamete Intra Fallopian Transfer), fertility studies, sterility studies, non-surgical procedures, and related treatment. However, charges for testing to determine the diagnosis of infertility are covered.

Maintenance Care – Services or supplies that cannot reasonably be expected to lessen the patient's disability or to enable him to live outside of an institution.

No Charge – Charges for which the Plan Participant and/or the Plan are not legally required to pay, including charges, which would not have been made if no coverage existed. This exclusion is subject to the right, if any, of the United States Government to recover reasonable and customary charges for care provided in a military or veterans' hospital.

No Obligation to Pay – Expenses for services that are furnished under conditions, which the Plan Participant has no legal obligation to pay. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where federal law requires the employer's plan to be primary.

No Physician Recommendation – Care, treatment, services or supplies not recommended, prescribed, performed, or approved by a legally qualified physician; or treatment, services or supplies when the Plan Participant is not under the regular care of a physician. Regular care means ongoing medical supervision or treatment that is appropriate care for the injury or illness.

Non-Emergency Hospital Admissions – Care and treatment billed by a Hospital for non- Medical Emergency admissions. This does not apply if surgery is performed within 24 hours of admission.

Not Medically Necessary – Charges, which are determined not to be medically necessary.

Not Specified as Covered – Services, treatments and supplies that are not specified as covered under this Plan.

Obesity – Services, supplies for anorexiants, obesity or weight, except when provided for treatment of morbid obesity or as required under the preventive care benefit.

Occupational and/or Work Related – Any condition for which the Plan Participant has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose, or is otherwise deemed by Statute to be care or treatment compensable under the Nevada Industrial Insurance Act commencing at NRS Chapter et seq.
However, if the Plan provides benefits for any such condition, the Plan Administrator will be entitled to establish a lien upon such other benefits up to the amount paid.

Orthognathic Surgery – The surgical correction of a skeletal anomaly or malformation of the jaw involving the mandible or maxillary joint.

Penalties – For a charge refused by another Plan as a penalty assessed due to non-compliance with that Plan's rules and regulations.

Personal Comfort Items – Personal care or comfort items, such as, but not limited to, barber/beautician services, radio, television, and telephone services, guest meals, guest cots, rental of humidifiers, massage equipment, air conditioners, air-purification units, electric heating units, orthopedic mattresses, nonprescription drugs and medicines, elastic bandages or stockings, and first-aid supplies and non-hospital adjustable beds. Expenses for personal hygiene and convenience items considered personal comfort items are excluded from Plan coverage.

Plan design excludes – Charges excluded by the Plan design as mentioned in this document.

Postage – Any postage, shipping, or handling charges, which may occur in the transmittal of information.

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 will be covered.

Relative Providing Services – Charges for treatment or services of physicians, nurses, chiropractors, physiotherapists, or other practitioners, who live in your home and/or if the provider of service is the employee, employee's spouse/grandfathered domestic partner, child, brother, sister, or parent, whether the relationship is by blood or exists in law.

Replacement Prosthetic Devices/Braces – Replacement of braces of the leg, arm, back, neck or artificial arms or legs, unless there is sufficient change in the Plan Participant's physical condition to make the original device no longer functional.

Residential Treatment Center – a live-in health care facility providing therapy for substance abuse, mental illness, or other behavioral problems.

Routine Care – Charges for the examinations, subsequent diagnostic testing, or corresponding forms including, but not limited to the following: premarital exams; physicals for college, camp, sports, or travel; examinations for insurance, licensing, or employment. Immunizations and inoculations are also excluded, except where specifically covered by the Plan.

Services Before or After Coverage – Charges for services and/or supplies provided before the effective date of coverage under the Plan or provided after termination of coverage under the Plan.

Sexual Dysfunction – Expenses for services, supplies or drugs related to sexual dysfunction not related to organic disease, sex therapy.

Sleep Disorders – Care and treatment for sleep disorders unless deemed medically necessary.

Surgical Sterilization Reversal – Care and treatment for the reversal of an elective surgical sterilization.

Third Party Liabilities – Any expenses caused by a third party when payment for such expenses has been paid (or will be paid) by the third party or the third party's insurance company (Please refer to the Coordination of Benefits and Subrogation sections).

Travel or Accommodations – Charges for travel or accommodations, whether recommended by a physician, except for ambulance charges as defined as a covered expense.

Vitamins or Dietary Supplements – Prescription or non-prescription organic substances used for nutritional purposes other than pre-natal vitamins by prescription only.

War – Treatment of injury or illness that is occasioned by insurrection of war or any act of war, whether declared or undeclared.

PRESCRIPTION DRUG EXPENSE BENEFIT

Clark County Self-Funded Group Medical and Dental Benefits Plan provides a Prescription Drug Plan. 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. The Plan Participant is responsible for the applicable co-payment when the card is presented in the drugstore.

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 but does accumulate towards the Prescription Drug Out-of-Pocket Maximum. 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 with the exception of the Retail 90-day program

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.). Certain medications, such as controlled substances for pain management, are not available through the mail order program. The list of covered mail order medications is available through the Pharmacy Benefit Manager and is the easiest 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 but does accumulate towards the Prescription Drug Out-of-Pocket Maximum. Any one covered prescription is limited to a maximum of a 90-day supply.

The Plan offers a Copay Max program for specialty drugs included in the specialty tier and dispensed only through the specialty pharmacy, Lumicera. This program will properly manage your expenses for eligible specialty medications while also lowering the Plan's overall cost if copay assistance is available. Under the program, your specialty medications are subject to a coinsurance of 30%. However, with this program your total payment will be $0 after utilization of available copay assistance for qualifying specialty medications. Only the amount you pay out-of-pocket will apply to your annual deductible and/or out-of-pocket maximum. If a specialty medication does not qualify or is removed from the program, your copay will default to the formulary's current tiered coinsurance/copay.

Qualifying expenses include:

- 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.
- All formulary compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- Insulin when prescribed by a Physician.
- Injectable medications when prescribed by a physician, and as authorized through the Drug Utilization Review Program.
- 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.

- Contraceptives. All FDA approved contraceptives Drugs and methods, in accordance with HRSA guidelines and NRS 689B.0376, which requires coverage for up to 12 months of contraceptives Drugs in certain circumstances.
- Over the Counter (OTC) Drugs. OTC Drugs related to Preventive and Wellness Services as specified by the Affordable Care Act of 2010. A description of these services can be found at: https://www.healthcare.gov/preventive-care-benefits/. This includes FDA-approved generic Drugs and Over-the-Counter (OTC) Drugs, devices and supplies related to Women's Preventive Services, as specified by the Affordable Care Act of 2010. A description of FDA- approved contraceptive methods can be found at: http://www.fda.gov/ForConsumers/ByAudience/ForWomen/WomensHealthTopics/ucm117971.htm.

Coverage for Injectable Medications

All covered injectable medications, with the exception of insulin, require prior authorization through the Pharmacy Benefit Manager. Covered injectable medications listed on the preferred formulary include injectable drugs which are an accepted standard of care for self-administration. Covered injectables must be purchased through a contracted Specialty pharmacy participating in the pharmacy program only if prior authorized through the Pharmacy Benefit Manager. Contact the Pharmacy Benefit Manager to determine how your injectable medication will be covered.

Limits To The Prescription Drug Benefit

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

- Refills only up to the number of times specified by a Physician.
- Refills up to one year from the date of order by a Physician.
- The reasonable and customary allowance as determined by the Pharmacy Benefit Manager.
- 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.
- 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.

No prescription benefits will be paid for charges incurred for:

- Charges for therapeutic devices or appliances 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.
- Any charge for the administration of a covered Prescription Drug (applies only to the Prescription Drug Program).
- Any drug or medicine that is consumed or administered at the place where it is dispensed (applies only to the Prescription Drug Program).
- Experimental drugs and medicines, even though a charge is made to the Plan Participant.
- Any drug not approved by the Food and Drug Administration.
- A charge for cosmetics, hair growth aids, dietary supplements, and vitamins.
- Immunization agents or biological sera.
- Investigational. A drug or medicine labeled: "Caution - limited by federal law to Investigational use".
- A charge excluded under Medical Plan Exclusions.
- A charge for Prescription Drugs which may be properly received without charge under local, state, or federal programs.
- A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

Employer Group Waiver Plan (EGWP)

The Plan Administrator offers a Medicare Employer Group Waiver Plan (EGWP) to Medicare-eligible retirees and Medicare eligible dependents covered under the Plan. The EGWP meets requirements applicable to Medicare Part D and retirees and dependents enrolled in either Medicare Part A or B or Parts A and B will be automatically enrolled in the EGWP upon becoming Medicare-eligible. The Plan Administrator will collect the Medicare premium for Part D drug plan coverage except any additional premium imposed due to exceeding the income threshold as defined by the Social Security Administration. Covered drugs will be subject to the formulary approved by the Centers for Medicare and Medicaid Services.

As with Medicare Part D plans, members of the EGWP with a higher income may be assessed an Income Related Monthly Adjustment Amount (IRMAA). Failure to pay the required IRMAA amount will result in benefits being paid on an out-of-network basis for prescription drugs. Any assessed penalties will not apply to the member's out-of-pocket maximum.

If a member is eligible for Part A or B or Parts A and B and does not enroll in Medicare coverage, the member will not have prescription benefits coverage under the Plan.

If a member elects Part D Prescription Drug Plan (PDP) outside of Clark County Self-Funded EGWP Plan, the member will not have prescription benefits coverage under the Plan. Prescription benefit coverage will be through the PDP plan otherwise selected by the member.

Contact the Pharmacy Benefit Manager for more information regarding EGWP.

CLAIMS PROCEDURES FOR SUBMITTING A CLAIM

How To File A Claim

For purposes of this Plan a filed claim for payment of benefits shall mean a completed paper or electronic claim form submitted to the Plan naming the specific claimant, the date of service, the charges, the specific medical condition or symptom, a specific treatment or service that was rendered or product provided by a qualified provider.

Preferred Network and In-Network (PPO) Claims

When a Plan Participant utilizes the services of PPO hospitals, physicians and other providers, involvement in the claims process will be minimal. After identifying as a Plan Participant of the Clark County Self-Funded Group Medical and Dental Benefits Plan, bills incurred for covered expenses under this Plan will be sent by the provider directly to the address identified on the Plan ID Card.

When the hospital or other provider submits bills, the payment will be sent to the providers directly. The Plan Participant will receive a copy of the Explanation of Benefits (EOB) showing the payments made and any deductibles or co-insurance involved in the benefits calculation.

To avoid a delay in claims processing, the PPO Provider should be provided with the Plan Participant's ID card listing the current billing instructions for the claim's administrator. If the claim is the result of an accident, please give date, place, and cause of accident, and a completed Accident Detail Form available from the Claims Administrator at: https://connect.healthaxis.com/hsbmember.aspx.

Out-of-Network Claims

When a Plan Participant incurs medical expenses for which it is believed reimbursement is due under the terms of the Plan, the necessary documentation must be filed with the Claims Administrator, HealthSCOPE Benefits, P.O. Box 99005, Lubbock, TX 79490-9005. Claim forms can be obtained from the Claims Administrator.

It is the Plan Participant's responsibility to provide any information that is necessary for the Plan to make a prompt and fair evaluation of your claim. It is suggested that each time a claim is filed, the following information is provided:

- Plan Participant's name, Plan ID Number and the Plan Number as shown on the ID card. If the claim is for a dependent, identify that individual in the same fashion as you did on your enrollment form.
- Have all charges presented on an original itemized bill listing dates of service, type of service and the charge for each service as rendered, including the provider's name, address, telephone number, and tax identification number.
- Have the attending physician identify the diagnosis for which treatment was rendered on the bill.
- If the claim is the result of an accident, please give date, place, and cause of accident, and a completed Accident Detail Form available from the Claims Administrator at: https://connect.healthaxis.com/hsbmember.aspx.

Claim Timely Filing

If a Plan Participant claims benefits, a proof of claim must be furnished to the claim's administrator within 60 days of the date charges for the service were incurred. If a written or electronic claim is not furnished to the claim's processor within 12 months, the claim will be denied. Benefits are based on the Plan's provisions at the time that the charges are incurred. Claims submitted after the 12-month period will not be considered for payment or may be reduced.

The Claim 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.

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 written notice of its denial. The request will be processed within 10 working days after receipt of 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 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.

Claim Overpayments

A Plan Participant shall be responsible for repaying the Plan any overpayments made to the Plan Participant, dependents, or any providers directly. Failure to make such repayment (or agree to terms acceptable to the Plan Administrator regarding such repayments) after written notice from the Plan Administrator requesting a repayment shall result in the reduction of future claim payments which would otherwise be payment to the Plan Participant and/or his/her dependents, or to a service provider on behalf of the Plan Participant and/or his/her dependents. In the event the Plan Administrator should be required to institute litigation to enforce this provision of the Plan, 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.

Non-U.S. Providers of Emergency Services

Expenses for Emergency Services which are rendered by a Provider whose principal place of business or address for payment is located outside the United States (a "Non-U.S. Provider") to treat an Emergency Medical Condition services are payable under the Plan at the out-of-network level, subject to all Plan exclusions, limitations, maximums, and other provisions, under the following conditions:

1. Benefits may not be assigned to a Non-U.S. Provider;
2. The Participant is responsible for making all payments to Non-U.S. Providers, and submitting receipts to the Plan for reimbursement;
3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred Date;
4. The Non-U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
5. Claims for benefits must be submitted to the Plan in English.

How To Appeal A Claim Denial

Time Sensitivity*: If any appeal does not comply with the timelines set forth in this provision below, the right to appeal the adverse benefit determination will be lost.*

To appeal an adverse benefit determination or to review administrative documents pertinent to the claim, send a written request to the Claims Administrator or Clark County Office of Risk Management within the time limits described herein. A full and fair review of the claim will be made with no deference given to the initial benefit determination. As part of the review, the Plan Participant or the Plan Participant's authorized representative are allowed to review all Plan Documents and other information that affect the claim and are allowed to submit issues, comments, documents, records, or other information that had not previously been submitted, as provided herein below.

During the period that the claim is being reconsidered, if there is reason to believe that medical records contain information that should be disclosed by a physician or other health professional, the Plan Participant or the Plan Participant's authorized representative will be referred to the physician for the information before the Plan will provide the requested documents directly to the Plan Participant or the Plan Participant's authorized representative. However, if the provider fails to provide the requested information to the Plan Participant or the Plan Participant's authorized representative in a reasonable period of time and

without charge, the request will be honored by the Plan. Neither the Plan Participant nor the Plan Participant's authorized representative will be provided access to or copies of files of other Plan Participants. For an appeal resulting in an adverse benefit determination, the identity of any medical or vocational expert consulted in connection with the appeal will be provided upon request, without regard to whether the advice was relied upon in making the determination.

All interpretations, determinations, and decisions of the reviewing entity with respect to any claim will be its sole decision based upon the Plan documents. All decisions of the Plan Administrator will be deemed final and binding.

Appeals of Adverse Benefit Determinations Will be Considered as Follows:

1. First Level Appeal – Plan Administrator
   The Plan Participant or the Plan Participant's authorized representative has **180 days** after receipt of an Explanation of Benefits (EOB) to appeal an adverse benefit determination to the Plan Administrator, through the Claims Administrator. The Plan Administrator will make a full and fair review of the claim, with no deference given to the initial determination. As part of the review, the Plan Participant or the Plan Participant's authorized representative are allowed to review all Plan documents and other papers that affect the claim and are allowed to submit issues and comments and argue against the denial in writing. The Plan Administrator will make a determination within 20 days after receiving a claim appeal.

2. Second Level Appeal – Group Health Committee
   If the Plan Administrator upholds the Claims Administrator's adverse benefit determination, the Plan Participant or the Plan Participant's authorized representative may, within **30 days** of receiving the Plan Administrator's written denial of a First Level Appeal, request review by the Plan's Group Health Committee. Appeals to the Group Health Committee (Committee) will be resolved according to the following procedure:

   - Only a Plan Participant or a Plan Participant's authorized representative may submit a written appeal to the Committee. The request for this Second Level Appeal should be submitted in writing to the Plan Administrator through the Clark County Office of Risk Management.
   - The Office of Risk Management will submit the request for Second Level Appeal to the Committee for its review at the next monthly meeting of the Committee.
   - The Plan Participant or Plan Participant's authorized representative will be notified of the date scheduled for the Committee review and may submit additional written information for the Committee's consideration, including medical records, medical opinions, or statements. Additional written material must be provided to the Office of Risk Management at least 5 business days in advance of the scheduled Committee review date.
   - Within 30 days after the Committee completes its review of the appeal, the Committee, through the Office of Risk Management, will provide the Plan Participant or Plan Participant's authorized representative with a written determination regarding the appeal.

3. Third Level Appeal – External Review
   Within **180 days** of the Plan Participant or Plan Participant's authorized representative's receipt of the Group Health Committee's written decision to uphold an adverse benefit determination, the Plan Participant or Plan Participant's authorized representative may request an External Review. To request an External Review, the Plan Participant or Plan Participant's authorized representative must submit a written request for External Review to the Claims Administrator. An independent organization will then review the decision and provide the Plan Participant or Plan Participant's authorized representative with a written determination. If this organization decides to overturn an adverse benefit determination, the Plan Administrator will provide coverage or payment as directed by the External Review, consistent with the Review's interpretation of the Plan Document.

If the adverse benefit determination is upheld, there is no further review available under the appeals process.

If you or your representative fail to file a request for review (appeal) in accordance with the claims procedures as described above, you or your representative will have no right to review. The denial of your

claim will become final and binding.

Frequently Asked Claims Procedure Questions:

What if a Plan Participant needs help understanding an adverse benefit determination?

Contact the Claims Administrator via the customer service phone number on the back of the ID Card for assistance in understanding an adverse benefit determination.

What if a Plan Participant doesn't agree with the determination? A Plan Participant has a right to appeal any adverse benefit determination as set forth in this section above.

What if a situation is urgent? If the situation meets the definition of urgent under the law, the review will be conducted on an expedited basis. Generally, an urgent situation is one in which a Plan Participant's health may be in serious jeopardy or, in the opinion of the physician, a Plan Participant may experience pain that cannot be adequately controlled while waiting for a decision on the appeal. A Plan Participant may request an expedited appeal by contacting customer service at the number on the back of the Plan Participant's ID Card.

Who may file an appeal? A Plan Participant or someone who is named to act for a Plan Participant (an authorized representative) may file an appeal. An authorized representative is a person who is chosen by and identified to assist or authorized to represent the Plan Participant, including a family member, provider, employer representative or attorney. An assignment of benefits by a Plan Participant to a health care provider does not constitute designation of an authorized representative.

Can a Plan Participant provide additional information about my claim? Yes, a Plan Participant may supply additional information to the Claims Administrator.

Can a Plan Participant request copies of information relevant to my claim? Yes, a Plan Participant may request copies (free of charge) by contacting the Claims Administrator at the number on the back of the ID Card.

Definitions and Rights Relevant to the Appeal Process

Adverse Benefit Determination Any denial, reduction or termination of a benefit, or failure to provide or make payment (in whole or in part) for a benefit. An adverse benefit determination includes denials made on the basis of eligibility, utilization review, and restrictions involving services determined to be experimental or investigational, or not medically necessary or appropriate.

Authorized Representative A person who is chosen by and identified to assist or authorized to represent the Plan Participant, including a family member, provider, employer representative or attorney. An assignment of benefits by a Plan Participant to a health care provider does not constitute designation of an authorized representative.

Right to Receive and Release Needed Information Certain facts are needed to adjudicate claims in accordance with the provisions set forth in the Plan. The Plan Administrator has the right to decide which facts are required and may obtain the needed facts from or provide them to any other organization or persons. Each person claiming benefits under this Plan must provide any information required to pay the claim.

Medical Privacy Medical information that is obtained and maintained in the course of processing claims will be secured and protected in accordance with state and federal laws, Health Insurance Portability and Accountability Act (HIPAA), regarding the Plan Participants' privacy rights.

DENTAL BENEFITS

Right to Waive Dental Coverage
Employees have the right to waive dental coverage at Open Enrollment or upon proof of a mid- year qualifying event. Please note choosing to waive the dental benefit does not reduce the health insurance premium.

If dental benefits have not been waived, 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 Plan Participant must meet the deductible shown in the Schedule of Dental 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 Plan Participant 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 Annual Maximum Dental Benefit Amount is shown in the Schedule of Dental Benefits.

D. DENTAL CHARGES

Dental charges are the Reasonable and Customary 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 incurred as each visit or treatment is completed.

SCHEDULE OF SELF-FUNDED DENTAL BENEFITS

	Dental Percentage Payable
Class A Services Preventive/Diagnostic Dental	100%
Class B Services Basic Dental after Deductible	80%
Class C Services Major Dental after Deductible	80%
Class D Services Orthodontia after Deductible	Covered for children up to age 19 See the Class D Services: Orthodontic treatment and Appliances section for details on how this benefit is paid.
Calendar Year Deductible	
Class A	Deductible Waived
Class B, Class C and Class D	$50.00 per Plan Participant $100.00 Per Family
Maximum Benefit Amount	
Class A, B, and C Services *(Combined)*	$2,000 Per Plan Participant Per Calendar Year $4,000 Per Covered Family Per Calendar Year
Class D Services	$3,000 Per Plan Participant per Lifetime on all County plans

The Plan provides access to the Diversified Dental PPO network for Plan Participants enrolled in dental coverage. Out-of-network benefits are subject to Reasonable and Customary charges.

COVERED DENTAL SERVICES

Class A Services: Preventative 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 on all County plans - payable $150)

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 12months)
- 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 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.)
- Subgingival curettage, root planing, scaling per quadrant (not prophylaxis)
- 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 (Sargent method)
- Bi-rooted canal therapy (Traditional method)
- Bi-rooted canal therapy (Sargent method)
- Tri-rooted canal therapy (Traditional method)
- Tri-rooted canal therapy (Sargent 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 Pontictype)
- Porcelain fused to gold
- Porcelain fused to non-preciousmetal
- 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), perdenture
- Adjustment to denture more than 6months after installation

Dental Implants

- Surgical placement of endostealimplant
- Surgical placement of epostealimplant
- Surgical placement of transostealimplant

Class D Services: Orthodontic 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.

These services are available for covered dependent children under age 19.

1. Orthodontia benefits terminate when a dependent child turns 19.

2. Orthodontia treatment will include preliminary study, including x-ray, diagnostic casts, active treatment and retention appliance.

3. The plan will pay a lifetime maximum of $3,000 on all County plans per covered dependent child.

4. Orthodontia benefits are subject to Coordination of Benefits provisions

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 prior to the member's effective date or after termination of coverage.

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 in the back of this booklet.

The Claims Administrator will notify the Dentist of the benefits payable under the Plan. The Plan Participant 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.

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 Diversified Dental PPO network allowable amount, or the Reasonable and Customary Charge for an out-of-network claim, for an amalgam filling. If the Plan bases its reimbursement on the Reasonable and Customary Charge, 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.

DENTAL EXCLUSIONS AND LIMITATIONS

Except as specifically stated, no benefits will be payable under this Plan for:

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. No listing. Services which are not included in the list of covered dental services.
5. Medical Services. Services that, to any extent, are payable under any medical expense benefits of the Plan.
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 replacementor 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. Dental implants to replace teeth extracted prior to the person becoming a covered individual under this Coverage.
16. Occupational. Care and treatment of an Injury or Illness that is occupational -- that is, arises from work for wage or profit including self-employment.
17. Restorations. Restorations for the purpose of splinting, or to increase vertical dimension or restore occlusion.

18. Cosmetic. Services for cosmetic purposes unless made necessary by an Injury occurring while covered, or dental care of a congenital or developmental malformation. Facings on molar crowns or pontics are always considered cosmetic.
19. Appointments. Charges for failure to keep a scheduled appointment with a Dentist and/or completion of claim forms.
20. Reasonable and Customary. The portion of any charge for any service in excess of the reasonable and customary dental charge which is performed by a non-participating provider in the Diversified Dental PPO network. 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.

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.

DEFINED TERMS

Accidental Injury – Unforeseen and unintended injury. Muscle strains due to athletic or physical activity is not an accidental injury.

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.

Administrative Period – An Administrative Period is a period of time between a Measurement Period and a Stability Period, during which Clark County will determine which employees classified as Variable Hour Employees are eligible for coverage, as well as notify and enroll those employees. For newly hired employees who are not determined to be Full-Time Employees on the date of hire, the Administrative Period also includes the period between date of hire until the end of the month after the date of hire, unless the date of hire is on the first of the month, and then the Administrative Period will start on the date of hire.

Ambulatory Surgical Center – 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.

Applied Behavior Analysis – Applied Behavior Analysis (ABA) shall mean 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.

Assignment of Benefits – Authorization by the employee for the Plan to pay benefits directly to the provider of the service.

Autism Spectrum Disorders – Autism Spectrum Disorders shall mean a neurobiological medical condition including, without limitation, autistic disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified.

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

Behavioral Therapy – Behavioral Therapy shall mean 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.

Biofeedback – Provides training to help an individual gain some element of voluntary control over autonomic body functions.

Birthing Center – Any freestanding health facility, place, professional office or institution, 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 (no more than 24 hours); 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.

Business Associate – A person who, on behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement:

- Performs, or assists in the performance of a function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice

management and repricing; or

- Provides, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

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

Centers of Excellence – Centers of Excellence shall mean medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation and other procedures (e.g., bariatric surgery). Refer to the Covered Medical Expenses section for more details.

Chiropractic Services – The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

Claims Administrator – contracted third party responsible for processing health benefit claims in accordance with this plan document.

COBRA – The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Cosmetic Surgery – Medically unnecessary surgical procedures which are primarily directed at improving an individual's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease; including, but not limited to, plastic surgery directed toward preserving beauty.

Covered Entity – In terms of the HIPAA Privacy Regulations a Covered Entity includes a health plan; a health care provider who transmits any health information in electronic form in connection with a covered transaction; or a health care clearinghouse that handles electronic claims from a provider.

Covered Expenses – Those expenses charged by a covered provider, medically necessary (see definition of medically necessary below) for the treatment of illness or injury, and not otherwise excluded by the Plan.

Custodial Care – 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 that 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 – 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, 2022. The provisions of the Plan as in effect on the date of service shall remain applicable with respect to Plan Participants on the date of service, and with respect to the Plan coverage available at the time the expenses were incurred.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Services – Health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including pre-hospital care and ancillary services routinely available to the emergency department of a hospital.

Employee – A person directly employed in the regular business of and compensated for services by Clark County on a regularly scheduled, full-time basis, and regularly scheduled to work for the employer in an employee/employer relationship.

Employer – Includes 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; the Regional Transportation Commission of Southern Nevada County, Mt. Charleston Fire Protection District, the Las Vegas Metropolitan Police Department and the Chief of the Moapa Valley Fire Protection District.

End Stage Renal Disease – A condition that may qualify the Plan Participant for Medicare benefits. Should a Plan Participant become eligible for Medicare benefits because of ESRD, this plan will provide primary coverage or coordinate against Medicare benefits, in accordance with the rules publicized by Medicare regarding the liability of Medicare to provide benefits for care related to ESRD, including but not limited to dialysis or transplant, when group coverage is available.

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

Essential Health Benefits – means ambulatory patient services; emergency services; hospitalizations; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative services; laboratory services; preventive and wellness services and chronic disease management; and pediatric services including oral and vision care as provided by the pediatrician.

Experimental/Investigational – 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/non-experimental 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:

- 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
- 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
- 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
- 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, procedure or technology.
The facility will not be deemed a nursing home, a hotel, a school or a similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

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

Fiduciary – The person or organization that has the authority to control and manage the operation and administration of the Plan.

Generic Drug – A prescription drug that 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 – 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.

Group Health Committee – means the committee established by the Plan Administrator in accordance with the section titled Responsibilities for Plan Administrator.

Group Health Plan – Any individual or group plan, private or governmental, that provides or pays for medical care, to the extent specified in the HIPAA Privacy Regulations, 65 Fed. Reg. No. 250 (82463). Coverage is defined by the Health Benefit Plan Document.

Habilitative or Rehabilitative Care – Habilitative or Rehabilitative Care shall mean any 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.

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.

HIPAA – The Health Insurance Portability and Accountability Act of 1996.

Home Health Care Agency – An organization that meets all these tests:

- Is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services;
- Has policies established by a professional group associated with the agency or organization which includes at least one registered graduate nurse (R.N.) to govern the services provided;
- Provides for full-time supervision of such services by a Physician or by a registered graduate nurse; Maintains a complete medical record on each patient; and
- Has a full-time administrator.

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 – An agency 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 – 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 – 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 – A facility or separate hospital unit, which provides treatment under a hospice care plan and admits at least two unrelated persons who are expected to die within six months.

Hospital – 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 thefollowing:

- A facility operating legally as a psychiatric hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- 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.

Illness – Illness or disease, including pregnancy, mental or nervous disorder, alcoholism and substance abuse, requiring treatment by a physician.

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.

Initial Administrative Period – An Initial Administrative Period is a period of time between an Initial Measurement Period and an Initial Stability Period, during which Clark County will determine which employees classified as Variable Hour Employees are eligible for coverage, as well as notify and enroll those employees. The Initial Administrative Period also includes the time period between the date of hire and the beginning of the Initial Measurement Period.

Initial Measurement Period – An Initial Measurement Period is a period of time that begins the first of the month following your date of hire and is twelve months in length. During an Initial Measurement Period, Clark County will calculate an employee's Hours of Service. If that employee averages 30 or more hours of service per week or 130 hours of service per month during that 12-month period, the employee will be considered a Full-Time Employee for purposes of health benefits during an Initial Stability Period.

Initial Stability Period – An Initial Stability Period is a period of time during which an employee will

either be considered to be a Full-Time Employee or Non-Full-Time Employee for purposes of eligibility for health benefits.

Injury – Accidental physical injury caused by unexpected external means requiring treatment by a physician.

Intensive Care Unit (ICU) – A separate, clearly designated service area, which is maintained within a hospital solely for the care and treatment of patients who are critically ill and or injured. This also includes what is referred to as a **coronary care unit** (CCU) or an **acute care unit** (ACU). It has: facilities for special nursing care not available in regular rooms and wards of the hospital; special lifesaving 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 – 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 – A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Licensed Behavior Analyst – 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 Maximum Benefit – Refers to the maximum amount of certain benefits paid while covered under ~~this Plan~~on all County plans.

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

Measurement Period – A Measurement Period is a period of time during which Clark County will "look back" to see how many hours of service per week Variable Hour Employees were credited on average. Clark County will use that average to determine the initial eligibility or continued eligibility for health benefits for those employees.

Medical Care Facility – A hospital, a facility that treats one or more specific ailments or any type of skilled nursing facility.

Medical Emergency – Accidental injury or sudden onset of a medical condition for which failure to get immediate medical care could be life threatening, cause serious harm to bodily functions, or seriously damage a body organ or part with acute symptoms requiring immediate medical care, including, but not limited to, conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary (Medical Necessity) – Care and treatment recommended or approved by a Physician or Dentist, which is consistent with the patient's condition and/or accepted standards of medical and dental practice; is medically proven to be effective treatment of the condition and restores a bodily function; is not performed solely for the convenience of the patient or provider; is not conducted for investigative, educational, experimental or research purposes; and is the most appropriate level of service that can be safely provided to the patient. **The fact that a physician may prescribe, order, recommend, or approve a service does not, of itself, make it medically necessary or make the charge a covered expense, even though it is not specifically listed as an exclusion under this Plan.**

Medicare – The program established by Title 1 of Public Law 89.97 (79 Stat. 291) as amended, entitled Health Insurance for the Aged Act, 42 U.S.C. §§ 1395 et seq. and which includes: Part A - Hospital Insurance Benefits for the Aged and Disabled; Part B - Supplementary Medical Insurance Benefits for the aged and disabled.

Medicare Entitlement – Means receiving coverage from Medicare. Normally this is accomplished when an individual who is age 65 signs up for Social Security benefits, which automatically enrolls the individual in the Medicare Program. Medicare coverage also is possible for individuals with kidney (end-stage renal) disease, or

for individuals younger than age 65 who Social Security deems disabled, effective on the first day of the 25^{the} month after the date the individual's Social Security disability began. Social Security disability benefits do not begin until the sixth full month of disability.

Member – An employee who is currently employed by one of the Employers participating in this benefit plan and who is covered by the Plan, or a Retired Employee formerly employed by one of the Employers participating in this benefit plan, and who is currently covered by the Plan.

Mental Disorder – Any disease or condition 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 – 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 Company tables (or similar actuarial tables) for a person of the same height, age and mobility as the Plan Participant.

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

Orthotic Device – A device added to the body to stabilize or immobilize a body part, prevent deformity, protect against injury or assist with function.

Outpatient Care – 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 – 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 – Physician shall mean 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 – The Clark County Self-Funded Group Medical and Dental Benefits Plan, which is a benefits plan for certain employees of Clark County, Nevada and is described in this document.

Plan Administrator – The Plan Administrator is Clark County, Nevada, and any affiliates who have adopted the Plan.

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

Plan Year – The 12-month period beginning on January 1st.

PPO Provider – A selected group of hospitals and physicians (preferred providers) offering quality care. Utilization management techniques are applied to covered services. The Plan pays network providers on a fee-for-service basis, usually at discounted rates.

Preferred Brand Name Prescription Drug – 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.

Pregnancy – Childbirth and conditions associated with pregnancy, including complications.

Prescription Drug – Any of the following: a 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 drug must be medically necessary in the treatment of an illness or injury.

Preventive/Wellness Care – This includes services and supplies for screening procedures used to establish a baseline and regularly scheduled exams performed for the purpose of promoting good health and early detection of disease. See the services established by the U.S. Preventive Task Force for specific details at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b- recommendations.

Prophylactic Surgery or Treatment – 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.

Prosthetic Device – Replacement of a missing part by an artificial substitute, such as an artificial extremity.

Protected Health Information – Information that is created or received by Plan, or a Business Associate of the Plan, whether oral, written, or in electronic form, and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Individually Identifiable Health Information includes information of persons living or deceased.

Reasonable and Customary (R&C) – The reimbursement amount for a specific item or benefit under the Plan. The *reasonable and customary* amount is calculated by the Plan after having analyzed at least one of the following:

- For PPO physicians, hospitals, or other medical professionals providing the service or medical supplies, R&C amounts will be determined by Clark County based on the negotiated rate established in a contractual arrangement; or
- For non-PPO (out-of-network) physicians, hospitals, or other medical professionals providing the service or medical supplies, R&C amounts will be determined by Clark County – based upon the existing Medicare and ASP allowed amounts. Any charges not available to be paid based upon Medicare and ASP fee schedules will be paid at a percentage of the billed amount determined by Clark County.

Recovery – Monies paid to the Plan Participant by way of judgment, settlement or otherwise to compensate for all losses related to the injuries or illness whether or not said losses reflect medical, dental or other charges covered by the Plan.

Recovery from another plan under which the Plan Participant is covered. This right of recovery also applies when a Plan Participant recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan or any liability plan.

Rehabilitation Inpatient – Inpatient Rehabilitative Admission for physical therapy, speech therapy and occupational therapy when Medically Necessary to restore and improve function that was previously normal but lost following an accidental injury or illness.

Reimbursement – Repayment to the Plan for medical or dental benefits that the Plan has advanced toward care and treatment of the injury or illness.

Retired Employee – A former Employee of an Employer participating in this benefit plan, who has retired from active employment with the Employer, and who is receiving retirement benefits through the Nevada

Public Employees Retirement Act (NRS Chapter 286) or the Las Vegas Valley Water District Retirement Plan, and who elects to continue Plan coverage upon retirement consistent with Plan and Nevada Revised Statute requirements, or elects to reinstate Plan coverage as allowed by the Nevada Revised Statutes on the date of reinstatement.

Routine Care – The medical treatment or services neither directly related nor medically necessary for the diagnosis or treatment of a specific injury, illness or pregnancy-related condition, which is known or reasonably suspected.

Skilled Nursing Facility – A facility that fully meets all of these tests:

- It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. 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.
- Its services are provided for compensation and under the full-time supervision of a Physician.
- It provides 24 hour per day nursing services by licensed nurses, under the direction of a full- time registered nurse.
- It maintains a complete medical record on each patient.
- It has an effective utilization review plan.
- 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.
- 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 – 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.

Stability Period – A Stability Period is a period of time during which an employee will either be considered to be a Full-Time Employee or Non-Full-Time Employee for purposes of eligibility for health benefits. If an employee is determined to be Full-Time Employee during the immediately prior Measurement Period, that employee will be considered a Full-Time Employee eligible for health benefits for the immediately subsequent Stability Period. However, if the employee is determined not to be a Full-Time Employee during the immediately prior Measurement Period, then that employee will be considered a Non-Full-Time Employee who is not eligible for health benefits for the immediately subsequent Stability Period, unless you have a Change in Employment Status that causes you to become eligible for health benefits.

Standard Administrative Period – The Standard Administrative Period is a period of time between a Standard Measurement Period and a Standard Stability Period, during which the employer will determine which employees classified as Variable Hour Employees or Seasonal Employees are eligible for coverage, as well as notify and enroll those employees. The Standard Administrative Period will occur annually from October 15 through December 31 of each year.

Standard Measurement Period – The Standard Measurement Period is a period of time that begins on October 15 each year and is twelve months in length. During a Standard Measurement Period, the employer will calculate an employee's Hours of Service. If that employee averages 30 or more hours of service per week or 130 hours of service per month during that 12-month period, the employee will be considered as a Full-Time Employee for purposes of health benefits during the Standard Stability Period. Hours will be credited for breaks longer than 4 weeks providing the break is no longer than 26 weeks. A maximum of 501 hours can be credited during a calendar year.

Standard Stability Period – The Standard Stability Period is a period of time during which an employee will either be considered to be a Full-Time Employee or Non-Full-Time Employee for purposes of eligibility for health benefits. The Standard Stability Period begins on January 1 and ends on December 31 each year.

Subrogation – The Plan's right to pursue the Plan Participant's claims for medical or dental charges.

Substance Abuse – The condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs which 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 – 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 jawbone 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.

Total Disability – A person's complete inability to perform any and every duty of his or her regular or customary occupation or similar occupation for which the Plan Participant is reasonably capable due to education and training, as a result of illness or injury, or a dependent's inability to perform the normal activities of a person of like age and sex who is in good health. A Plan Participant may not be engaged in any employment or occupation for wage or profit and be considered Totally Disabled.
A Physician (M.D. or D.O.) must certify a Plan Participant as Totally Disabled. Also, the individual must be under the care of a Physician (M.D. or D.O) in order to be Totally Disabled for benefit purposes.

Totally Disabled Child – A child who is incapable of self-sustaining employment by reason of mental challenge or incapacitation or physical disability and is primarily dependent upon the covered member for support and maintenance.

Treatment Center – A facility licensed as a psychiatric, alcohol or substance abuse treatment facility by the state in which it is located that provides a planned program of treatment for mental and nervous disorders, or alcohol or substance abuse based on a written plan established and supervised by aphysician.

Urgent Care – Medical treatment which if the regular time periods observed for claims were adhered to: (a) Could seriously jeopardize the life or health of the Plan Participant or their ability to regain maximum function; or (b) Would in the opinion of a physician with knowledge of the Plan Participants' medical condition, subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Utilization Review Administrator – Utilization Review Administrator is a group designed to monitor your proposed inpatient admissions and some surgical/diagnostic procedures (refer to the Care Management Program provisions of this booklet and your Self-Funded Group Medical and Dental Benefits Plan identification card).

Variable Hour Employee – A Variable Hour Employee is an employee whose Hours of Service an employer cannot determine at the time of hire will average at least 30 hours per week or 130 hours per month.

Waiting Period – The period that must pass before an employee or dependent is eligible to enroll under the terms of a group health plan. If an employee or dependent enrolls on a special enrollment date, any period before such special enrollment is not a waiting period.

LEGISLATIVE COMPLIANCE – HIPAA OPT-OUT

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 the following requirement:

(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.

EFFECTIVE DATE: SEPTEMBER 23, 2019

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 Benefits 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 privacypractices.

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 yourmedical 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 contact 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/audit/services/Pages/HIPAAProgramManagementOffice.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.

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.

Others Involved in Your Healthcare: After we provide you an opportunity to object, and 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 because of incapacity or emergency circumstances, we may disclose such information as necessary that directly relates to that persons involvement in your care or payment for your care 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.

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 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 corner, 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 your medical information for marketing purposes or that constitute a sale of medical information can only be made with your written authorization. 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.

The Plan is prohibited from using or disclosing protected health information that is genetic information for underwriting purposes.

Members will be notified following a breach of unsecured protected health information.

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

UMR Inc. 115 W.
Wausau Ave.
Wausau, ,WI 54401
(800) 826-9781

Vision Plan

EyeMed Vision Care
111 Wacker Drive, Suite 700
Chicago, IL 60601
(888) 439-3633

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.

In addition, 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 affect 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 of the committee members present and voting. The committee will be responsible for Level 2 review of an adverse benefit determination as provided by the Plan Document. The committee may review and consider coverage determinations made by the Claims Administrator, but the committee may not authorize payment for services which are not covered by the Plan, or which are specifically excluded from Plan coverage.

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.

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.

FINAL AUTHORITY OF THE PLAN DOCUMENT

The terms and provisions contained in this Plan Document and Summary Plan Description shall be final and binding upon all Participants. Contradictory benefit information received from any other source will not affect the terms of the Plan as set forth herein. Participants are advised to conclusively rely upon the benefit information provided in this Plan Document and Summary Plan Description only.

APPENDIX A – SPECIAL PROVISIONS

SPECIAL PROVISIONS CONCERNING EMPLOYEES OF THE MOUNT CHARLESTON FIRE PROTECTION DISTRICT

The following provisions shall apply concerning benefits for the Employees of the Mount Charleston Fire Protection District and their covered dependents who were covered by the Public Employee's Benefit Plan (PEBP) and who enrolled in the Plan prior to June 1, 2015.

(1) Waiting Period. A Mount Charleston Fire Protection District employee described above and his or her dependents are not required to serve a waiting period.

(2) Effective Date June 1, 2015

SPECIAL PROVISIONS CONCERNING APPOINTED EMPLOYEES AND APPOINTED RETIREES OF THE LAS VEGAS METROPOLITAN POLICE DEPARTMENT (LVMPD)

The following provisions shall apply concerning benefits for Appointed Employees and Appointed Retirees of the Las Vegas Metropolitan Police Department (LVMPD) and their covered dependents, effective January 1, 2016, who were covered by the LVMPD Health and Welfare Trust, or the insurance offered through the Police Protective Associate – Civilian Employees, as of December 31, 2015, or who retired as an appointed employee where the LVMPD was their last Nevada public employer.

(1) Waiting Period. An Appointed LVMPD employee/retiree described above, and his or her dependents are not required to serve a waiting period.

(2) Enrollment. An Appointed LVMPD employee described above, and his or her covered dependents, must satisfy the Plan's requirements concerning eligibility and enrollment.

(3) Effective Date: January 1, 2016.

SPECIAL PROVISIONS CONCERNING THE CHIEF OF THE MOAPA VALLEY FIRE PROTECTION DISTRICT

The following provisions shall apply concerning benefits for the Chief of the Moapa Valley Fire Protection District and his or her covered dependent(s).

(1) Waiting Period. Chief of the Moapa Valley Fire Protection District described above and his or her dependent(s) are not required to serve a waiting period.

(2) Effective Date July 21, 2020

SPECIAL PROVISIONS CONCERNING THE RESOLUTION FOR THE VOLUNTARY SEPARATION PROGRAM (VSP) APPROVED BY CLARK COUNTY, UNIVERSITY MEDICAL CENTER, AND WATER RECLAMATION DISTRICT EMPLOYEES:

The VSP program provides for a total of 24 months coverage window, which consists of a core 18 months of COBRA plus an additional 6 months of continuation (or retiree coverage). The specific requirements for eligibility under this program can be found in the resolution approved by the Clark County Board of County Commissioners (and each respective employer mentioned above) and was limited to those who were approved between May 19, 2020 through August 7, 2020. While this was a voluntary program, the approval process was maintained by the employer and WILL NOT be considered outside the approved resolution.

This Plan Document will be amended from time to time to reflect any such statutory mandates and will be made available to all participants for future reference.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION
The Plan is a self-funded health plan, and the claims 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 Benefits Plan

PLAN EFFECTIVE DATE: January 1, 2022

PLAN YEAR ENDS: December 31st

GOVERNING LAW AND FORUM: The Plan is subject to, and governed by, the laws of the State of Nevada. Any and all claims, legal actions or proceedings relating to this Plan must be brought in the Eighth Judicial District Court of the State of Nevada. The aforementioned choice of forum is mandatory and not permissive in nature.

EMPLOYER INFORMATION
Clark County, Nevada
PO Box 551711
Las Vegas, Nevada 89155-1711
702.455.4544

ADDITIONAL PARTICIPATING EMPLOYERS	
Clark County Water Reclamation District 702.668.8066	University Medical Center of Southern Nevada 702.383.2230
Las Vegas Convention & Visitors Authority 702.892.7527	Las Vegas Valley Water District 702.258.3115
Regional Transportation Commission of Southern Nevada 702.676.1500	Clark County Regional Flood Control District 702.685.0000
Southern Nevada Health District 702.759.1101	Henderson District Public Libraries 702.207.4278
Mt. Charleston Fire Protection District 702.486.5123	Las Vegas Metropolitan Police Department Appointed Employees 702.828.2904
Chief of the Moapa Valley Fire Protection District 702.398-3568	

PLAN ADMINISTRATOR
Clark County, Nevada
PO Box 551711
Las Vegas, Nevada 89155-1711
702.455.4544

CLAIMS ADMINISTRATOR
UMR Inc. 115 W.
Wausau Ave.
Wausau, ,WI 54401
(800) 826-9781

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: _____
MARILYN KIRKPATRICK, Chair
Board of County Commissioners

BY: _____
LYNN MARIE GOYA, County Clerk

CLARK COUNTY WATER RECLAMATION DISTRICT

ATTEST:

BY: _____
TICK SEGERBLOM, Chair
Board of Trustees

BY: _____
LYNN MARIE GOYA, County Clerk

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA

ATTEST:

BY: _____
WILLIAM MCCURDY II, Chair
Board of Trustees

BY: _____
LYNN MARIE GOYA, County Clerk

LAS VEGAS CONVENTION AND VISITORS AUTHORITY

BY: _____
JOHN MARZ, Chair
Board of Directors

ATTEST:

BY: _____
MARILYN SPIEGEL, Vice Chair

LAS VEGAS VALLEY WATER DISTRICT

ATTEST:

BY: _____
MARILYN KIRKPATRICK, President
Board of Directors

BY: _____
JOHN ENTSMINGER, Secretary

CLARK COUNTY REGIONAL FLOOD CONTROL DISTRICT

ATTEST:

BY: _____
DEBRA MARCH, Chair
Board of Directors

BY: _____
DEANNA HUGHES, Secretary

ATTEST:

BY: _____
ANA DIAZ, Executive Secretary

ATTEST:

BY: _____
FERMIN LEGUEN, M.D.
District Health Officer or Designee

ATTEST:

BY: _____
TRUDY CASEY, Notary

ATTEST:

BY: _____
LYNN MARIE GOYA, County Clerk

ATTEST:

BY: _____
TANAKA WILSON

ATTEST:

BY: _____
LYNN MARIE GOYA, County Clerk

APPROVED AS TO FORM:

STEVEN B. WOLFSON, District Attorney

BY: Lisa Logsdon for
MARY ANNE MILLER
Deputy District Attorney

REGIONAL TRANSPORTATION COMMISSION
OF SOUTHERN NEVADA

BY: _____
DEBRA MARCH, Chair
Board of Commissioners

SOUTHERN NEVADA HEALTH DISTRICT

BY: _____
SCOTT BLACK, Chair
Board of Health

HENDERSON DISTRICT PUBLIC LIBRARIES

BY: _____
DAVID ORTLIPP, Chair
Board of Trustees

MOUNT CHARLESTON FIRE PROTECTION DISTRICT

BY: _____
ROSS MILLER, Chair
Board of Fire Commissioners

LAS VEGAS METROPOLITAN POLICE DEPARTMENT

BY: _____
SHERIFF JOSEPH LOMBARDO

MOAPA VALLEY FIRE PROTECTION DISTRICT

BY: _____
MARILYN KIRKPATRICK, Chair
Board of Fire Commissioners

CLARK COUNTY
EXCLUSIVE PROVIDER ORGANIZATION (EPO) PLAN

Health and Dental Benefit Summary Plan Description
7670-00-414937
7670-05-414937
7670-02-414937

Benefit Plan(s) 003, 004
Benefit Plan(s) 002

BENEFITS ADMINISTERED BY

UMR℠

A UnitedHealthcare Company

Table of Contents

CLARK COUNTY EPO

GROUP HEALTH BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on benefits available under this Plan as well as with information on a Covered Person's rights and obligations under the CLARK COUNTY EPO, Group Health Benefit Plan (the "Plan"). You are a valued Employee of CLARK COUNTY EPO, and Your employer is pleased to sponsor this Plan that may assist in Your health care needs. Please read this document carefully and contact Your Health Benefits Department if you have questions or require further assistance.

CLARK COUNTY, NEVADA is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of an independent Third-Party Administrators to process claims and handle other duties for this self-funded Plan. The Third-Party Administrators for this Plan are UMR, Inc. (hereinafter "UMR") for medical claims, and Navitus Health Solutions for pharmacy claims. The Third-Party Administrators do not assume liability for benefits payable under this Plan, since they are solely claims-paying agents for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket amounts, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits.

Some of the terms used in this document begin with capital letters, even though such terms normally would not be capitalized. These terms have special meaning under the Plan. Most capitalized terms are listed in the Glossary of Terms, but some are defined within the provisions in which they are used. Becoming familiar with the terms defined in the Glossary of Terms will help You to better understand the provisions of this Plan.

Each individual covered under this Plan will be receiving an identification card that he or she may present to providers whenever he or she receives services. On the back of this card are phone numbers to call in case of questions or problems.

This document contains information on the benefits and limitations of the Plan and will serve as both the Summary Plan Description (SPD) and Plan document. Therefore it will be referred to as both the SPD and the Plan document.

This document became effective on January 1, 2022.

PLAN INFORMATION

Plan Name	CLARK COUNTY EXCLUSIVE PROVIDER ORGANIZATION (EPO) GROUP HEALTH BENEFIT PLAN
Name And Address Of Employer	CLARK COUNTY, NEVADA 500 S GRAND CENTRAL PKWY LAS VEGAS NV 89155
Name, Address, And Phone Number Of Plan Administrator	CLARK COUNTY, NEVADA 500 S GRAND CENTRAL PKWY LAS VEGAS NV 89155 702-455-4544
Named Fiduciary	CLARK COUNTY, NEVADA
Claims Appeal Fiduciary For Medical Claims	UMR
Employer Identification Number Assigned By The IRS	88-6000028
Type Of Benefit Plan Provided	Self-Funded Health and Welfare Plan providing group health benefits.
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical claims.
Name And Address Of Agent For Service Of Legal Process	KIMBERLY BUCHANAN CLARK COUNTY, NEVADA 500 S GRAND CENTRAL PKWY / DEPUTY DISTRICT ATTORNEY LAS VEGAS NV 89155
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
Compliance	It is intended that this Plan comply with all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law will be deemed controlling, and any conflicting part of this Plan will be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator will perform its duties as the Plan Administrator and in its sole discretion, will determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator will have full and sole discretionary authority to interpret all Plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator will be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third-Party Administrators for this Plan. Any interpretation, determination, or other action of the Plan Administrator or the Third-Party Administrators will be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third-Party Administrators will be based only on such evidence presented to or considered by the Plan Administrator or the Third-Party Administrators at the time they made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third-Party Administrators make, in their sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 003, 004

All health benefits shown on this Schedule of Benefits are subject to the following: Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Benefits listed in this Schedule of Benefits are subject to all provisions of the Plan, including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the in-network or out-of-network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, it is a combined Maximum Benefit for services that the Covered Person receives from all in-network and out-of-network providers and facilities.

	UNIVERSITY MEDICAL CENTER/SHO	**IN-NETWORK AND OOA SHO/ UHC CP**	**OUT-OF-NETWORK**
Plan Participation Rate, Unless Otherwise Stated Below: • Paid By Plan	100%	100%	
Annual Total Out-Of-Pocket Maximum Excluding The Prescription Benefit Out-Of-Pocket Maximum: • Per Person • Per Family – Individual Embedded Out-Of-Pocket Maximum ***Note: Embedded Out-Of-Pocket Maximum Means That If You Have Family Coverage, Any Combination Of Covered Family Members May Help Meet The Family Out-Of-Pocket Maximum; However, No One Person Will Pay More Than His Or Her Embedded Individual Out-Of-Pocket Maximum Amount.***	 $3,750 $7,750 $3,750	 $3,750 $7,750 $3,750	
Ambulance Transportation: **Ground:** • Co-pay Per Trip (Waived If Patient Is Admitted As Inpatient) • Paid By Plan	No Benefit	 $50 100%	

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
Air: • Co-pay Per Trip (Waived If Patient Is Admitted As Inpatient) • Maximum Benefit Per Occurrence • Paid By Plan ***Note: SHO Non-Emergency Arranged Transfers Are Covered At 100%.***		$50 $12,500 100%	
Anti-Cancer Drug Therapy, Non-Cancer Related Drug Therapy Or Other Medically Necessary Therapeutic Drug Services: • Co-pay Per Day • Paid By Plan ***Note: Co-pay Is In Addition To The Physician's Office Visit Co-pay / Cost Share.***	$10 100%	$10 100%	No Benefit
Autism Services - Refer To The Covered Medical Benefits Section For Details: **Autism Services:** • Paid By Plan **ABA Therapy:** • Co-pay Per Visit • Maximum Benefit Per Calendar Year • Dollar Maximum Per Calendar Year • Paid By Plan ***Note: Covered For Children Under The Age Of 18 Or If Enrolled In High School, Until Such Member Reaches The Age Of 22. Benefit Applies When Billed With Primary Diagnosis Of Autism.***	100% $10 1,500 Hours $72,000 100%	100% $10 100%	No Benefit
Dialysis: • Co-pay Per Day • Paid By Plan ***Note: Co-pay Is In Addition To The Physician's Office Visit Co-pay / Cost Share.***	$10 (University Medical Center) 100%	$10 (Fresenius) 100%	No Benefit
Durable Medical Equipment: • Maximum Benefit Every 3 Years • Paid By Plan	No Benefit	1 Purchase Of A Type Of Durable Medical Equipment Including Repair And Replacement 100%	No Benefit

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
Breast Prostheses:			
• Maximum Benefit Per Calendar Year		1 Prosthesis Per Breast	
• Paid By Plan		100%	
Camisoles:			
• Maximum Benefit Per Calendar Year		2 Camisoles	
• Paid By Plan		100%	
Compression Stockings:			
• Maximum Benefit Per Calendar Year		6 Pairs	
• Paid By Plan		100%	
Note: One Pair Equals Two Units, One Limb Equals One Unit And Compression Panty Hose Equals One Unit.			
Insulin Pumps And Diabetic Equipment:			
• Co-pay Per Device		$20	
• Paid By Plan		100%	
Emergency Services / Treatment:			
Urgent Care:			
• Co-pay Per Visit	$20	$20	
• Paid By Plan	100% (UMC Quick Care Only)	100%	
Walk-In Retail Health Clinics:			No Benefit
• Co-pay Per Visit	$10	$20	
• Paid By Plan	100%	100%	
Emergency Room Only:			
• Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hour(s))	$500	$500	
• Paid By Plan	100%	100%	
Emergency Physicians Only:			
• Paid By Plan	100%	100%	
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility:			No Benefit
• Co-pay Per Admission (Waived If Admitted From An Acute Care Facility)	Not Applicable	$250	
• Maximum Days Per Calendar Year	100 Days		
• Paid By Plan	100%	100%	

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
Gender Transition: From Age 18 • Maximum Benefit Per Lifetime On All County Plans – 1 Change • Paid By Plan ***Note: Also, Member Must Have Been Confirmed With Gender Dysphoria And Actively Participating In A Recognized Gender Identity Treatment Program. There Will Be No Coverage For The Reversal Of Such Surgery, Travel Costs Or Cosmetic Surgery.***	100% After All Applicable Copayments		No Benefit
Hearing Services: **Exams, Tests:** • Paid By Plan **Hearing Aids:** • Maximum Benefit Every 3 Years • Paid By Plan **Implantable Hearing Devices:** • Paid By Plan	 100% No Benefit 100%	 100% $3,000 100% 100%	No Benefit
Home Health Care Benefits: • Paid By Plan ***Note: A Home Health Care Visit Will Be Considered A Periodic Visit By A Nurse, Qualified Therapist, Or Qualified Dietician, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.***	No Benefit	 100%	No Benefit
Hospice Care Benefits: **Inpatient Hospice Services Only:** • Co-pay Per Day • Maximum Co-pay Per Admission • Paid By Plan **Inpatient Hospice Physician Charges Only:** • Paid By Plan **Outpatient Hospice Services / Outpatient Hospice Physician Charges:** • Paid By Plan	 Not Applicable Not Applicable 100% 100% No Benefit	 $350 $1,750 100% 100% 100%	No Benefit

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
Bereavement Counseling:			
• Co-pay Per Visit	$10	$20	
• Maximum Benefit Per Calendar Year	5 Sessions		
• Paid By Plan	100%	100%	
Note: Limit Applies To Group Therapy Sessions. Group Therapy Is The Only Covered Benefit Under Bereavement Counseling.			
Inpatient Respite Care:			
• Maximum Benefit Including Outpatient Respite Care	5 Inpatient Days Or 5 Outpatient Visits Per 90 Days Of Home Hospice Care		
• Paid By Plan	100%	100%	
Outpatient Respite Care: Included In Inpatient Respite Care Maximum	No Benefit		
• Co-pay Per Visit		$10	
• Paid By Plan		100%	
Hospital Services:			No Benefit
Pre-Admission Testing:			
• Paid By Plan	100%	100%	
Inpatient Services Only; Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:			
• Co-pay Per Day	Not Applicable	$350	
• Maximum Co-pay Per Admission	Not Applicable	$1,750	
• Paid By Plan	100%	100%	
Inpatient Physician Charges Only:			
• Paid By Plan	100%	100%	
Inpatient Rehabilitation (Specifically Physical Therapy / Occupational Therapy / Speech Therapy):			
• Maximum Days Per Calendar Year	60 Days		
• Paid By Plan	100%	100%	
Outpatient Services / Outpatient Physician Charges:			
• Paid By Plan	100%	100%	
Outpatient Advanced Imaging Charges:			
• Co-pay Per Test Or Procedure	Not Applicable	$10	
• Paid By Plan	100%	100%	
Outpatient Lab And X-Ray Charges:			
• Co-pay Per Visit	Not Applicable	$5	
• Paid By Plan	100%	100%	

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
Outpatient Surgery Only:			
• Co-pay Per Test Or Procedure	Not Applicable	$250	
• Paid By Plan	100%	100%	
Outpatient Surgeon Charges Only:			
• Paid By Plan	100%	100%	
Note: Any Co-pay / Cost Share Is In Addition To Any Physician Office Visit Co-pay / Cost Share.			
Ambulatory Surgery - Facility Charges Only:	No Benefit		
• Co-pay Per Test Or Procedure		$75	
• Paid By Plan		100%	
Ambulatory Surgery - Physician Charges Only:	No Benefit		
• Co-pay Per Surgery		$40	
• Paid By Plan		100%	
Note: Any Co-pay / Cost Share Is In Addition To Any Physician Office Visit Co-pay / Cost Share.			
Physician Clinic Visits In An Outpatient Hospital Setting - Facility Claim:			
• Paid By Plan	100%	100%	
Physician Clinic Visits In An Outpatient Hospital Setting - Physician Claim:			
• Co-pay Per Visit - Primary Care Physician	$10	$20	
• Co-pay Per Visit - Specialist	Not Applicable	$40	
• Paid By Plan	100%	100%	
Physician Clinic Visits In An Outpatient Hospital Setting - Physician Claim For Allergy Testing, Serum And Injections (Must Be Performed By An Allergist), And Advanced Imaging (CT, MRI, PET):			
• Co-pay Per Visit	$10	$10	
• Paid By Plan	100%	100%	
Note: All Co-pays Are In Addition To The Physician Office Visit Co-pay / Cost Share. Allergy Testing, Serum And Injections Not Performed By An Allergist Are Not Covered.			
Infant Formula:			No Benefit
• Maximum Benefit Per Calendar Year	1 Thirty-Day Therapeutic Supply For Up To 4 Times		
• Paid By Plan	100%	100%	
Note: Any Additional Therapeutic Supplies Would Require Prior Authorization.			

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
Infertility Treatment:			No Benefit
Office Visit Evaluation:			
• Co-pay Per Visit	Not Applicable	$20	
• Paid By Plan	100%	100%	
Artificial Insemination Services:			
• Maximum Benefit Per Lifetime On All County Plans	6 Cycles		
• Paid By Plan	100%	100%	
All Other Infertility Services:			
• Paid By Plan	100%	100%	
Manipulations:	No Benefit		No Benefit
• Co-pay Per Visit		$20	
• Maximum Visits Per Calendar Year		20 Visits	
• Paid By Plan		100%	
Note: Prior Authorization Is Required For Additional Visits.			
Mental Health, Substance Use Disorder, And Chemical Dependency Benefits:			No Benefit
Inpatient Services Only:			
• Co-pay Per Day	Not Applicable	$350	
• Maximum Co-pay Per Admission	Not Applicable	$1,750	
• Paid By Plan	100%	100%	
Inpatient Physician Charges Only:			
• Paid By Plan	100%	100%	
Residential Services Only:	No Benefit		
• Co-pay Per Admission (Waived If Admitted From An Acute Care Facility)		$250	
• Maximum Days Per Calendar Year		100 Days	
• Paid By Plan		100%	
Residential Physician Charges Only:	No Benefit		
• Paid By Plan		100%	
Outpatient Or Partial Hospitalization Services And Physician Charges:			
• Paid By Plan	100%	100%	
Office Visit:	No Benefit		
• Co-pay Per Visit		$20	
• Paid By Plan		100%	

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
Morbid Obesity Treatment: • Paid By Plan **Bariatric Surgery:** • Maximum Benefit Per Lifetime On All County Plans • Paid By Plan ***Note: Complications Will Be Covered Under The Normal Medical Benefit.***	100% After All Applicable Copayments 1 Surgery 100% After All Applicable Copayments		No Benefit
Nursery And Newborn Expenses: • Paid By Plan ***Note: Co-pay Will Be Waived For Newborn Charges, Initial Stay (Days 0-5).***	100%	100%	No Benefit
Nutritional Supplement: • Paid By Plan **Enteral Feedings:** • Maximum Benefit Per Calendar Year • Paid By Plan ***Note: Any Additional Therapeutic Supplies Would Require Prior Authorization.***	100% 1 Thirty-Day Therapeutic Supply For Up To 4 Times 100%	100% 100%	No Benefit
Orthotic Appliances: • Co-pay Per Device • Maximum Benefit Every 3 Years • Paid By Plan **Custom Molded Foot Orthotics:** • Maximum Benefit Per Lifetime On All County Plans • Paid By Plan **Diabetic Shoes:** • Maximum Benefit Per Calendar Year • Paid By Plan **Diabetic Inserts:** • Maximum Benefit Per Calendar Year • Paid By Plan ***Note: No Prior Authorization Required If Primary Diagnosis Is Diabetes Otherwise Prior Authorization Is Required.***	Not Applicable 1 Purchase Of A Type Of Orthotic Device Including Repair And Replacement 100% $500 100% 1 Pair Of Shoes 100% 3 Pairs Of Inserts 100%	$200 100% 100% 100% 100%	No Benefit

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
Physician Office Visit. This Section Applies To Medical Services Billed From A Physician Office Setting: **This Section Does Not Apply To:** ➢ **Preventive / Routine Services** ➢ **Manipulation Services Billed By Any Qualifying Provider** ➢ **Dental Services Billed By Any Qualifying Provider** ➢ **Therapy Services Billed By Any Qualifying Provider** ➢ **Any Services Billed From An Outpatient Hospital Facility**			No Benefit
Primary Care Physician Visit: • Co-pay Per Visit • Paid By Plan	 $10 100%	 $20 100%	
Specialist Visit: • Co-pay Per Visit • Paid By Plan	No Benefit	 $40 100%	
The Co-pays Will Not Apply To: ➢ **Independent Lab** ➢ **Services Billed By Radiologist Or Pathologist Including Independent Radiology Facility (Freestanding Radiology Facility)**			
Physician Office Services: • Paid By Plan	 100%	 100%	No Benefit
Office Surgery: • Co-pay Per Visit - Primary Care Physician • Co-pay Per Visit - Specialist • Paid By Plan	 Not Applicable Not Applicable 100%	 $20 $40 100%	
Allergy Injections And Sublingual Drops: • Co-pay Per Visit • Paid By Plan ***Note: Allergy Injections Not Performed By An Allergist Are Not Covered.***	 Not Applicable 100%	 $10 100%	
Allergy Testing: • Co-pay Per Visit • Paid By Plan ***Note: Allergy Testing Not Performed By An Allergist Are Not Covered.***	 Not Applicable 100%	 $10 100%	

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
Allergy Serum:			
• Co-pay Per Visit	Not Applicable	$10	
• Paid By Plan	100%	100%	
Note: Allergy Serum Not Performed By An Allergist Are Not Covered.			
Diagnostic X-Ray And Laboratory Tests:			
• Co-pay Per Visit	Not Applicable	$5	
• Paid By Plan	100%	100%	
Office Advanced Imaging:			
• Co-pay Per Visit	Not Applicable	$10	
• Paid By Plan	100%	100%	
Note: All Co-pays Are In Addition To The Physician Office Visit Co-pay / Cost Share.			
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:			No Benefit
Preventive / Routine Physical Exams At Appropriate Ages:			
• Paid By Plan	100%	100%	
Immunizations:			
• Paid By Plan	100%	100%	
Note: Foreign Travel Immunizations Are Not Covered.			
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages:			
• Paid By Plan	100%	100%	
Preventive / Routine Mammograms And Breast Exams:			
From Age 35 To Age 40			
• Maximum Exams Including 3D Mammograms For Preventive Screenings	1 Exam		
From Age 40			
• Maximum Exams Per Calendar Year Including 3D Mammograms For Preventive Screenings	1 Exam		
• Paid By Plan	100%	100%	
3D Mammograms For Preventive Screenings:			
Included In Preventive / Routine Mammograms And Breast Exams Maximum			
• Paid By Plan	100%	100%	

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
3D Mammograms For Diagnosis / Treatment Of A Covered Medical Benefit:			
• Paid By Plan	100%	100%	
Preventive / Routine Pelvic Exams And Pap Tests:			
• Maximum Exams Per Calendar Year	1 Exam		
• Paid By Plan	100%	100%	
Preventive / Routine PSA Tests And Prostate Exams:			
• Maximum Exams Per Calendar Year	1 Exam		
• Paid By Plan	100%	100%	
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:			
• Paid By Plan	100%	100%	
Preventive / Routine Autism Screening: From Age 0 To 22			
• Paid By Plan	100%	100%	
Preventive / Routine Colonoscopies: From Age 50 To Age 76			
• Maximum Exams Every 10 Years	1 Exam		
• Paid By Plan	100%	100%	
Note: Initial Colonoscopy Paid Routine Regardless Of Diagnosis.			
Preventive / Routine Cologuard: From Age 50			
• Paid By Plan	100%	100%	
Preventive / Routine Sigmoidoscopies:			
• Maximum Exams Per Calendar Year	1 Exam		
• Paid By Plan	100%	100%	
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco / Nicotine Use, Obesity, Diet, And Nutrition:			
• Paid By Plan	100%	100%	
Preventive / Routine Bone Density: From Age 60			
• Paid By Plan	100%	100%	

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➢ **Screening For Gestational Diabetes** ➢ **Papillomavirus DNA Testing*** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-Deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies, And Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*** • Paid By Plan ***These Services May Also Apply To Men.**	100%	100%	
Prosthetic Devices: • Co-pay Per Device • Maximum Benefit Every 3 Years • Paid By Plan	Not Applicable 1 Purchase Of A Type Of Prosthetic Device Including Repair And Replacement 100%	$200 100%	No Benefit
Teladoc Services: **General Medicine:** • Co-pay Per Occurrence • Paid By Plan ***Note: Multiple Co-pays Apply When Multiple Claims Are Billed On The Same Date Of Service.***		$10 100%	
Telehealth: • Co-pay Per Visit - Primary Care Physician • Co-pay Per Visit - Specialist • Paid By Plan **Mental Health / Substance Use Disorder Office Visit:** • Co-pay Per Visit • Paid By Plan	$10 Not Applicable 100% $10 100%	$20 $40 100% $10 100%	No Benefit
Temporomandibular Joint Disorder Benefits: **Office Visit:** • Co-pay Per Visit • Paid By Plan **All Other Temporomandibular Joint Disorder Services:** • Paid By Plan	Not Applicable 100% 100%	$20 100% 100%	No Benefit

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
Therapeutic Radiology (Treatment Of Cancer And Other Diseases With Radiation):			No Benefit
• Co-pay Per Day	$10	$10	
• Paid By Plan	100%	100%	
Note: Co-pay Is In Addition To The Physician's Office Visit Co-pay / Cost Share.			
Therapy Services:			No Benefit
Occupational Outpatient Hospital And Office Therapy:			
• Co-pay Per Visit	$5	$5	
• Maximum Visits Per Calendar Year	30 Visits		
• Paid By Plan	100%	100%	
Physical Outpatient Hospital And Office Therapy:			
• Co-pay Per Visit	$5	$5	
• Maximum Visits Per Calendar Year	30 Visits		
• Paid By Plan	100%	100%	
Speech Outpatient Hospital And Office Therapy:			
• Co-pay Per Visit	$5	$5	
• Maximum Visits Per Calendar Year	30 Visits		
• Paid By Plan	100%	100%	
Note: Prior Authorization Is Required At First Visit And For Any Additional Visits After Limit Is Reached.			
Vision Care Benefits:			No Benefit
• Maximum Benefit Per Surgery	1 Pair		
Lenses - All:			
Included In Maximum			
• Co-pay Per Set	$10	$10	
• Paid By Plan	100%	100%	
Frames:			
Included In Maximum			
• Co-pay Per Pair	$10	$10	
• Paid By Plan	100%	100%	
Necessary Contacts:			
Included In Maximum			
• Co-pay Per Set	$10	$10	
• Paid By Plan	100%	100%	
All Other Covered Expenses:			No Benefit
• Paid By Plan	100%	100%	

TRANSPLANT SCHEDULE OF BENEFITS

The program for Transplant Services At Designated Transplant Facilities is:

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Benefit Plan(s) 003, 004

Transplant Services: Designated Transplant Facility **Transplant Services:** • Paid By Plan **Travel And Housing:** • Maximum Benefit Per Transplant • Paid By Plan **Lodging And Meals:** • Maximum Benefit Per Day • Paid By Plan Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	 100% $10,000 100% $200 100%		
	UNIVERSITY MEDICAL CENTER / SHO	**IN-NETWORK AND OOA SHO / UHC CP**	**OUT-OF-NETWORK**
Transplant Services: Non-Designated Transplant Facility **Transplant Services:** • Paid By Plan **Travel And Housing:** • Maximum Benefit Per Transplant • Paid By Plan **Lodging And Meals:** • Maximum Benefit Per Day • Paid By Plan Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	 100% $10,000 100% $200 100%	No Benefit	No Benefit

OUT-OF-POCKET EXPENSES AND MAXIMUMS

CO-PAYS

A Co-pay is the amount that the Covered Person pays each time certain services are received. The Co-pay is typically a flat dollar amount and is paid at the time of service or when billed by the provider. Co-pays do not apply toward satisfaction of Deductibles. Co-pays apply toward satisfaction of in-network out-of-pocket maximums. The Co-pay and out-of-pocket maximum are shown on the Schedule of Benefits.

PLAN PARTICIPATION

Plan Participation is the Co-pay of Covered Expenses that the Covered Person is responsible for paying. The Covered Person pays this amount until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits.
Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is the most the Covered Person pays each year for Covered Expenses. Annual out-of-pocket maximums are shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). If the Covered Person's out-of-pocket expenses in a Plan Year exceed the annual out-of-pocket maximum, the Plan pays 100% of the Covered Expenses through the end of the Plan Year.

The following will not be used to meet the out-of-pocket maximums:

- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Pharmacy Co-pays and Plan Participation amounts for Prescription benefits.
- Expenses Incurred as a result of failure to comply with prior authorization requirements.
- Any amounts over the Reasonable Reimbursement, Usual and Customary amount, Negotiated Rate, or established fee schedule that this Plan pays.

The eligible out-of-pocket expenses that the Covered Person incurs at an in-network provider will apply to the in-network total out-of-pocket maximum. The eligible out-of-pocket expenses that the Covered Person incurs at an out-of-network provider will apply to the out-of-network total out-of-pocket maximum.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles, Co-pays, or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses may not be waived by a provider under any "fee forgiveness," "not out-of-pocket," or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person's claim may be denied and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. From time to time, the Plan may request documentation from You or Your Dependents in order to make determinations for continuing eligibility. The coverage choices that will be offered to You will be the same choices offered to other, similarly situated Employees.

WAITING PERIOD (Applies to All Other Employees)

If eligible, You must complete a Waiting Period before coverage becomes effective for You and Your Dependents. A Waiting Period is a period of time that must pass before an Employee or Dependent becomes eligible for coverage under the terms of this Plan.

You are eligible for coverage on the date listed below under the Effective Date section, upon completion of 60 calendar days of continuous employment in a covered position.

The start of Your Waiting Period is the first full day of employment for the job that made You eligible for coverage under this Plan.

ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full-time 30 or more hours per week, and participants meeting the below criteria are also benefit eligible:

- 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.
- 20-hour benefited positions at UMC (University Medical Center).

But for purposes of this Plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion:

- Leased Employees.
- Independent Contractors as defined in this Plan.
- Consultants who are paid on other than a regular wage or salary basis by the employer.
- Members of the employer's Board of Directors, owners, partners, unless engaged in the conduct of the business on a full-time, regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, which may be combined with the employer's short-term disability policy, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. Employees who meet eligibility requirements during a measurement period as required by the Affordable Care Act (ACA) regulations will have been deemed to have met the eligibility requirements for the resulting stability period as required by the ACA regulations. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a Third-Party, whether by a court, governmental agency, or otherwise, without regard to whether or not the employer agrees to such reclassification, will change a person's eligibility for benefits.

An eligible Employee who is covered under this Plan and who retires under the employer's formal retirement plan will be eligible to continue participating in the Plan upon retirement, provided the individual continues to make the required contribution. See the Coordination of Benefits section for more information on how this Plan coordinates with Medicare coverage. Retirees may continue coverage under this Plan until death, non-payment of premium, or if they no longer meet the eligibility requirements, whichever occurs first. A surviving Spouse of a Retired Employee is eligible to remain on the plan until death or non-payment of premium provided such spouse was covered under the Plan at the time of the Retired Employee's death.

Employees who retire from participating Employers under the Plan, and the Retired Employee's dependents, are eligible to continue Plan coverage at the time of Retiree's retirement, on a contributory basis. To retain coverage upon retirement the Retiring Employee, or the Employee's spouse if the Employee is physically incapacitated, must enroll for continued Plan coverage within 31 days of retirement. Failure to enroll within 31 days of retirement will cause coverage to terminate.

Employees who retire from participating Employers under the Plan, and who did not elect to continue Plan coverage at the time of retirement, or the surviving spouse of such a Retired Employee who is deceased, may re-enroll in Plan coverage in January of any even numbered year as provided by Nevada Revised Statute 287.0205. Only a surviving spouse, who was a Plan Participant under the Plan at some point during the Retired Employee's lifetime, is eligible for enrollment under this provision.

Retiree Reinstatement

Retirees of a Plan Participant Employer are eligible to re-instate coverage with this Plan in January of an even numbered year, as provided by NRS 287.0205, so long as:

- The retiree was covered by the Plan on the last day of his or her active employment with the Participant Employer;
- The Participant Employer was the retiree's last public employer;
- The retiree has retired into a defined benefit retirement plan, sponsored by the Participant Employer, including but not limited to PERS; and
- The retiree complies with the requirements of NRS 287.0205 to seek reinstatement.

This provision shall be interpreted and applied in harmony with NRS 287.0205 and where NRS 287.0205 is in conflict with this provision, NRS 287.0205 will control, being interpreted to extend to the retirees of the Non-PERS participating Employers who are Participant Employers under this Plan.

Retiree / Dependent Reinstatement Enrollment:

The following enrollment process must be completed, and documentation received by Clark County Risk Management no later than January 31st, of an even numbered year.

- 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 birth certificate for each child being reinstated will be required.
- 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. Non-PERS participating Employers shall collect retiree premiums on behalf of the Plan and deliver the premium payments to the Plan on behalf of the Non-PERS retirees.

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

Note: Eligible Employees and Dependents who decline to enroll in this Plan must state so in writing. In order to preserve potential special enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or health insurance policy. Proof of such plan or policy may be required upon application for special enrollment. See the Special Enrollment Provision section of this Plan.

An **eligible Dependent** includes:

- Your legal spouse, provided he or she is not covered as an Employee under this Plan. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator. An Employee's spouse who is not a United States Citizen is not eligible for coverage, unless the individual is a lawful resident actively seeking permanent residency in the United States.

- Your Domestic Partner, as long as he or she meets the definition of Domestic Partner as stated in the Glossary of Terms, and the person is not covered as an Employee under this Plan. When a person no longer meets the definition of Domestic Partner, that person no longer qualifies as Your Dependent. Anyone enrolled as a domestic partner on 12/31/2021 is considered grandfathered into the future (until noticed otherwise). NEW domestic partnerships post on 1/1/2022 will not be eligible for coverage.

- A Dependent Child until the Child reaches his or her 26th birthday. The term "**Child**" includes the following Dependents:

  - A natural biological Child;
  - A stepchild;
  - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state, or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
  - A Child under Your (or Your spouse's) Legal Guardianship as ordered by a court. Birth to age 18 only. Coverage is only available to guardianship children for whom the Subscriber covered as a Dependent on December 31, 2010;
  - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO);
  - A natural child of the covered grandfathered Domestic Partner.

- A Dependent does not include the following:

  - A foster Child;
  - A Child of a Domestic Partner or a Child under Your Domestic Partner's Legal Guardianship;
  - A grandchild;
  - A Domestic Partner;
  - A Dependent Child if the Child is covered as a Dependent of another Employee at this company;
  - Any other relative or individual unless explicitly covered by this Plan.

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage. The Plan Administrator, at the administrator's discretion, may require documentation such as certified marriage certificates, grandfathered domestic partner registrations, divorce decrees, social security identification, tax returns, certified birth certificates, adoption decrees, or copies of certified court orders.

Eligibility Criteria: To be an eligible Totally Disabled Dependent Child, a Totally Disabled Dependent Child age 26 or over must be dependent upon the Employee for more than 50 percent of his or her support and maintenance. This financial requirement does not apply to Children who are enrolled in accordance with a Qualified Medical Child Support Order because of the Employee's divorce or separation decree.

NON-DUPLICATION OF COVERAGE: Any person who is covered as an eligible Employee will not also be considered an eligible Dependent under this Plan.

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have an obligation to notify the Plan should the Dependent's eligibility status change during the Plan Year. Please notify Your Health Benefits Department regarding status changes.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
- The Dependent Child is a Dependent of an Employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a special enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 31 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of a Totally Disabled Dependent, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Continuation of Coverage section in this document.

Employees have the right to choose which eligible Dependents are covered under the Plan.

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of the following dates:

- If You apply within Your Waiting Period, Your coverage will become effective the first day of the month following the date You complete Your Waiting Period. If Your Waiting Period ends on the first day of the month, Your coverage will not begin until the first day of the following month; or **(Applies to All Other Employees)**

- If You are an Elected Official, You and Your eligible Dependents will be covered under this Plan effective on the date You take the oath of office, so long as You comply with the Plan's Enrollment Requirements within 31 days of the date the oath of office is taken; or **(Applies to Elected Officials)**

- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 60 calendar days of the event for marriage, birth or adoption and within 31 calendar days in the case of a loss of coverage.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of the following dates:

- The date Your coverage under the Plan begins if You enroll the Dependent at that time; or

- The date You acquire Your Dependent if application is made within 60 calendar days of acquiring the Dependent for marriage, birth or adoption and within 31 calendar days in the case of a loss of coverage; or

- The date set forth under the Special Enrollment Provision if Your Dependent is eligible to enroll under the Special Enrollment Provision and application is made within 60 calendar days following the event for marriage, birth or adoption and within 31 calendar days in the case of a loss of coverage; or

- The date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

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 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.

ANNUAL OPEN ENROLLMENT PERIOD

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Covered Employees and covered Retirees will be able to make changes in coverage for themselves and their eligible Dependents.

(Applies to All Other Employees) Coverage Waiting Periods are waived during the annual open enrollment period for covered Employees, covered Retirees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If You and/or Your Dependent becomes covered under this Plan as a result of electing coverage during the annual open enrollment period, the following will apply:

- The employer will notify eligible Employees prior to the start of an annual open enrollment period; and

- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person’s coverage; and

- The Effective Date of coverage will be January 1 following the annual open enrollment period.

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

This Plan gives an eligible person special enrollment rights if the person experiences a loss of other health coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other, similarly situated Employees.

LOSS OF HEALTH COVERAGE

You and Your Dependents may have a special opportunity to enroll for coverage under this Plan if You experience a loss of other coverage.

In order for You to be eligible for special enrollment rights, You must meet the following conditions:

- You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan was offered; and

- You and/or Your Dependents stated in writing that You declined coverage due to coverage under another group health plan or health insurance policy; and

- The coverage under the other group health plan or health insurance policy was:

  - COBRA continuation coverage and that coverage was exhausted; or
  - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
  - Terminated and no substitute coverage was offered; or
  - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 60 calendar days following the event for marriage, birth or adoption and within 31 calendar days in the case of a loss of coverage after the date the other coverage ended.

You and/or Your Dependents were covered under a Medicaid plan or state child health plan and coverage for You or Your Dependents was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

You or Your Dependents may not enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause, such as making a fraudulent claim or an intentional misrepresentation of material fact, or

- You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

NEWLY ELIGIBLE FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

A current Employee and his or her Dependents may be eligible for a special enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependents are determined to be eligible for such assistance.

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries, and other eligible persons have special opportunities to enroll for coverage under this Plan if they experience changes in family status.

If a person becomes an eligible Dependent through marriage, attestation of a grandfathered Domestic Partnership, birth, adoption or Placement for Adoption, the Employee, spouse, and newly acquired Dependent(s) who are not already enrolled may enroll for health coverage under this Plan during a special enrollment period. The Employee must request and apply for coverage within 60 calendar days of the marriage, attestation of a grandfathered Domestic Partnership, birth, adoption, or Placement for Adoption, and within 31 calendar days in the case of a loss of coverage.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective as follows:

- In the case of marriage, on the first day of the month following the date the completed request for enrollment and supporting documentation is received by the Plan (note that eligible individuals must submit their enrollment forms prior to the Effective Dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or

- In the case of a Dependent's birth, on the date of such birth. 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 affirmatively enrolled as a Dependent in the plan; or

- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or

- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the first day of the month following the date the completed request for enrollment and supporting documentation is received by the Plan; or

- In the case of loss of coverage, the first day of the month following the date the completed request for enrollment and supporting documentation is received by the Plan.

RELATION TO SECTION 125 CAFETERIA PLAN

This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information.

TERMINATION

For information about continuing coverage, refer to the COBRA Continuation of Coverage section of this SPD.

EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made if You fail to make any required contribution toward the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment or at annual open enrollment periods; or
- The end of the stability period in which You became a member of a non-covered class, as determined by the employer except as follows:
    - If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave for up to the end of the six (6) calendar month period that next follows the month in which the person last worked as an Active Employee, provided the applicable Employee contribution is paid when due. 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.
    - If You are temporarily absent from work due to disability leave, the date the Employer ends the continuance.
    - If You are temporarily absent from work as a furloughed Employee, the Plan Administrator may extend Plan coverage to Employees who have been furloughed by a participating entity as a result of a decline in the economy or workload. The responsible entity shall continue to remit the full cost of the premium to the Plan for the period of time the member is furloughed. A member is eligible for continued coverage for a period not to exceed 24-months as a result of his/her furlough status. A member is considered in furlough status when he/she is in an continuous unpaid status for a specified period.
    - If You are temporarily absent from work due to active military duty, refer to USERRA under the Uniformed Services Employment and Reemployment Rights Act of 1994 section; or
- The last day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other fraudulent act related to this Plan or any other group plan.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The day of the month in which Your coverage ends; or

- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state in which You reside; or

- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility and Enrollment section; or

- If Your Dependent Child qualifies for extended Dependent coverage because he or she is Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or

- The last day of the month in which Your Dependent Child no longer satisfies a required eligibility criterion listed in the Eligibility and Enrollment section; or

- The date Dependent coverage is no longer offered under this Plan; or

- The last day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment, or at annual open enrollment periods; or

- The last day of the month in which the Dependent becomes covered as an Employee under this Plan; or

- The date You or Your Dependent submits a false claim or is involved in any other fraudulent act related to this Plan or any other group plan.

RESCISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is **not** a rescission if:

- it has only a prospective effect; or
- it is attributable to non-payment of premiums or contributions; or
- it is initiated by You or Your personal representative.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, Your coverage will be reinstated. If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 13-week period, You will be treated as a new hire and will be required to meet all the requirements of a new Employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions, or contact Your Health Benefits or Personnel office.

EXTENSION OF BENEFITS

In the event coverage terminates for any reason while benefits are being paid, and it is

established •that: You or your Dependent was totally disabled when such coverage terminated;
- You provide a statement from a physician verifying the disability, and your disability was certified by and our utilization review company; and
- Expenses are incurred in connection with the accident or illness causing such total disability; and
- The total Maximum Annual Benefit Amount of benefits has not been paid.

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:

- Twelve months from the date on which coverage terminated;
- The total Maximum Annual Benefit Amount has been paid;
- The Employee or Dependent ceases to be totally disabled; or
- Termination of the Plan, whichever occurs first.

COBRA CONTINUATION OF COVERAGE

Note: UMR (the claims administrator) does not administer the benefits or services described within this provision. Please contact the benefit manager or Your employer with any questions related to this coverage or service.

Important: Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You and Your Dependents need to do to protect the right to receive it. When You become eligible for COBRA, You may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You or Your Dependents as required.

You may have other options available to You when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, You may qualify for lower costs on Your monthly premiums and lower out-of-pocket costs. Additionally, You may qualify for a 30-day special enrollment period for another group health plan for which You are eligible (such as a spouse's plan), even if that plan generally does not accept Late Enrollees.

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits beyond the date that they might otherwise lose coverage. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event (outlined below). When a Qualifying Event causes (or will cause) a Loss of Coverage, the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage, even if You or Your Dependent is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

If You are an Employee, You will become a Qualified Beneficiary if You lose coverage under the Plan because either one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• Your employment ends for any reason other than Your gross misconduct	up to 18 months
• Your hours of employment are reduced	up to 18 months

(There are two ways in which this 18-month period of COBRA continuation coverage may be extended. See the section below entitled "The Right to Extend the Length of COBRA Continuation Coverage" for more information.)

The spouse of an Employee will become a Qualified Beneficiary if he or she loses coverage under the Plan because any one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• The Employee dies	up to 36 months
• The Employee's hours of employment are reduced	up to 18 months
• The Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
• The Employee and spouse become divorced or legally separated	up to 36 months

The Dependent Children of an Employee will become Qualified Beneficiaries if they lose coverage under the Plan because any one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• The parent-Employee dies	up to 36 months
• The parent-Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The parent-Employee's hours of employment are reduced	up to 18 months
• The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
• The parents become divorced or legally separated	up to 36 months
• The Child loses eligibility for coverage under the Plan as a Dependent	up to 36 months

Note: A spouse or a Dependent Child newly acquired through birth or adoption during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A Dependent other than a newborn or newly adopted Child who is acquired and enrolled after the original Qualifying Event is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

COBRA NOTICE PROCEDURES

THE NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

In order to be eligible to receive COBRA continuation coverage, covered Employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Employee and spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrator, whether to Your employer or to the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information (a form for notifying the COBRA Administrator is available upon request):

- The Qualified Beneficiary's name, current address, and complete phone number,
- The group number and the name of the Employee's employer,
- A description of the Qualifying Event (i.e., the life event experienced), and
- The date the Qualifying Event occurred or will occur.

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes to the addresses of family members. Keep copies of all notices You send to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your employer will give notice to the COBRA Administrator when coverage terminates due to the Employee's termination of employment or reduction in hours, the death of the Employee, or the Employee's becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days of when one of these events occurs.

EMPLOYEE OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of divorce or legal separation of the Employee and a spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar-day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would be a Loss of Coverage) due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, the covered Employee, or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that should be completed in order to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of his or her election in writing in order to continue group health coverage and must make the required payments when due in order to remain covered. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, group health coverage will be reinstated retroactively to the date coverage was lost, provided the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will become effective on the date the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and Employee contributions. This cost may also include a 2% additional fee to cover administrative expenses (or, in the case of the 11-month extension due to disability, a 50% additional fee). The cost of continuation coverage is subject to change at least once per year.

If Your employer offers annual open enrollment opportunities for active Employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage. However, the Qualified Beneficiary will receive specific payment information, including due dates, when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA Administrator receives a check that is missing information or contains discrepancies regarding the information on the check (e.g., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary with information regarding what needs to be done to correct the mistake.

Note: Payment will not be considered made if a check is returned for non-sufficient funds.

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, written notice to the COBRA Administrator is required within 30 calendar days of the date any one of the following events occurs:

- The Qualified Beneficiary marries. Refer to the Special Enrollment Provision section of this SPD for additional information regarding special enrollment rights.

- A Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment Provision section of this SPD for additional information regarding special enrollment rights.

- A final determination is made by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.

- Any Qualified Beneficiary becomes covered by another group health plan or enrolls in Medicare Part A or Part B.

Additionally, if the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information in the timeframe outlined in the request document.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- For Employees and Dependents: 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent Children will be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)

- For Dependents only: 36 months from the Qualifying Event if coverage is lost due to one of the following events:

  - The Employee's death.
  - The Employee's divorce or legal separation.
  - The former Employee's enrollment in Medicare.
  - A Dependent Child's loss of eligibility as a Dependent as defined by the Plan.

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided written notice is given to the COBRA Administrator as soon as possible, but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA, in the event that the Social Security Administration determines the Qualified Beneficiary to be disabled either before becoming eligible for, or within the first 60 days of being covered by, COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the Qualified Beneficiary has non-disabled family members who are also Qualified Beneficiaries, those non-disabled family members are also entitled to the disability extension.

The Qualified Beneficiary must give the COBRA Administrator a copy of the Social Security Administration letter of disability determination before the end of the initial 18-month period and within 60 days of the later of:

- The date of the Social Security Administration disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA.

If the Social Security Administration determines the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Events (Dependents Only): If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family who are Qualified Beneficiaries may receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent Children who are Qualified Beneficiaries if the Employee or former Employee dies, becomes entitled to Medicare (Part A, Part B, or both) or is divorced or legally separated, or if the Dependent Child loses eligibility under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event or in the case of a newborn Child being added as a result of a HIPAA special enrollment right. Dependents acquired during COBRA continuation (other than newborns and newly adopted Children) are not eligible to continue coverage as the result of a subsequent Qualifying Event. These events will lead to the extension only when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

You or Your Dependents must provide the notice of a second Qualifying Event to the COBRA Administrator within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

There may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or other group health plan coverage (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

In general, if You do not enroll in Medicare Part A or B when You are first eligible because You are still employed, after the Medicare initial enrollment period You have an eight-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of (a) the month after Your employment ends, or (b) the month after group health plan coverage based on current employment ends.

If You do not enroll in Medicare and elect COBRA continuation coverage instead, You may have to pay a Part B late enrollment penalty and You may have a gap in coverage if You decide You want Part B later. If You elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate Your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if You enroll in the other part of Medicare after the date of the election of COBRA coverage. If You are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (as the primary payer) and COBRA continuation coverage will pay second. For more information visit https://www.medicare.gov/medicare-and-you.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group health plan for any Employees. (Note that if the employer terminates the group health plan under which the Qualified Beneficiary is covered, but still maintains another group health plan for other, similarly situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same.)

- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled in Medicare.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan.

- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.

- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE

If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the Qualified Beneficiary will lose his or her special enrollment rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the Qualified Beneficiary since it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After COBRA continuation coverage is exhausted, the Qualified Beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange, in accordance with his or her HIPAA special enrollment rights.

DEFINITIONS

Qualified Beneficiary means a person covered by this group health Plan immediately before a Qualifying Event. A Qualified Beneficiary may be an Employee, the spouse of a covered Employee, or the Dependent Child of a covered Employee. This includes a Child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the Child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted Children. This also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered Employee.
- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).
- A reduction in work hours of the covered Employee.
- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)
- The covered former Employee becomes enrolled in Medicare.
- A Dependent Child no longer qualifies as a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before a Qualifying Event. Loss of Coverage includes a change in coverage terms, a change in plans, termination of coverage, partial Loss of Coverage, an increase in Employee cost, and other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after a Qualifying Event, but must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA rights.

CONTINUED COVERAGE FOR DOMESTIC PARTNERS

Domestic Partners do not qualify as Qualified Beneficiaries under federal COBRA law. Therefore, under federal law, a Domestic Partner does not have the right to elect COBRA independently and separately from an eligible Employee.

However, this Plan allows grandfathered Domestic Partners to elect to continue coverage under a "COBRA-like" extension, separately and independently of eligible Employees, subject to the same terms and conditions that are outlined for Qualified Beneficiaries under COBRA when a Qualifying Event occurs.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

The Plan Administrator:
CLARK COUNTY, NEVADA
500 S GRAND CENTRAL PKWY
LAS VEGAS NV 89155

The COBRA Administrator

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in a loss of coverage. Employees on leave for military service must be treated as if they are on leaves of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leaves of absence or furloughs. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave. Reinstatement following a military leave of absence may not be subject to Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is the lesser of:

- 24 months beginning on the day that the uniformed service leave begins, or
- A period beginning on the day that the service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if giving notice is otherwise impossible or unreasonable under the circumstances.

Upon notice of intent to leave for uniformed service, Employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election of, payment for, and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Continuation of Coverage section, to the extent the COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. For periods of 31 days or longer, if an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENTLY

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will be deemed eligible for the COBRA extension only because they are not eligible for a separate, independent right of election under USERRA.

PROVIDER NETWORK

The word **"Network"** means an organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the Negotiated Rates as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Plan Participation amounts, or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing to which Network a provider belongs will help a Covered Person determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons should receive services from In-Network providers. However, this Plan does not limit a Covered Person's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

A provider may enter into an agreement to provide only certain covered health services, but not all covered health services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the covered health services and products included in the participation agreement, and a non-Network provider for other covered health services and products. The participation status of providers may change from time to time.

To find out to which Network a provider belongs, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits:

  Clark County Nevada

- For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits.

EXCEPTIONS TO THE PROVIDER NETWORK BENEFITS

Some benefits may be processed at In-Network benefit levels when provided by Out-of-Network providers. When Out-of-Network charges are covered in accordance with Network benefits, the charges may be subject to Plan limitations. The following exceptions may apply:

- Ambulance Transportation services will be payable at the In-Network level of benefits when provided by an Out-of-Network provider.
- Covered services (including Preventive Services) provided by a radiologist, anesthesiologist, certified registered nurse anesthetist, or pathologist will be payable at the In-Network level of benefits when services are provided at a Network facility even if the provider is an Out-of-Network provider.
- Covered services provided by a Physician (including surgeons and assistant surgeons only if Medically Necessary) during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital. The covered charge will not exceed 20% of the surgeon's allowance.
- Urgent Care services will be payable at the In-Network level of benefits when provided by an Out-of-Network provider.

CONTINUITY OF CARE

You or Your Dependents have the option of requesting extended care from Your current health care provider or facility if the provider or facility is no longer working with Your health Plan and is no longer considered In-Network.

The In-Network benefit level may continue for up to 90 days or until You no longer meet the criteria below, whichever is earlier, despite the fact that these expenses are no longer considered In-Network due to provider or facility termination from the Network. In order to be eligible, You or Your Dependents must have been, and must continue to be, under a treatment plan by a provider or facility who was a member of the participating Network. You must also be one of the following:

- An individual undergoing a course of treatment for a serious and complex condition that is either:
  - An acute Illness, meaning a condition serious enough to require specialized medical care to avoid the reasonable possibility of death or permanent harm.
  - A chronic Illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time.
- An individual undergoing Inpatient or institutional care.
- An individual scheduled for non-elective surgical care, including necessary postoperative care.
- An individual who is pregnant and being treated.
- An individual who is terminally ill and receiving treatment for such Illness by a provider or facility.

To obtain a Continuity of Care form that You and Your provider will need to complete for the request to be considered, call the number on the back of Your ID card or access the benefit portal.

Provider Directory Information

Each covered Employee, COBRA participant, and Child or guardian of a Child who is considered an alternate recipient under a Qualified Medical Child Support Order will automatically be given or electronically provided a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in his or her household. If a covered spouse or Dependent wants a separate provider list, he or she may make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

COVERED MEDICAL BENEFITS

This Plan provides coverage for the following covered benefits if services are authorized by a Physician or other Qualified Provider, if applicable, and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions, or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent International Classification of Diseases (ICD) or Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the UMR CARE section of this SPD for a description of these services and prior authorization procedures.

1. **3D Mammograms,** for the diagnosis and treatment of a covered medical benefit or for preventive screenings as described under the Preventive / Routine Care benefits.

2. **Abortions:** If a Physician states in writing that the mother's life would be in danger if the fetus were to be carried to term or if the pregnancy was the result of incest or rape.

3. **Acupuncture Treatment.**

4. **Allergy Treatment,** including injections and sublingual drops, testing and serum. Allergy testing, serum and injections not performed by an allergist are not covered.

5. **Ambulance Transportation:** Medically Necessary ground and air transportation by a vehicle designed, equipped, and used only to transport the sick and injured to the nearest medically appropriate Hospital. Medically Necessary Ambulance Transportation does not include, and this Plan will not cover, transportation that is primarily for repatriation (e.g., to return the patient to the United States) or transfer to another facility, unless appropriate medical care is not available at the facility currently treating the patient and transport is to the nearest facility able to provide appropriate medical care.

6. **Anesthetics and Their Administration.**

7. **Anti-cancer drug therapy, non-cancer related drug therapy or other Medically Necessary therapeutic drug services.**

8. **Augmentation Communication Devices** and related instruction or therapy.

9. **Autism Spectrum Disorders (ASD) Treatment.**

   ASD treatment may include any of the following services: diagnosis and assessment; psychological, psychiatric, and pharmaceutical (medication management) care; speech therapy, occupational therapy, and physical therapy; or Applied Behavioral Analysis (ABA) therapy.

   Treatment is subject to all other Plan provisions as applicable (such as Prescription benefit coverage, behavioral/mental health coverage, and/or coverage of therapy services).

Coverage does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Experimental, Investigational, or Unproven treatment, custodial care, nutritional or dietary supplements, or educational services that should be provided through a school district).

10. **Breast Pumps** and related supplies. Benefits for breast pumps include the lesser cost of purchasing or renting one breast pump per pregnancy in conjunction with childbirth. Member can purchase within 30 days of delivery date. Plan does not allow for breast pumps purchased through hospital.

11. **Breast Reductions** if Medically Necessary.

12. **Breastfeeding Support, Supplies, and Counseling** in conjunction with each birth. The Plan also covers comprehensive lactation support and counseling by a trained provider during pregnancy and in the postpartum period.

13. **Cardiac Pulmonary Rehabilitation** when Medically Necessary when needed as a result of an Illness or Injury.

14. **Cardiac Rehabilitation** programs are covered when Medically Necessary, if referred by a Physician, for patients who have certain cardiac conditions.

    Covered services include:

    - Phase I cardiac rehabilitation, while the Covered Person is an Inpatient.
    - Phase II cardiac rehabilitation, while the Covered Person is in a Physician-supervised Outpatient, monitored, low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure, and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.

15. **Cataract or Aphakia Surgery** as well as surgically implanted conventional intraocular cataract lenses following such a procedure. Multifocal intraocular lenses are not allowable. Eye refractions and one set of contact lenses or glasses (frames and lenses) after cataract surgery are also covered.

16. **Circumcision** and related expenses when care and treatment meet the definition of Medical Necessity. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.

17. **Cleft Palate and Cleft Lip,** benefits will be provided for initial and staged reconstruction of cleft palate or cleft lip. Such coverage includes Medically Necessary oral surgery and pre-graft palatal expander.

18. **Contraceptives and Counseling:** All Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling.

    The following contraceptives will be processed under the medical Plan:

    - Contraceptive injections (such as Depo-Provera) and their administration regardless of purpose.
    - Contraceptive devices such as IUDs and implants, including their insertion and removal regardless of purpose.

19. **Cornea Transplants** are payable at the percentage listed under "All Other Covered Expenses" on the Schedule of Benefits.

20. **Dental Services** include:

- The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), or for treatment of cleft palate, including implants. Treatment must be completed within 12 months of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period. Examples of Covered Services, in such (accidental) instances, include:
  - Root canal therapy, post and build up.
  - Temporary crowns.
  - Temporary partial bridges.
  - Temporary and permanent fillings.
  - Pulpotomy.
  - Extraction of broken teeth.
  - Incision and drainage.
  - Tooth stabilization through splinting.

  No benefits are provided for removable dental prosthetics, dentures (partial or complete) or subsequent restoration of teeth, including permanent crowns.
- Inpatient or Outpatient Hospital charges, including professional services for X-rays, laboratory services, and anesthesia while in the Hospital, if necessary due to the patient's age of 5 years or under, due to intellectual disabilities, or because an individual has medical conditions that may cause undue medical risk.
- Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.

21. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs, diabetic shoes and nutritional counseling.

22. **Dialysis:** Charges for dialysis treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. Coverage also includes use of equipment or supplies, unless covered through the Prescription Drug Benefits section. Charges are paid the same as for any other Illness.

23. **Durable Medical Equipment,** subject to all of the following:

- The equipment must meet the definition of Durable Medical Equipment in the Glossary of Terms. Examples include, but are not limited to, crutches, wheelchairs, Hospital-type beds, and oxygen equipment.
- The equipment must be prescribed by a Physician.
- The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied toward the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
- The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to the growth of the person or if changes to the person's medical condition require a different product, as determined by the Plan.
- If the equipment is purchased, benefits may be payable for subsequent repairs excluding batteries, or replacement only if required:
  - due to the growth or development of a Dependent Child;
  - because of a change in the Covered Person's physical condition; or
  - because of deterioration caused from normal wear and tear.

  The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered, and replacement is subject to prior approval by the Plan.

- Post-surgical bras, camisoles, breast prosthesis, compression stockings are covered.
- Insulin pumps and diabetic equipment are also covered.
- Over-the-counter and convenience supplies Items not covered, examples include shower chairs, toilet seats, or alcohol wipes.

24. **Emergency Room Hospital and Physician Services,** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits.

25. **Extended Care Facility Services** for both mental and physical health diagnoses. Charges will be paid under the applicable diagnostic code. The following services are covered:

    - Room and board.
    - Miscellaneous services, supplies, and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.

26. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

    - Treatment of any condition resulting from weak, strained, flat, unstable, or unbalanced feet when surgery is performed.
    - Treatment of corns, calluses, and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
    - Physician office visit for diagnosis of bunions. The Plan also covers treatment of bunions when an open cutting operation or arthroscopy is performed.

27. **Gender Transition:** Treatment, drugs, medicines, services, and supplies for, or leading to and including, gender transition surgery. Cross-sex hormone therapy is covered. Puberty suppressing medication is not cross-sex hormone therapy.

28. **Genetic Testing or Genetic Counseling in relation to Genetic Testing** based on Medical Necessity.

    Genetic testing MUST meet the following requirements:

    The test must not be considered Experimental, Investigational, or Unproven. The test must be performed by a CLIA-certified laboratory. The test result must directly impact or influence the disease treatment of the Covered Person.

    Genetic testing must also meet at least one of the following:

    - The patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes).
    - Conventional diagnostic procedures are inconclusive.
    - The patient has risk factors or a particular family history that indicates a genetic cause.
    - The patient meets defined criteria that place him or her at high genetic risk for the condition.

29. **Hearing Services** include:

    - Exams, tests, services, and supplies to diagnose and treat a medical condition.
    - Purchase or fitting of hearing aids. Bone anchored hearing aids, used according to U.S. Food and Drug Administration (FDA) approved indications, are covered under the applicable medical/surgical benefit for a member who is not a candidate for an air-conduction hearing aid.
    - Implantable hearing devices, including semi-implantable hearing devices.

30. **Home Health Care Services:** (Refer to the Home Health Care Benefits section of this SPD.)

31. **Hospice Care Services:** Treatment given at a Hospice Care facility must be in place of a stay in a Hospital or Extended Care Facility, and may include:

- **Assessment,** which includes an assessment of the medical and social needs of the Terminally Ill person and a description of the care required to meet those needs.
- **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time Home Health Care services.
- **Outpatient Care,** which provides or arranges for other services related to the Terminal Illness, including the services of a Physician or Qualified physical or occupational therapist or nutrition counseling services provided by or under the supervision of a Qualified dietician.
- **Respite Care** to provide temporary relief to the family or other caregivers in the case of an Emergency or to provide temporary relief from the daily demands of caring for a terminally ill person.
- **Bereavement Counseling:** services that are received by a Covered Person's Close Relative when directly connected to the Covered Person's death and the charges for which are bundled with other hospice charges. Counseling services must be provided by a Qualified social worker, Qualified pastoral counselor, Qualified psychologist, Qualified psychiatrist, or other Qualified Provider, if applicable. The services must be furnished within six months of death.

The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. However, services are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

32. **Hospital Services (Including Inpatient Services, Surgical Centers, and Inpatient Birthing Centers).** The following services are covered:

- Semi-private room and board. For network charges, this rate is based on network re-pricing. For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi-private rooms, the Plan will allow the private room rate, subject to the Reasonable Reimbursement, Usual and Customary charges, or Negotiated Rate, whichever is applicable.
- Intensive care unit room and board.
- Miscellaneous and Ancillary Services.
- Blood, blood plasma, and plasma expanders, when not available without charge.

Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

33. **Hospital Services (Outpatient).**

Observation in a Hospital room will be considered Outpatient treatment if the duration of the observation status is 72 hours or less. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

34. **Infant Formula** administered through a tube as the sole source of nutrition for the Covered Person.

35. **Infertility Treatment** to the extent required to treat or correct underlying causes of infertility, when such treatment is Medically Necessary and cures the condition of, alleviates the symptoms of, slows the harm to, or maintains the current health status of the Covered Person. Once the patient is receiving fertility treatment to achieve pregnancy, diagnostic tests and treatments are then considered part of the infertility benefit.

    Covered Infertility Treatment includes genetic testing to diagnose infertility. Covered services are limited to:

    - Laboratory studies.
    - Diagnostic procedures.
    - Artificial insemination services.

36. **Laboratory or Pathology Tests and Interpretation Charges** for covered benefits. Charges by a pathologist for interpretation of computer-generated automated laboratory test reports are not covered by the Plan.

37. **Manipulations:** Treatments for musculoskeletal conditions when Medically Necessary. Also refer to Maintenance Therapy under the General Exclusions section of this SPD.

38. **Maternity Benefits** for Covered Persons include:

    - Hospital or Birthing Center room and board.
    - Vaginal delivery or Cesarean section.
    - Non-routine prenatal care.
    - Postnatal care.
    - Diagnostic testing.
    - Abdominal operation for intrauterine pregnancy or miscarriage.
    - Outpatient Birthing Centers.
    - Midwives.
    - Amniocentesis requires medical necessity review.
    - Lactation Education covered in hospital setting.

39. **Medical Supplies** obtained outside of a medical office visit.

40. **Mental Health Treatment.** (Refer to the Mental Health Benefits section of this SPD.)

41. **Morbid Obesity Treatment** includes only the following treatments if those treatments are determined to be Medically Necessary and be appropriate for an individual's Morbid Obesity condition. Refer to the Glossary of Terms for a definition of Morbid Obesity.

    - Bariatric surgery, including, but not limited to:
        - Gastric or intestinal bypasses (Roux-en-Y, biliopancreatic bypass, and biliopancreatic diversion with duodenal switch).
        - Stomach stapling (vertical banded gastroplasty, gastric banding, and gastric stapling).
        - Lap band (laparoscopic adjustable gastric banding).
        - Gastric sleeve procedure (laparoscopic vertical gastrectomy and laparoscopic sleeve gastrectomy).
    - Charges for diagnostic services.

    This Plan does not cover diet supplements, exercise equipment or any other items listed in the General Exclusions section of this SPD. Skin removal after Morbid Obesity surgery is not covered even if found medically necessary.

42. **Nursery and Newborn Expenses, Including Circumcision,** are covered for the following Children of the covered Employee or covered spouse: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.

    Newborns covered automatically for first 31 days following birth. Coverage will cease beginning with the 32nd day unless the newborn child has been affirmatively enrolled as a dependent in the plan by completing and submitting an approved enrollment change form by the end of the 60th day following the date of birth.

43. **Nutritional Counseling.**

44. **Nutritional Supplements, Enteral Feedings, Vitamins, and Electrolytes** that are prescribed by a Physician and administered through a tube, provided they are the sole source of nutrition or are part of a chemotherapy regimen. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings), provided the feedings are prescribed by a Physician and are the sole source of nutrition or are part of a chemotherapy regimen.

45. **Occupational Therapy.** (See Therapy Services below.)

46. **Oral Surgery** includes:

    - Excision of partially or completely impacted teeth only covered when dental benefit is exhausted.
    - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological examinations.
    - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
    - Reduction of fractures and dislocations of the jaw.
    - External incision and drainage of cellulitis.
    - Incision of accessory sinuses, salivary glands, or ducts.
    - Frenectomy (the cutting of the tissue in the midline of the tongue).
    - Excision of exostosis of jaws and hard palate.
    - Removal of teeth which is necessary in order to perform radiation therapy and Oral Surgical Services which treat the correction of non-dental, physiological conditions which have resulted in a severe functional impairment.

47. **Orthotic Appliances, Devices, and Casts,** including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after Injury. These devices can be used for acute Injury or to prevent Injury. Orthotic appliances and devices include custom molded shoe orthotics, supports, trusses, elastic compression stockings, and braces. Diabetic shoes are covered with prescription and related to a diabetic condition, otherwise only when an integral part of a lower body brace. Deluxe upgrades determined not to be medically necessary are not covered.

48. **Oxygen and Its Administration.**

49. **Pharmacological Medical Case Management** (medication management and lab charges).

50. **Physical Therapy.** (See Therapy Services below.)

51. **Physician Services** for covered benefits.

52. **Pre-Admission Testing** if necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

53. **Prescription Medications** that are administered or dispensed as take-home drugs as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility, or Skilled Nursing Facility) and that require a Physician's Prescription. Coverage does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.

54. **Preventive / Routine Care** as listed under the Schedule of Benefits.

The Plan pays benefits for Preventive Care services provided on an Outpatient basis at a Physician's office, an Alternate Facility, or a Hospital that encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes, and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- Well-women Preventive Care visit(s) for women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The well-women visit should, where appropriate, include the following additional preventive services listed in the Health Resources and Services Administrations guidelines, as well as others referenced in the Affordable Care Act:

  - Screening for gestational diabetes;
  - Human papillomavirus (HPV) DNA testing;
  - Counseling for sexually transmitted infections;
  - Counseling and screening for human immune-deficiency virus;
  - Screening and counseling for interpersonal and domestic violence; and
  - Breast cancer genetic test counseling (BRCA) for women at high risk.

  Please visit the following links for additional information:

  https://www.healthcare.gov/preventive-care-benefits/
  https://www.healthcare.gov/preventive-care-children/
  https://www.healthcare.gov/preventive-care-women/

55. **Prosthetic Devices.** The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) that replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:

- Due to the growth or development of a Dependent Child; or
- When necessary because of a change in the Covered Person's physical condition; or
- Because of deterioration caused from normal wear and tear.

The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

Bionic, myoelectric, microprocessor-controlled, and computerized prosthetics are not covered. Deluxe upgrades determined not to be medically necessary are not covered.

56. **Qualifying Clinical Trials** as defined below, including routine patient care costs Incurred during participation in a Qualifying Clinical Trial for the treatment of:

- Cancer or other Life-Threatening Disease or Condition. For purposes of this benefit, a Life-Threatening Disease or Condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from participation in a Qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the Qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for Qualifying Clinical Trials may include:

- Covered health services (e.g., Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;
- Covered health services required solely for the administration of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered health services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational service or item as it is typically provided to the patient through the clinical trial.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other Life-Threatening Diseases or Conditions, a Qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and that meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

  - National Institutes of Health (NIH), including the National Cancer Institute (NCI);
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or Veterans Administration (VA);
  - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or

- The Department of Veterans Affairs, the DOD, or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
  - It is comparable to the system of peer review of studies and investigations used by the NIH; and
  - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an Investigational new drug application reviewed by the U.S. Food and Drug Administration;
- The study or investigation is a drug trial that is exempt from having such an Investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (*IRBs*) before participants are enrolled in the trial. The Plan Sponsor may, at any time, request documentation about the trial; or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

57. **Radiology and Interpretation Charges.**

58. **Reconstructive Surgery** includes:

- Surgery following a mastectomy under the Women's Health and Cancer Rights Act (WHCRA). Under the WHCRA, the Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments that include all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
- Surgery to restore a bodily function that has been impaired by a congenital Illness or anomaly, or by an Accident, or from an infection or other disease of the involved part.

59. **Respiratory Therapy.** (See Therapy Services below.)

60. **Second Surgical Opinion** if given by a board-certified Specialist in the medical field related to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

61. **Sexual Function:** Diagnostic services in connection with treatment for male or female impotence.

62. **Sleep Disorders** if Medically Necessary.

63. **Sleep Studies.**

64. **Speech Therapy.** (See Therapy Services below.)

65. **Sterilizations.**

66. **Substance Use Disorder Services.** (Refer to the Substance Use Disorder and Chemical Dependency Benefits section of this SPD.)

67. **Surgery and Assistant Surgeon Services.**

- If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the allowance for the primary procedure performed. For in-network providers, the assistant surgeon's allowable amount will be determined per the network contract.
- If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the allowance for the primary procedure; and a percentage of the allowance for the subsequent procedure(s). If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the allowance for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the allowable amount for that procedure.

68. **Telehealth.** Consultations made by a Covered Person to a Physician.

69. **Telemedicine.** (Refer to the Teladoc Services section of this SPD for more details.)

70. **Temporomandibular Joint Disorder (TMJ) Services** include:

- Diagnostic services.
- Surgical treatment of the temporomandibular joint.
- Non-surgical treatment (including intraoral devices or any other non-surgical method to alter occlusion and/or vertical dimension).

Coverage does not include orthodontic services.

71. **Therapeutic Radiology** (treatment of cancer and other diseases with radiation).

72. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

- **Occupational therapy** by a Qualified occupational therapist (OT) or other Qualified Provider, if applicable.
- **Physical therapy** by a Qualified physical therapist (PT) or other Qualified Provider, if applicable.
- **Respiratory therapy** by a Qualified respiratory therapist (RT) or other Qualified Provider, if applicable.
- **Speech therapy** necessary for the diagnosis and treatment of speech and language disorders that result in a communication disability by a Qualified speech therapist (ST) or other Qualified Provider, if applicable, including therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing only when the disorder results from Injury, stroke, cancer, a Congenital Anomaly, or Autism Spectrum Disorder.

The Plan allows coverage for medical charges and occupational and/or physical therapy for Developmental Delays due to Accidents or Illnesses such as Bell's palsy, CVA (stroke), apraxia, cleft palate/lip, recurrent/chronic otitis media, vocal cord nodules, Down's syndrome and cerebral palsy when performed by a Qualified Provider.

73. **Tobacco Addiction:** Preventive / Routine Care as required by applicable law.

74. **Transplant Services.** (Refer to the Transplant Benefits section of this SPD.)

75. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.

76. **Vision Care Services.** (Refer to Vision Care section of this SPD.)

77. **Walk-In Retail Health Clinics:** Charges associated with medical services provided at Walk-In Retail Health Clinics.

TELADOC SERVICES

Note: Teladoc Services described below are subject to state availability. Access to telephonic or video based consultations may be restricted in some states.

This Plan has a special benefit allowing Covered Persons of all ages to receive telephone or web-based video consultations with Physicians for routine primary medical diagnoses.

Teladoc may be used:

- When immediate care is needed.
- When considering the ER or Urgent Care center for non-Emergency issues.
- When You are on vacation or on a business trip.

Teladoc can provide care for the following types of conditions:

- General medicine, including, but not limited to:
  - Colds and flu
  - Allergies
  - Bronchitis
  - Pink eye
  - Upper respiratory infections
- A refill of a recurring Prescription.
- Pediatric care.
- Non-Emergency medical assistance.

In order to obtain this benefit, a Covered Person must complete a medical history disclosure form that will serve as an electronic medical record for consulting Physicians. This form can be completed via the Teladoc website, via the call center, or via the Teladoc mobile app. Once enrolled, a Covered Person may phone 1-800-TELADOC (1-800-835-2362) and request a consultation with a Physician. A Physician will then return the Covered Person's phone call. If a Covered Person requests a web-based video consultation, the consultation will be scheduled and an appointment reminder notification will be sent prior to the appointed time. If necessary, the Physician will write a Prescription. The Prescription will be called in to a pharmacy of the Covered Person's choice. Benefits for this service are shown in the Schedule of Benefits.

Teladoc does not guarantee that every consultation will result in a Prescription. Medications are prescribed at the Physician's discretion based on the symptoms reported at the time of the consultation. A Covered Person has 72 hours after his or her consultation to call Teladoc with any clarification questions. A member of the Teladoc clinical team will assist the Covered Person at no additional cost during this time. If a Covered Person requests another Physician consultation, he or she will be charged the Teladoc consultation fee.

Teladoc may not be used for:

- Drug Enforcement Agency (DEA) controlled Prescriptions.
- Charges for telephone or online consultations with a Physician and/or other providers who are not contracted through Teladoc.
- Consultations in states/jurisdictions where not available due to regulations or interpretations affecting the practice of telemedicine for medical conditions.

HOME HEALTH CARE BENEFITS

Home Health Care services are provided for patients when Medically Necessary, as determined by the Utilization Review Organization.

A Home Health Care Visit is defined as a visit by a nurse providing intermittent nurse services (each visit includes up to a 4-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a Qualified therapist, Qualified dietician, or other Qualified Provider, if applicable.

Information regarding Private Duty Nursing can be found elsewhere in this SPD.

Prior authorization may be required before receiving services. Please refer to the UMR CARE section of this SPD for more details. Covered services may include:

- Home visits instead of visits to the provider's office that do not exceed the maximum allowable under this Plan.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed 4 hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a Qualified dietician or other Qualified Provider, if applicable.
- Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a Qualified therapist or other Qualified Provider, if applicable.
- Medical supplies, drugs, laboratory services, or medication prescribed by a Physician.
- Home infusion.

EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services.
- Supportive environment materials such as handrails, ramps, air conditioners, and telephones.
- Services performed by family members or volunteer workers.
- "Meals on Wheels" or similar food service.
- Separate charges for records, reports, or transportation.
- Expenses for the normal necessities of living, such as food, clothing, and household supplies.
- Legal and financial counseling services, unless otherwise covered under this Plan.

TRANSPLANT BENEFITS

Refer to the UMR CARE section of this SPD for prior authorization requirements

The program for Transplant Services at Designated Transplant Facilities is:

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This coverage provides You with a choice for transplant care. The Plan provides incentives to You and Your covered Dependents by giving You the option of using a Designated Transplant Facility. While the Plan does not require You to use a Designated Transplant Facility in order to receive benefits You may receive better benefits if You do so. A Designated Transplant Facility is a facility that must meet extensive criteria in the areas of patient outcomes that include patient and graft survival, patient satisfaction, Physician and program experience, program accreditations, and patient and caregiver education.

DEFINITIONS

The following terms are used for the purpose of the Transplant Benefits section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Approved Transplant Services means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician charges, organ and tissue procurement, tissue typing, and Ancillary Services.

Designated Transplant Facility means a facility that has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network or rental network with which the Plan has a contract.

Non-Designated Transplant Facility means a facility that does not have an agreement with the transplant provider network with whom the Plan has a contract. This may include a facility that is listed as a participating provider.

Organ and Tissue Acquisition/Procurement means the harvesting, preparation, transportation, and the storage of human organ and tissue that is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant includes autologous, allogeneic, and syngeneic transplant of bone marrow and peripheral and cord blood stem cells and may include chimeric antigen receptor T-cell therapy (CAR-T).

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated or Non-Designated Transplant Facility due to an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Reasonable Reimbursement, the Usual and Customary charge, or the Plan's Negotiated Rate.

Prior authorization is required for all transplant-related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be an individual Plan exclusion.

COVERED EXPENSES

The Plan will pay for Approved Transplant Services at a Designated or Non-Designated Transplant Facility for Organ and Tissue Acquisition/Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including a bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition/Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition/Procurement. Coverage includes the cost of donor testing, blood typing, and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services for donor-related complications during the transplant period, per the transplant contract, if the recipient is a Covered Person under this Plan.

The Plan will provide donor services at a Non-Designated Transplant Facility for initial acquisition/procurement only, up to the maximum listed on the Schedule of Benefits, if any. Complications, side effects, or injuries are not covered unless the donor is a Covered Person.

Benefits are payable for the following transplant types:

- Kidney.
- Kidney/pancreas.
- Pancreas, if the transplant meets the criteria determined by care management.
- Liver.
- Heart.
- Heart/lung.
- Lung.
- Bone marrow or Stem Cell Transplant (allogeneic and autologous), which may include chimeric antigen receptor T-cell therapy (CAR-T) for certain conditions.
- Small bowel.

SECOND OPINION

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by the transplant facility, the Plan will allow him or her to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant-related services or supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

ADDITIONAL PROVISIONS

TRAVEL EXPENSES (Applies to Covered Person who is a recipient)

If the Covered Person lives more than 100 miles from the transplant facility, the Plan will pay for travel and housing related to the transplant, up to the maximum listed on the Schedule of Benefits. Expenses will be paid for the Covered Person and:

- One or two parents of the Covered Person (if the Covered Person is a Dependent Child, as defined in this Plan); or
- An adult to accompany the Covered Person.

Covered travel and housing expenses include the following:

- Transportation to and from the transplant facility, including:
  - Airfare.
  - Gas/mileage.
- Lodging at or near the transplant facility, including:
  - Apartment rental.
  - Hotel rental.

  Lodging for purposes of this Plan does not include private residences.

  Lodging reimbursement that is greater than $50 per person per day may be subject to IRS codes for taxable income.

Benefits will be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.

TRANSPLANT EXCLUSIONS

In addition to the items listed in the General Exclusions section of this SPD, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.
- Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells, or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.
- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.
- Transplants considered Experimental, Investigational, or Unproven unless covered under a Qualifying Clinical Trial.
- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell), or allogeneic transplant (bone marrow or peripheral stem cell) for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehensive Cancer Network (NCCN) and/or Transplant Review Guidelines.
- Expenses related to, or for, the purchase of any organ.

PRESCRIPTION DRUG BENEFITS

Administered by Navitus Health Solutions

Note: UMR (the claims administrator) does not administer the benefits or services described within this provision. Please contact the Pharmacy Benefit Manager (PBM) or Your Health Benefits Department with any questions related to this coverage or service.

Covered Drugs

Your Prescription Drug benefit provides coverage for most commonly used drugs that are Federal Legend Drugs. Federal Legend Drugs are drugs that require a label stating, “Caution: Federal law prohibits dispensing without a Prescription.” Your pharmacist or the prescribing Physician can verify coverage for a drug by contacting the Pharmacy Benefit Manager (PBM) at the number on Your Prescription ID card. A complete list of covered and excluded drugs may be available on the Pharmacy Benefit Manager’s website. If You are unable to access the website, Your employer will provide a copy upon request at no charge.

How to Use the Prescription Drug Card

Present Your ID card and the Prescription to a Participating Pharmacy. Then sign the pharmacist's voucher and pay the pharmacist the appropriate Co-pay amount, if applicable.

If You are without Your prescription ID card or if You are at a non-Participating Pharmacy, You may be required to pay for the Prescription and submit a claim to the PBM. Please contact the PBM or Your employer for information on how to submit a claim.

Home Delivery Drug Service

If You are using an ongoing Prescription drug, You may purchase that drug on a home delivery basis. Most drugs covered by the PBM may be purchased through the home delivery service. The home delivery drug service is most often used to purchase drugs that treat an ongoing medical condition and are taken on a regular basis.

There may be a Co-pay for home delivery Prescriptions.

Home delivery Prescriptions should be sent to the PBM. Order forms may be available on the PBM’s website or from Your employer. All Prescriptions will be mailed directly to Your home.

A directory of Participating Pharmacies is available on the PBM’s website. You will also be automatically provided a copy of the pharmacy directory at no charge. The pharmacy directory is a document that is separate from this SPD. The directory contains the names, addresses, and phone numbers of the pharmacies that are part of the PBM’s program.

Schedule of Benefits

Prescription Coverage	Not Applicable	$25 Generic $50 Specialty $75 Non-Formulary

Employer Group Waiver Plan (EGWP)

The Plan Administrator offers a Medicare Employer Group Waiver Plan (EGWP) to Medicare-eligible retirees and Medicare eligible dependents covered under the Plan. The EGWP meets requirements applicable to Medicare Part D and retirees and dependents enrolled in either Medicare Part A or B or Parts A and B will be automatically enrolled in the EGWP upon becoming Medicare-eligible. The Plan Administrator will collect the Medicare premium for Part D drug plan coverage except any additional premium imposed due to exceeding the income threshold as defined by the Social Security Administration. Covered drugs will be subject to the formulary approved by the Centers for Medicare and Medicaid Services.

As with Medicare Part D plans, members of the EGWP with a higher income may be assessed an Income Related Monthly Adjustment Amount (IRMAA). Failure to pay the required IRMAA amount will result in benefits being paid on an out-of-network basis for prescription drugs. Any assessed penalties will not apply to the member's out-of-pocket maximum.

If a member is eligible for Part A or B or Parts A and B and does not enroll in Medicare coverage, the member will not have prescription benefits coverage under the Plan.

If a member elects Part D Prescription Drug Plan (PDP) outside of Clark County Self-Funded EGWP Plan, the member will not have prescription benefits coverage under the Plan. Prescription benefit coverage will be through the PDP plan otherwise selected by the member.

Contact the Pharmacy Benefit Manager for more information regarding EGWP.

Note: The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides all Medicare-eligible individuals the opportunity to obtain Prescription Drug coverage through Medicare. A Medicare-eligible individual generally must pay an additional monthly premium for this coverage. In addition, electing Medicare Part D may affect Your ability to obtain Prescription coverage under this Plan. Individuals may be able to postpone enrollment in the Medicare Prescription Drug coverage if their current drug coverage is at least as good as Medicare Prescription Drug coverage. If individuals decline Medicare Prescription Drug coverage and do not have coverage at least as good as Medicare Prescription Drug coverage, they may have to pay additional monthly penalties if they change their minds and sign up later. Medicare-eligible individuals should have received notices informing them of whether or not their current Prescription Drug coverage provides benefits that are at least as good as benefits provided by the Medicare Prescription Drug coverage and explaining whether or not election of Medicare Part D will affect coverage available under this Plan. For a copy of this notice, please contact the Plan Administrator.

HEARING AID BENEFITS

This Plan includes a benefit that allows Covered Persons to access discounted hearing aids and related testing and fitting. This benefit is being offered under the Plan by UnitedHealthcare Hearing.

UnitedHealthcare Hearing provides a full range of hearing health benefits that deliver value, choice, and a positive experience.

UnitedHealthcare Hearing offers:

- Name-brand and private-labeled hearing aids from major manufacturers at discounted prices.
- Access to a network of credentialed hearing professionals at more than 5,000 locations nationwide.
- Convenient ordering with hearing aids available in person or through home delivery.

How To Use This Hearing Benefit:

- Contact UnitedHealthcare Hearing at 1-855-523-9355, between 8:00 a.m. and 8:00 p.m. Central Time Monday through Friday, or visit uhchearing.com to learn more about the ordering process and for a referral to a UnitedHealthcare Hearing provider location (if a hearing test is needed).
- Receive a hearing test by a UnitedHealthcare Hearing provider. During the appointment, You will decide if You would like to have Your hearing aids fitted in person with Your hearing provider or to have Your hearing aids delivered directly to Your home (for select hearing aid models only). A broad selection of name-brand and private-labeled hearing aids is available.
- If You choose to purchase hearing aids through the UnitedHealthcare Hearing provider, the hearing aids will be ordered by the provider and sent directly to the provider's office. You will be fitted with the hearing aid(s) by the local provider. If You choose home delivery, the hearing aids will be sent directly to Your home within 5-10 business days from the order date.

In the event that You have questions or complaints about the hearing aid products or services offered under the Plan, contact UnitedHealthcare Hearing at 1-855-523-9355 or visit uhchearing.com.

MENTAL HEALTH BENEFITS

The Plan will pay for the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Co-pays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Reasonable Reimbursement, the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of Mental Health Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a subacute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

ADDITIONAL PROVISIONS AND BENEFITS

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for the change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

MENTAL HEALTH EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.
- Bereavement counseling, unless specifically listed as a covered benefit elsewhere in this SPD.
- Services provided for conflict between the Covered Person and society that is solely related to criminal activity.
- Services for biofeedback.

SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS

The Plan will pay for the following Covered Expenses for a Covered Person, subject to any Deductibles, Co-pays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Reasonable Reimbursement, the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of substance use disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a subacute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for substance-related disorders. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

ADDITIONAL PROVISIONS AND BENEFITS

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for the change. Such records must include the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.

SUBSTANCE USE DISORDER EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for the following:

- Treatment or care considered inappropriate or substandard as determined by the Plan.
- Inpatient charges for the period of time when full, active, Medically Necessary treatment for the Covered Person's condition is not being provided.

UMR CARE: CLINICAL ADVOCACY RELATIONSHIPS TO EMPOWER

Utilization Management

Utilization Management is the process of evaluating whether services, supplies, or treatment is Medically Necessary and are appropriate level of care. Utilization Management can determine Medical Necessity, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. Covered Persons are responsible for ensuring the provider calls the phone number on the back of the Plan identification card to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for fact gathering and independent medical review, if necessary.

Special Note: The Covered Person will not be penalized for failure to obtain Prior Authorization if a Prudent Layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. Covered Persons who have received care on this basis are responsible for ensuring the provider contacts the Utilization Review Organization (see below) as soon as possible by phone or fax within 24 hours, or by the next business day if on a weekend or holiday, from the time coverage information is known. If notice is provided past the timeframe shown above, the extenuating circumstances must be communicated. The Utilization Review Organization will then review the services provided.

This Plan complies with the Newborns' and Mothers' Health Protection Act. Prior Authorization is not required for a Hospital or Birthing Center stay of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Prior Authorization may be required for a stay beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR**

DEFINITIONS

The following terms are used for the purpose of the UMR CARE section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Prior Authorization is the process of determining benefit coverage prior to a service being rendered to an individual member. A determination is made based on Medical Necessity criteria for drugs, supplies, tests, procedures, and other services that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent, and duration of stay.

Utilization Management is the evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits Plan. This management is sometimes called "utilization review." Such assessment may be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Review Organization **before** receiving services for the following:

- Inpatient stays in Hospitals, Extended Care Facilities, or residential treatment facilities (only an option if Skilled Nursing Facility requires authorization).
- Partial hospitalizations.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment, excluding braces, any equipment purchased and rentals.
- Prosthetics and orthotics over $750.
- Qualifying Clinical Trials.
- Inpatient stays in Hospitals or Birthing Centers that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.
- Bariatric surgeries.
- Non-Preventive Routine Labs and X-Ray Services.
- Non-Emergency Ambulance Services.
- Outpatient Hospital Services.
- Ambulatory Surgical Facility Services (authorization not required for contracted facilities and providers).
- Inpatient and Outpatient Short-Term Rehabilitative and Habilitative Services.
- Anesthesia Services.
- Post-Cataract Surgical Services (including frames, lenses and contact lenses).
- Genetic Disease Testing Services.
- Medical Supplies (obtained outside of the office visit).
- Complex Diagnostic Imaging (MRI, CT, PET, etc.).
- Special Food Products and Enteral Formula.
- Mental Health and Substance Abuse.
- ABA Therapy.
- Inpatient and Outpatient Hospice Services (including Respite Care and Bereavement Services).
- Chiropractic Care after 20 visits.
- Infertility Office Visit Evaluation.
- Diagnostic and Therapeutic Services (anti-cancer drug therapy, Dialysis, complex allergy, therapeutic radiology, otologic evals.
- Hearing Aids.

Note that if a Covered Person receives Prior Authorization for one facility, but then is transferred to another facility, Prior Authorization is also needed before going to the new facility, except in the case of an Emergency (see Special Notes above).

PENALTIES FOR NOT OBTAINING PRIOR AUTHORIZATION

A non-Prior Authorization penalty is the amount that must be paid by a Covered Person who does not call for Prior Authorization prior to receiving certain services. A penalty may be applied to applicable claims if a Covered Person receives services but does not obtain the required Prior Authorization. Failure to obtain precertification will result in no coverage for All Related Charges (includes all ancillary services).

The phone number to call for Prior Authorization is listed on the back of the Plan identification card.

The fact that a Covered Person receives Prior Authorization from the Utilization Review Organization does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this SPD, including additional information obtained that was not available at the time of the Prior Authorization.

Medical Director Oversight. A UMR CARE medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine Medical Necessity using evidence-based clinical criteria.

Complex Condition CARE, Complex Condition CARE +, or GenerationYou CARE Support Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case-to-case management for review. Complex Condition CARE, Complex Condition CARE +, or GenerationYou CARE Support opportunities are identified by using system-integrated, automated, and manual trigger lists during the Prior Authorization review process. Other trigger points include the following criteria: length of stay, level of care, readmission, and utilization, as well as employer referrals or self-referrals.

Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review is conducted upon request and a determination will be issued within the required timeframe of the request, unless an extension is approved. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures and a final determination will be made no later than 30 days after the request for review.

MAYO CLINIC CENTERS OF EXCELLENCE PROGRAM

The Plan covers eligible services ("the Services") as part of the Plan's Mayo Clinic Centers of Excellence Program, which is administered by UMR and HealthSCOPE Benefits, a UMR company. This program may provide access to Mayo Clinic for certain complex conditions.

Participation in this program is voluntary and is subject to the Plan participant's meeting Plan eligibility requirements. In order to participate in the program, the patient (or the patient's parent or legal guardian) must:

- agree to abide by program requirements;
- acknowledge that Mayo Clinic will receive necessary medical records prior to acceptance into the program;
- be able to safely travel for medical care and not require Emergency care at the time of travel;
- identify a designated caregiver(s). The caregiver(s) must agree to and be able to meet caregiver requirements; and
- provide the Mayo Clinic Physician with contact information for a local Physician who has agreed to manage follow-up care after the participant returns home.

Members participating in this program may receive an enhanced benefit for eligible services which may include coverage for services that would normally be excluded under this Plan, if approved through and performed at Mayo Clinic. Precertification and/or Prior authorization requirement is waived for Mayo Clinic when receiving care through the Mayo Clinic Complex Care Program.

The Plan pays covered travel expenses for the participant and a companion caregiver (or two companion caregivers if the patient is a pediatric patient) when the Services are performed at Mayo Clinic. UMR and HealthSCOPE Benefits, a UMR company, will coordinate the travel and care for the participant and companion caregiver(s).

SERVICES REQUIRING A REFERRAL

Services that may be eligible for this program include:

- Acute leukemia of any type.
- Non-Hodgkin's lymphoma of any type.
- Chronic myelogenous leukemia.
- Multiple myeloma.
- Cancer of the pancreas.
- Cancer of the anus and rectum (but not including other forms of colon cancer).
- Head and neck cancers.
- Esophageal cancer.
- Stomach cancer.
- Liver and bile duct cancers.
- Brain and central nervous system tumors.
- Stage IV breast cancer with failing treatment.
- Ovarian and other gynecologic cancers other than cervical cancer.
- Failed first line therapy.
- Rare, aggressive, or complex care needs.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. **It does not, however, apply to prescription benefits.** The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim. The balance remaining after the Primary Plan's payment, not to exceed the Covered Person's responsibility, is the amount that will be used in determining the benefits payable under the Secondary Plan. The Deductible, Co-pays, or Plan Participation amounts, if any, will be applied before benefits are paid on the balance.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of $200 per day.
- Specified disease policies.
- Foreign health care coverage.
- Medical care components of group long-term care contracts, such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies (including no-fault policies). See the order of benefit determination rules (below).
- Medical benefits under homeowner’s insurance policies.
- Medicare or other governmental benefits, as permitted by law, not including Medicaid. See below.

However, this Plan does not coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges will not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider’s contracted amount and the provider’s regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person’s situation is the rule that will apply:

- The plan that has no coordination of benefits provision is considered primary.

- If an individual is covered under one plan as a dependent and another plan as an employee, member, or subscriber, the plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) is considered primary. This does not apply to COBRA participants. See continuation coverage below. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any employee plan beneficiary to be eligible for primary benefits from his or her employer’s benefit plan.

- The plan that covers a person as a dependent is generally secondary. The plan that covers a person as a dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a dependent. See continuation coverage below. Also see the section on Medicare, below, for exceptions.

- If an individual is covered under a spouse's plan and also under his or her parent's plan, the Primary Plan is the plan that has covered the person for the longer period of time. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the plan of the parent or spouse whose birthday falls earlier in the calendar year is the Primary Plan. If the parents and/or spouse have the same birthday, the plan that has covered the parent or spouse for the longer period of time is the Primary Plan.

- If one or more plans cover the same person as a dependent child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

    If both parents have the same birthday, the plan that has covered either of the parents the longest is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.

  - If the parents are not married and reside separately, or are divorced or legally separated, (whether or not they have ever been married), the order of benefits is:

    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the non-custodial parent; and then
    - The plan of the spouse of the non-custodial parent.

- Active or Inactive Employee: If an individual is covered under one plan as an active employee (or dependent of an active employee), and is also covered under another plan as a retired or laid-off employee (or dependent of a retired or laid-off employee), the plan that covers the person as an active employee (or dependent of an active employee) will be primary. This rule does not apply if the rule in the third paragraph (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

- Continuation Coverage Under COBRA or State Law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies. (See the exception in the Medicare section.)

- Longer or Shorter Length of Coverage: The plan that has covered the person as an employee, member, subscriber, or retiree the longest is primary.

- If an active employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active employee, member, or subscriber is considered primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses may be shared equally between the plans. This Plan will not pay more than it would have paid had it been primary.

MEDICARE

If You or Your covered spouse or Dependent is also receiving benefits under Medicare, including through Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim. The balance remaining after the Primary Plan's payment, not to exceed the Covered Person's responsibility, is the amount that will be used in determining the benefits payable under the Secondary Plan. The Deductible, Co-pays, or Plan Participation amounts, if any, will be applied before benefits are paid on the balance.

When Medicare is primary to this Plan and a Covered Person has not elected Medicare, this Plan will coordinate benefits using an estimate of what Medicare would have paid.

Medicare Carve-Out: If a retiree or any dependent of a retiree is eligible for Medicare Coverage and does not elect Medicare Part B, the member or dependent is subject to a penalty. If a retiree or active member/dependent becomes eligible for Medicare due to ESRD, they must also be enrolled in Medicare Part B after their 30-month coordination period, otherwise a penalty will apply. Penalty is as follows: Plan will provide coverage to the member and/or dependent at 20% of the plan allowable, either at the contracted rate or the reasonable and customary 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.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally pays first under the following circumstances:

  - You continue to be actively employed by the employer and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.

  - You continue to be actively employed by the employer, Your covered spouse becomes eligible for and enrolls in Medicare, and Your spouse is also covered under a retiree plan through his or her former employer. In this case, this Plan pays first for You and Your covered spouse, Medicare pays second, and the retiree plan pays last.

  - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period may also include COBRA continuation coverage or another source of coverage. At the end of the 30-month period, Medicare becomes the primary payer.

- Medicare generally pays first under the following circumstances:

  - You are no longer actively employed by an employer; and

- You or Your spouse has Medicare coverage due to age, plus You or Your spouse also has COBRA continuation coverage through the Plan; or

- You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first; however, COBRA may pay first for Covered Persons with ESRD until the end of the 30-month period; or

- You or Your covered spouse has retiree coverage plus Medicare coverage; or

- Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability ***before*** being diagnosed with ESRD and Medicare was previously paying as the Primary Plan, the person may continue to receive Medicare benefits on a primary basis).

- Medicare is the secondary payer when no-fault insurance, Workers' Compensation, or liability insurance is available as the primary payer.

TRICARE

If an eligible Employee is on active military duty, TRICARE is the only coverage available to that Employee. Benefits are not coordinated with the Employee's health insurance plan.

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD-PARTY ORGANIZATION

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as if it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than the Plan should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid, or from any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

The Plan has a right to subrogation and reimbursement. References to "You" or "Your" in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any Third-Party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any Third-Party for the benefits that the Plan has paid that are related to the Illness or Injury for which any Third-Party is considered responsible.

The right to reimbursement means that if it is alleged that any Third-Party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any Third-Party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor in a Workers' Compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners', or otherwise), Workers' Compensation coverage, other insurance carriers, or Third-Party administrators.
- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any Third-Party.
- Any person or entity that is liable for payment to You on any equitable or legal theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan's legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any Third-Party for acts that caused benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or Injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any Third-Party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect Third-Party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any Third-Party before You receive payment from that Third-Party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible Third-Party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You, Your representative, Your estate, Your heirs, or Your beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, punitive, and any other alleged damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.

- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.

- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.

- By participating in and accepting benefits from the Plan, You agree that:

  - Any amounts recovered by You from any Third-Party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
  - You and Your representative will be fiduciaries of the Plan with respect to such amounts; and
  - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.

- The Plan's rights to recovery will not be reduced due to Your own alleged negligence.

- By participating in and accepting benefits from the Plan, You agree to assign to the Plan any benefits, claims, or rights of recovery You have under any automobile policy (including no-fault benefits, Personal Injury Protection benefits, and/or medical payment benefits), under other coverage, or against any Third-Party, to the full extent of the benefits the Plan has paid for the Illness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, You acknowledge and recognize the Plan's right to assert, pursue, and recover on any such claim, whether or not You choose to pursue the claim, and You agree to this assignment voluntarily.

- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other Third-Party; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by any Third-Party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.

- If any Third-Party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.

- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any Third-Party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect Third-Party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

GENERAL EXCLUSIONS

Exclusions, including complications from excluded items, are not considered covered benefits under this Plan and will not be considered for payment as determined by the Plan.

The Plan does not pay for expenses Incurred for the following, unless otherwise stated below. The Plan does not apply exclusions to treatment listed in the Covered Medical Benefits section based upon the source of the Injury when the Plan has information that the Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

1. **3D Mammograms,** unless covered elsewhere in this SPD.

2. **Abdominoplasty.**

3. **Abortions:** Unless a Physician states in writing that the mother's life would be in danger if the fetus were carried to term, or unless the pregnancy is the result of incest or rape.

4. **Acts of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

5. **Alternative / Complementary Treatment** including treatment, services or supplies for holistic or homeopathic medicine, hypnosis or other alternate treatment that is not accepted medical practice as determined by the Plan.

6. **Appointment Missed:** An appointment the Covered Person did not attend.

7. **Aquatic Therapy.**

8. **Assistance With Activities of Daily Living.**

9. **Assistant Surgeon, Co-Surgeons, or Surgical Team Services,** unless determined to be Medically Necessary by the Plan.

10. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins or after coverage ends under this Plan.

11. **Biofeedback Services.**

12. **Blood:** Blood donor expenses.

13. **Blood Pressure Cuffs / Monitors,** unless covered elsewhere in this SPD.

14. **Breast Pumps,** unless covered elsewhere in this SPD.

15. **Cardiac Rehabilitation** beyond Phase II, including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.

16. **Claims** received later than 12 months from the date of service.

17. **Contraceptive Products and Counseling,** unless covered elsewhere in this SPD.

18. **Cosmetic Treatment**, **Cosmetic Surgery,** or any portion thereof, unless the procedure is otherwise listed as a covered benefit.

19. **Court-Ordered:** Any treatment or therapy that is court-ordered, or that is ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving-while-intoxicated conviction or other classes ordered by the court.

20. **Custodial Care** as defined in the Glossary of Terms of this SPD.

21. **Dental Services,** unless covered elsewhere in this SPD.

22. **Duplicate Services and Charges or Inappropriate Billing,** including the preparation of medical reports and itemized bills.

23. **Education:** Charges for education, special education, job training, music therapy, and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics.

24. **Environmental Devices:** Environmental items such as, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, and vacuum devices.

25. **Examinations:** Examinations for employment, insurance, licensing, or litigation purposes.

26. **Excess Charges:** Charges or the portion thereof that are in excess of the Reasonable Reimbursement, the Usual and Customary charge, the Negotiated Rate, or the fee schedule.

27. **Experimental, Investigational, or Unproven:** Services, supplies, medicines, treatment, facilities, or equipment that the Plan determines are Experimental, Investigational, or Unproven, including administrative services associated with Experimental, Investigational, or Unproven treatment. This exclusion does not apply to Qualifying Clinical Trials as described in the Covered Medical Benefits section of this SPD.

28. **Extended Care:** Any Extended Care Facility Services that exceed the appropriate level of skill required for treatment as determined by the Plan.

29. **Family Planning:** Consultations for family planning.

30. **Fees for Medical Records.**

31. **Financial Counseling.**

32. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment, and health club memberships, or other utilization of services, supplies, equipment, or facilities in connection with weight control or bodybuilding.

33. **Foot Care (Podiatry):** Routine foot care.

34. **Foreign Coverage for Medical Care Expenses, Including Preventive Care or Elective Treatment.** Costs for repatriation from outside of the United States are also not covered.

35. **Genetic Testing or Genetic Counseling,** unless covered elsewhere in this SPD.

36. **Growth Hormones.**

37. **Home Births** and associated costs.

38. **Home Modifications:** Modifications to Your home or property, such as, but not limited to, escalators, elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, or ramps.

39. **Illegal Acts:** Charges for an injury or illness caused wholly, partially, directly or indirectly by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. In compliance with the Health Insurance Portability and Accountability Act, if an injury results from a medical condition or act of domestic violence, the plan will not deny benefits for the injury. A medical condition includes both physical and mental illnesses.

40. **Infant Formula** not administered through a tube as the sole source of nutrition for the Covered Person.

41. **Infertility Treatment:**

    - Surgical reversal of a sterilized state that was a result of a previous surgery.

    This exclusion does not apply to services required to treat or correct underlying causes of infertility where such services cure the condition of, slow the harm to, alleviate the symptoms of, or maintain the current health status of the Covered Person.

42. **Intraocular Lenses Other Than Conventional Intraocular Cataract Lenses.**

43. **Lamaze Classes** or other childbirth classes.

44. **Learning Disability:** Non-medical treatment, including, but not limited to, special education, remedial reading, school system testing, and other habilitation (such as therapies)/rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

45. **Liposuction,** unless covered elsewhere in this SPD.

46. **Maintenance Therapy** if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve a condition, or if clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

47. **Mammoplasty or Breast Augmentation,** unless covered elsewhere in this SPD.

48. **Marriage Counseling.**

49. **Massage Therapy.**

50. **Maximum Benefit.** Charges in excess of the Maximum Benefit allowed by the Plan.

51. **Military:** A military-related Illness of or Injury to a Covered Person on active military duty, unless payment is legally required.

52. **Nocturnal Enuresis Alarm** (Bed wetting).

53. **Non-Custom-Molded Shoe Inserts.**

54. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of his or her license.

55. **Not Medically Necessary:** Services, supplies, treatment, facilities, or equipment that the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities, or equipment that reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy above.

56. **Nursery and Newborn Expenses** for a grandchild of a covered Employee or spouse.

57. **Nutrition Counseling,** unless covered elsewhere in this SPD.

58. **Nutritional Supplements, Enteral Feedings, Vitamins, and Electrolytes** unless covered elsewhere in this SPD.

59. **Occupational and/or Work Related:** Any condition for which the Plan Participant has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose, or is otherwise deemed by Statute to be care or treatment compensable under the Nevada Industrial Insurance Act commencing at NRS Chapter et seq. However, if the Plan provides benefits for any such condition, the Plan Administrator will be entitled to establish a lien upon such other benefits up to the amount paid.

60. **Orthognathic, Prognathic, and Maxillofacial Surgery.**

61. **Over-the-Counter Medication, Products, Supplies, or Devices,** unless covered elsewhere in this SPD.

62. **Palliative Foot Care.**

63. **Panniculectomy,** unless determined by the Plan to be Medically Necessary.

64. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as, but not limited to, private rooms, televisions, telephones and guest trays.

65. **Pharmacy Consultations.** Charges for or related to consultative information provided by a pharmacist regarding a Prescription order, including, but not limited to, information related to dosage instruction, drug interactions, side effects, and the like.

66. **Prescription Medication Written by a Physician:** A Covered Person with a written Physician's Prescription who obtains medication from a pharmacy should refer to the Prescription Drug Benefits section of this SPD for coverage.

67. **Preventive / Routine Care Services,** unless covered elsewhere in this SPD.

68. **Private Duty Nursing Services.**

69. **Reconstructive Surgery** when performed only to achieve a normal or nearly normal appearance, and not to correct an underlying medical condition or impairment, as determined by the Plan, unless covered elsewhere in this SPD.

70. **Return to Work / School:** Telephone or Internet consultations, or the completion of claim forms or forms necessary for a return to work or school.

71. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization, unless covered by the Plan in connection with Infertility Treatment.

72. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.

73. **Self-Administered Services** or procedures that can be performed by the Covered Person without the presence of medical supervision.

74. **Services at No Charge or Cost:** Services for which the Covered Person would not be obligated to pay in the absence of this Plan or that are available to the Covered Person at no cost, or for which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.

75. **Services Provided By a Close Relative.** See the Glossary of Terms section of this SPD for a definition of Close Relative.

76. **Services Provided By a School.**

77. **Sex Therapy.**

78. **Sexual Function:** Non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Drug Benefits section of this SPD) in connection with treatment for male or female impotence.

79. **Standby Surgeon Charges.**

80. **Subrogation.** Charges for an Illness or Injury suffered by a Covered Person due to the action or inaction of any Third-Party if the Covered Person fails to provide information as specified in the Right of Subrogation, Reimbursement, and Offset section. See the Right of Subrogation, Reimbursement, and Offset section for more information.

81. **Surrogate Parenting and Gestational Carrier Services,** including any services or supplies provided in connection with a surrogate parent, not including pregnancy and maternity charges Incurred by a covered Employee or covered spouse acting as a surrogate parent.

82. **Taxes:** Sales taxes and shipping and handling charges, unless covered elsewhere in this SPD.

83. **Telehealth.** Consultations made by a Covered Person's treating Physician to another Physician.

84. **Tobacco Addiction:** Diagnoses, services, treatment, or supplies related to addiction to or dependency on nicotine, unless covered elsewhere in this SPD.

85. **Transportation:** Transportation services that are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.

86. **Travel:** Travel costs, unless covered elsewhere in this SPD.

87. **Vision Care,** unless covered elsewhere in this SPD. (Refer to the Vision Care Benefits section of this SPD).

88. **Vitamin B-12 Injections.**

89. **Vitamins, Minerals, and Supplements,** even if prescribed by a Physician, except for IV iron therapy that is prescribed by a Physician for Medically Necessary purposes.

90. **Vocational Services:** Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning, and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.

91. **Weekend Admissions** to Hospital confinement (admissions taking place after 3:00 pm on Fridays or before noon on Sundays) unless the admission is deemed an Emergency or is for care related to pregnancy that is expected to result in childbirth.

92. **Weight Control:** Treatment, services, or surgery for weight control**,** whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling. This exclusion does not apply to specific services for Morbid Obesity as listed in the Covered Medical Benefits section of this SPD.

93. **Wigs (Cranial Prostheses), Toupees, Hairpieces, Hair Implants or Transplants, or Hair Weaving,** or any similar item for replacement of hair regardless of the cause of hair loss, unless covered elsewhere in this SPD.

94. **Wrong Surgeries:** Additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, etc.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

Pre-Determination

A Pre-Determination is a determination of benefits by the claims administrator, on behalf of the Plan, prior to services being provided. Although Pre-Determinations are not required by the Plan, a Covered Person or provider may voluntarily request a Pre-Determination. A Pre-Determination informs individuals of whether, and under which circumstances, a procedure or service is generally a covered benefit under the Plan. A Covered Person or provider may wish to request a Pre-Determination before Incurring medical expenses. A Pre-Determination is not a claim and therefore may not be appealed. A Pre-Determination that a procedure or service may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing prior authorization as required by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person is required to obtain approval from the Plan ***before*** obtaining medical care, such as in the case of prior authorization of health care items or services that the Plan requires. If a Covered Person or provider calls the Plan for the sole purpose of learning whether or not a claim will be covered, that call is not considered a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization. (See "Pre-Determination" above.) The fact that the Plan may grant prior authorization does not guarantee that the Plan will ultimately pay the claim.

  Note that this Plan does not require prior authorization for urgent or Emergency care claims; however, Covered Persons may be required to notify the Plan following stabilization. Please refer to the UMR CARE section of this SPD for more details. A condition is considered to be an urgent or Emergency care situation if a sudden and serious condition occurs such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of the patient's bodily functions would result unless immediate medical care is rendered. Examples of an urgent or Emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.

- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who may contact the Plan on the Covered Person's behalf to help with claims, appeals, or other benefit issues. A minor Dependent must have the signature of a parent or Legal Guardian in order to appoint a Third-Party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: the name of the Personal Representative, the date and duration of the appointment, and any other pertinent information. In addition, the Covered Person must agree to grant his or her Personal Representative access to his or her Protected Health Information. The Covered Person should contact the Claim Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, the Covered Person will need to send the claim to the Plan within the timelines outlined below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

A Covered Person who receives services in a country other than the United States is responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse the Covered Person for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if the paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person's/patient's ID number, name, sex, date of birth, address, and relationship to Employee
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services, or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient's account number (if applicable)
- Total billed charges
- Provider's billing name, address, and telephone number
- Provider's Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, an auto Accident, or another Accident (if applicable)
- Assignment of benefits (if applicable)

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third-Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. If Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veterans Administration Hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all the information that is necessary in order to process the claim. Claims received after the timely filing period will not be allowed.

INCORRECTLY FILED CLAIMS (Applies to Pre-Service Claims only)

If a Covered Person or Personal Representative attempts to, but does not properly, follow the Plan's procedures for requesting prior authorization, the Plan will notify the person and explain the proper procedures within five calendar days following receipt of a Pre-Service Claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Personal Representative.

HOW HEALTH BENEFITS ARE CALCULATED

When UMR receives a claim for a service that has been provided to a Covered Person, it will determine if the service is a covered benefit under this group health Plan. If the service is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If the service is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to the billed charges, a Negotiated Rate, the Reasonable Reimbursement, or based on the Usual and Customary amounts, minus any Deductible, Plan Participation rate, Co-pay, or penalties that the Covered Person is responsible for paying.

Negotiated Rate: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service, such as transplant services, Durable Medical Equipment, Extended Care Facility treatment, or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Co-pay, Deductible, Plan Participation rate, or penalties that the Covered Person is responsible for paying. If a network contract is in place, the network contract determines the Plan's Negotiated Rate.

Modifiers or Reducing Modifiers, if Medically Necessary. These terms apply to services and procedures performed on the same day and may be applied to surgical, radiological, and other diagnostic procedures. For a provider participating with a primary or secondary network, claims will be paid according to the network contract. For a provider who is not participating with a network, where no discount is applied, the industry guidelines are to allow the Reasonable Reimbursement or the Usual and Customary fee allowance for the primary procedure and a percentage of the Reasonable Reimbursement or Usual and Customary fee allowance for all secondary procedures. These allowances are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

The specific reimbursement formula used will vary depending upon the Physician or facility providing the service(s) and the type of service(s) received.

Usual and Customary (U&C) - reimbursement for covered services received from providers, including Physicians or health care facilities, who are not part of Your network are determined based on one of the following:

- Fee(s) that are negotiated with the Physician or facility; or
- The amount that is usually charged by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment based on the 100th percentile for Medicare allowable, 60% of billed charges (with approval) for non-Medicare allowable, or
- Using current publicly available data reflecting the costs for health care providers providing the same or similar services, adjusted for geographical differences plus a margin factor.

When covered health services are received from a non-network provider as a result of an Emergency or as arranged by Your plan administrator, eligible expenses are an amount negotiated by Your claims administrator or an amount permitted by law. Please contact Your plan administrator if You are billed for amounts in excess of Your applicable Plan Participation, Co-payment or any Deductible. The Plan will not pay excessive charges or amounts You are not legally obligated to pay.

See “Surgery and Assistant Surgeon Services” in the Covered Medical Benefits section for exceptions related to multiple procedures. A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

For services received from a non-network provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits. These providers charge their normal rates for services, so Covered Persons may need to pay more. Covered Persons are responsible for paying the balance of these claims after the Plan pays its portion, if any.

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person’s responsibility due to cost-sharing obligations, non-covered benefits, penalties, or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears to be correct. If You have any questions or concerns about the EOB form, call the Plan at the number listed on the EOB form or on the back of the group health identification card. The provider will receive a similar form for each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

UMR will process claims within the following timelines, although a Covered Person may voluntarily extend these timelines:

- Pre-Service Claims: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan may have an extra 15-day extension when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan may have an additional 15-day extension when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the coverage for the treatment ending or being reduced.
- Emergency and/or Urgent Care claims as defined by the Affordable Care Act: The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or Urgent Care as soon as possible, taking into account the Medical Necessity, but not later than 72 hours after the receipt of the claim by the Plan, and deference will be made to the treating Physician.

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims may be denied for any of the following reasons:

- Termination of Your employment.
- A Covered Person’s loss of eligibility for coverage under the health Plan.
- Charges are Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- A Covered Person reached the Maximum Benefit under this Plan.
- Amendment of the group health Plan.

- Termination of the group health Plan.
- The Employee, Dependent, or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- The Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations, or penalties.
- Application of the Reasonable Reimbursement, the Usual and Customary fee limits, the fee schedule, or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Procedures are considered Experimental, Investigational, or Unproven.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied, in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person may take to submit the claim for appeal (review).

If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental, Investigational, or Unproven treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or his or her Personal Representative may request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before taking any outside legal action.

- The Covered Person must file the appeal within 180 days of the date he or she received the EOB form from the Plan showing that the claim was denied. The Plan will assume the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- The Covered Person or his or her Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- The Covered Person may submit written comments, documents, records, and other information related to the claim to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records, and other information submitted that relates to the claim. This will include comments, documents, records, and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or his or her Personal Representative must submit a written request for a second review within 30 calendar days following the date he or she received the Plan's decision regarding the first appeal. The Plan will assume the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- The Covered Person may submit written comments, documents, records, and other pertinent information to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records, and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.

- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on his or her rights to any other benefits under the Plan. If You have any questions regarding the voluntary level of appeal, including applicable rules, a Covered Person's right to representation (i.e., to appoint a Personal Representative), or other details, please contact the Plan.

Appeals should be sent within the prescribed time period as stated above to the following address(es).

Note: Post-Service Appeal Request forms are available at www.umr.com to assist You in providing all the recommended information to ensure a full and fair review of Your Adverse Benefit Determination. You are not required to use this form.

Send Post-Service Claim Medical appeals to:
UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

Send Pre-Service Claim Medical appeals to:
UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

This Plan contracts with various companies to administer different parts of this Plan. A Covered Person who wants to appeal a decision or a claim determination that one of these companies made should send appeals directly to the company that made the decision being appealed. This includes the RIGHT TO EXTERNAL REVIEW.

Send Pharmacy appeals to:
NAVITUS HEALTH SOLUTIONS
361 INTEGRITY DR
MADISON WI 53717

TIME PERIODS FOR MAKING DECISIONS ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where the Plan is unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

URGENT CLAIM APPEALS THAT REQUIRE IMMEDIATE ACTION

A request by a Covered Person or his or her authorized representative for the review and reconsideration of coverage that requires notification or approval prior to receiving medical care may be considered an urgent claim appeal. Urgent claim appeals must meet one or both of the following criteria in order to be considered urgent in nature:

- A delay in treatment could seriously jeopardize life or health or the ability to regain maximum functionality.
- In the opinion of a Physician with knowledge of the medical condition, a delay in treatment could cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

UMR must respond to the urgent claim appeal request as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receiving the request for review.

The timelines below will apply only to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- Pre-Service Claims: Within a reasonable period of time appropriate to the medical circumstances, but no later than 30 calendar days after the Plan receives the request for review.
- Post-Service Claims: Within a reasonable period of time, but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

RIGHT TO EXTERNAL REVIEW

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program applies only if the Adverse Benefit Determination involves:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven services;
- Determinations related to Your entitlement to a reasonable alternative standard for a reward under a Wellness Program;
- Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits); or
- Other requirements of applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a pre-determination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to You after You have exhausted the appeals process identified above and You receive a decision that is unfavorable, or if UMR or Your employer fails to respond to Your appeal within the timelines stated above.

You may request an independent review of the Adverse Benefit Determination. Neither You nor UMR nor Your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request as indicated below.

Notice of the right to external review for Pre-Service appeals should be sent to:

UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

Alternatively, You may fax Your request to 888-615-6584, ATTN: UMR Appeals

Notice of the right to external review for Post-Service appeals should be sent to:

UMR
EXTERNAL REVIEW APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include: (1) Your specific request for an external review; (2) the Employee's name, address, and member ID number; (3) Your designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

Any requests for an independent review must be made within 180 days of the date You receive the Adverse Benefit Determination. You or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a qualified medical care expense under the Plan. The Independent Review Organization (IRO) has been contracted by UMR and has no material affiliation or interest with UMR or Your employer. UMR will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by UMR and/or Your employer in making a decision on the case; and
- All other information or evidence that You or Your Physician has already submitted to UMR or Your employer.

If there is any information or evidence that was not previously provided and that You or Your Physician wishes to submit in support of the request, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information in order to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or Your employer with the reviewer's decision, a description of the qualifications of the reviewer, and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the claims administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person's coverage should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud, or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (e.g., COBRA notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. (Please note that the examples listed are not all-inclusive.)

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate claims. If someone else, such as the Covered Person's spouse or another family member, files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on his or her knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under his or her identity. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. He or she should answer all questions to the best of his or her knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

In order to maintain the integrity of this Plan, each Covered Person is encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under the Family and Medical Leave Act of 1993 (FMLA), his or her employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided the following conditions are met:

- Contributions are paid; and
- The Employee has a written, approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the FMLA and any amendment; or
- The leave period required by applicable state law.

An Employee may choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken. For more information, please contact Your Health Benefits or Personnel office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree, or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy, at no charge, of the written procedures that the Plan uses when administering Qualified Medical Child Support Orders.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Physician (i.e., Your Physician, nurse, midwife, or physician assistant) after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain precertification. For information on precertification, contact Your plan administrator.

This group health Plan also complies with the provisions of the:

- Americans With Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- Genetic Information Non-discrimination Act (GINA).

The Plan Sponsor has opted out of complying with the following federal regulations as is allowed by law for governmental or church group health plans:

- Mental Health Parity Act.

HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care, and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan will Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care, or Health Care Operations.

The Plan Sponsor will Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care, or Health Care Operations that it performs on behalf of this Plan.

This Plan agrees that it will Disclose a Covered Person's PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will Use and Disclose a Covered Person's PHI (including Electronic PHI) only for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;

- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not Use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Each Covered Person has the right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books, and records related to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of Plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees, or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Clark County Risk Management

This list includes every Employee, class of Employees, or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violation, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions, and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy, and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a person to whom the CE Discloses Protected Health Information (PHI) so that a person may carry out, assist with the performance of, or perform a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third-Party Administrators, health care clearinghouses, data processing firms, billing firms, and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse, or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Person's PHI. This includes medical records, billing records, enrollment records, Payment records, claims adjudication records, and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of six years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities related to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management, and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk related to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health condition of a Covered Person, the provision of health care, or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person, or there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan, including quality assurance, claims processing, auditing, and monitoring.

Plan Sponsor means Your employer.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic, or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend, or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the relevant facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, alternatively, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals of no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or the Third-Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy, will be excluded from any benefit consideration.

The Plan will assume that the Covered Person receives the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed to the Covered Person.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Contact Your Health Benefits or Personnel office for information regarding distribution of assets upon termination of Plan.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as, a contract of employment between any Covered Person and the employer.

GLOSSARY OF TERMS

ABA / IBI / Autism Spectrum Disorder Therapy means intensive behavioral therapy programs used to treat Autism Spectrum Disorder. These programs are often referred to as Intensive Behavioral Intervention (IBI), Early Intensive Behavioral Intervention (EIBI), or Applied Behavior Analysis (ABA). These interventions aim to reduce problem behaviors and develop alternative behaviors and skills in those with Autism Spectrum Disorder. In a typical therapy session, the Child is directed to perform an action. Successful performance of the task is rewarded with a positive reinforcer, while noncompliance or no response receives a neutral reaction from the therapist. For Children with maladaptive behaviors, plans are created to utilize the use of reinforcers to decrease problem behavior and increase more appropriate responses. Although once a component of the original Lovaas methodology, aversive consequences are no longer used. Parental involvement is considered essential to long-term treatment success; parents are taught to continue behavioral modification training when the Child is at home, and may sometimes act as the primary therapist.

Accident means an unexpected, unforeseen, and unintended event that causes bodily harm or damage to the body.

Activities of Daily Living (ADL) means the following, with or without assistance: bathing, dressing, toileting, and associated personal hygiene; transferring (moving in or out of a bed, chair, wheelchair, tub, or shower); mobility; eating (getting nourishment into the body by any means other than intravenous); and continence (voluntarily maintaining control of bowel and/or bladder function, or, in the event of incontinence, maintaining a reasonable level of personal hygiene).

Acupuncture means a technique used to deliver anesthesia or analgesia, or to treat conditions of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

Advanced Imaging means the action or process of producing an image of a part of the body by radiographic techniques using high-end radiology such as MRA, MRI, CT, or PET scans and nuclear medicine.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Alternate Facility means a health care facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

- Surgical services;
- Emergency services; or
- Rehabilitative, laboratory, diagnostic, or therapeutic services.

Ambulance Transportation means professional ground or air Ambulance Transportation in an Emergency situation, or when deemed Medically Necessary, which is:

- To the closest facility most able to provide the specialized treatment required; and
- The most appropriate mode of transportation consistent with the well-being of You or Your Dependent.

Ancillary Services means services rendered in connection with care provided to treat a medical condition whether scheduled or unscheduled, including, but not limited to: surgery, anesthesia, diagnostic testing, and imaging or therapy services. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency.

Birthing Center means a legally operating institution or facility that is licensed and equipped to provide immediate prenatal care, delivery services and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24-hour nursing care provided by registered nurses or certified nurse midwives.

Child (Children) means any of the following individuals with respect to an Employee: a natural biological Child; a natural child of the covered grandfathered Domestic Partner; a stepchild; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Employee's or spouse's Legal Guardianship; or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Close Relative means a member of the immediate family. Immediate family includes the Employee, spouse, mother, father, grandmother, grandfather, stepparents, step-grandparents, siblings, stepsiblings, half-siblings, Children, stepchildren, grandchildren, grandfathered Domestic Partner, Children of the grandfathered Domestic Partner.

Co-pay means the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits, if applicable.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to qualifying events.

Common-Law Marriage means a partnership whereby two adult individuals are considered married because they have lived together for a certain period of time, hold themselves to be married even without a license and a formal ceremony, and meet other applicable requirements of the state in which the Common-Law Marriage was established.

Cosmetic Treatment means medical or surgical procedures that are primarily used to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expense means any expense, or portion thereof, that is Incurred as a result of receiving a covered benefit under this Plan.

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

Custodial Care means non-medical care given to a Covered Person, such as administering medication and assisting with personal hygiene or other Activities of Daily Living, rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered health care provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce a disability or improve the condition of a Covered Person.

Deductible means an amount of money paid once per Plan Year by the Covered Person (up to a family limit, if applicable) before any Covered Expenses are paid by the Plan. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent – see the Eligibility and Enrollment section of this SPD.

Developmental Delays means conditions that are characterized by impairment in various areas of development, such as social interaction skills, adaptive behavior, and communication skills. Developmental Delay may not necessarily have a history of birth trauma or other Illness that could be causing the impairment, such as a hearing problem, mental Illness, or other neurological symptoms or Illness.

Domestic Partner / Domestic Partnership means an unmarried person of the same sex with whom the covered Employee shares a committed relationship, who is jointly responsible for the other's welfare and financial obligations, who is at least 18 years of age, who is not related by blood, who maintains the same residence, and who is not married to or legally separated from anyone else.

In order for Your Domestic Partner to qualify as a Dependent, You and Your partner must complete a certification declaring that You and Your partner:

- Are in a relationship of mutual support, care, and commitment, and are responsible for each other's welfare;
- Have maintained this relationship for the past six months and intend to do so indefinitely;
- Have shared a primary residence for the past six months and intend to do so indefinitely;
- Are not married to anyone else and do not have other Domestic Partners;
- Are financially interdependent.

Durable Medical Equipment means equipment that meets all of the following criteria:

- It can withstand repeated use.
- It is primarily used to serve a medical purpose with respect to an Illness or Injury.
- It is generally not useful to a person in the absence of an Illness or Injury.
- It is appropriate for use in the Covered Person's home.

A cochlear implant is not considered Durable Medical Equipment.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as his or her Enrollment Date, as Enrollment Date is defined by the Plan.

Emergency means a serious medical condition, with acute symptoms that require immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Employee – see the Eligibility and Enrollment section of this SPD.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the date that coverage begins. **(Applies to Elected Officials)**
- For anyone who applies for coverage when first eligible, the first day of the Waiting Period. **(Applies to All Other Employees)**
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the first day coverage begins.

Experimental, Investigational, or Unproven means any drug, service, supply, care, or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational, or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials OR at least one or more large, controlled, national, multi-center, population-based studies;

- Items based on anecdotal and Unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care or treatment is considered Experimental, Investigational, or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility means a facility including, but not limited to, a skilled nursing, rehabilitation, convalescent, or subacute facility. It is an institution or a designated part of an institution that is operating pursuant to the law for such an institution and is under the full-time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: provide 24-hour-per-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; not be a place primarily for Custodial Care; require compensation from its patients; admit patients only upon Physician orders; have an agreement to have a Physician's services available when needed; maintain adequate medical records for all patients; and have a written transfer agreement with at least one Hospital, be licensed by the state in which it operates, and provide the services to which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Gender Dysphoria means a disorder characterized by the following diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association:

Diagnostic criteria for adults and adolescents:

- A marked incongruence exists between one's experienced/expressed gender and one's assigned gender, of at least six months' duration, as manifested by at least two of the following:
  - A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics).
  - A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
  - A strong desire for the primary and/or secondary sex characteristics of the other gender.
  - A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
  - A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
  - A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).

  The condition must be associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Diagnostic criteria for children:

- A marked incongruence exists between one's experienced/expressed gender and one's assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be the criterion shown in the first bullet below):
  - A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
  - In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
  - A strong preference for cross-gender roles in make-believe play or fantasy play.
  - A strong preference for the toys, games, or activities stereotypically used or engaged in by the other gender.
  - A strong preference for playmates of the other gender.
  - In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
  - A strong dislike of one's sexual anatomy.
  - A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.

  The condition must be associated with clinically significant distress or impairment in social, school, or other important areas of functioning.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information, among other things.

Home Health Care means a formal program of care and intermittent treatment that is: performed in the home; prescribed by a Physician; intermittent care and treatment for the recovery of health or physical strength under an established plan of care; prescribed in place of a Hospital or an Extended Care Facility stay or results in a shorter Hospital or Extended Care Facility stay; organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Plan means a formal, written plan made by the Covered Person's attending Physician that is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for a Covered Person suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours per day, 7 days per week; is certified by Medicare as a Hospice Care Agency; and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services, medical social worker services, psychological and dietary counseling, Physician services, physical or occupational therapy, home health aide services, pharmacy services, and Durable Medical Equipment.

Hospital means a facility that:

- Is a licensed institution authorized to operate as a Hospital by the state in which it is operating; and
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- Is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency or, if outside the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- Continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, the term "Hospital" also includes Surgical Centers and Birthing Centers licensed by the states in which they operate.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy, or complication of pregnancy. The term "Illness," when used in connection with a newborn Child, includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Incurred means the date on which a service or treatment is given, a supply is received, or a facility is used, without regard to when the service, treatment, supply, or facility is billed, charged, or paid.

Independent Contractor means someone who signs an agreement with the employer as an Independent Contractor, or an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer, and who retains control over how work is completed. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor will be made consistent with Section 530 of the Internal Revenue Code.

Infertility Treatment means services, tests, supplies, devices, or drugs that are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is performed in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams performed to prepare for induced conception; surgical reversal of a sterilized state that was a result of a previous surgery; sperm-enhancement procedures; direct attempts to cause pregnancy by any means, including, but not limited to: hormone therapy or drugs; artificial insemination; in vitro fertilization; gamete intrafallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury means a physical harm or disability to the body that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. The term "Injury" does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at a Hospital. A person is not Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made. Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas, including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation, and mathematical reasoning. Specific Learning Disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling, and level of intelligence.

Legal Guardianship / Legal Guardian means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Life-Threatening Disease or Condition means a condition likely to cause death within one year of the request for treatment.

Manipulation means the act, process, or instance of manipulating a body part by manual examination and treatment, such as in the reduction of faulty structural relationships by manual means and/or the reduction of fractures or dislocations or the breaking down of adhesions.

Maximum Benefit means the maximum amount or the maximum number of days or treatments that are considered a Covered Expense by the Plan.

Medically Necessary / Medical Necessity means health care services provided for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Injury, mental illness, substance use disorder, condition, or disease or its symptoms, that generally meet the following criteria as determined by us or our designee, within our sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice*; and
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for Your Illness, Injury, mental illness, substance use disorder, or disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Is the most appropriate care, supply, or drug that can be safely provided to the member and is at least as likely as an alternative service or sequence of services to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, disease, or symptoms; and

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment, or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment, or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion will be within our sole discretion.

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards, and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to Covered Persons by calling UMR at the telephone number on the Plan ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act, as amended.

Mental Health Disorder means a syndrome that is present in an individual and that involves clinically significant disturbance in behavior, emotion regulation, or cognitive functioning. These disturbances are thought to reflect a dysfunction in biological, psychological, or developmental processes that are necessary for mental functioning.

Morbid Obesity means a condition in which an individual 18 years of age or older has a Body mass Index of 40 or more, or 35 or more if experiencing health conditions directly related to his or her weight, such as high blood pressure, diabetes, sleep apnea, etc.

Multiple Surgical Procedures means that more than one surgical procedure is performed during the same period of anesthesia.

Negotiated Rate means the amount that providers have contracted to accept as payment in full for Covered Expenses of the Plan.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, or too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliance means a brace, splint, cast, or other appliance that is used to support or restrain a weak or deformed part of the body, that is designed for repeated use, that is intended to treat or stabilize a Covered Person's Illness or Injury or improve function, and that is generally not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services, or supplies in a facility in which a patient is not registered as a bed patient and for whom room and board charges are not Incurred.

Palliative Foot Care means the cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventive maintenance care or debridement, such as cleaning and soaking of the feet and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

Pediatric Services means services provided to individuals under the age of 19.

Physician means any of the following licensed practitioners, acting within the scope of his or her license in the state in which he or she practices, who performs services payable under this Plan: a doctor of medicine (MD), doctor of medical dentistry, including an oral surgeon (DMD), doctor of osteopathy (DO); doctor of podiatric medicine (DPM); doctor of dental surgery (DDS); doctor of chiropractic (DC); doctor of optometry (OPT). Subject to the limitations below, the term "Physician" also includes the following practitioner types: physician assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), or certified registered nurse anesthetist (CRNA), when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which he or she practices, the services being provided are within his or her scope of practice, and the services are payable under this Plan.

Placed for Adoption / Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means the CLARK COUNTY, NEVADA Group Health Benefit Plan.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means an employer who sponsors a group health plan.

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug that could be a medication or supply for the person for whom it is prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom it is prescribed. It must also identify the name, strength, quantity, and directions for use of the medication or supply prescribed.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive / Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive / Routine is based upon the recommendation of the Centers for Disease Control and Prevention. Preventive / Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

Primary Care Physician means a Physician engaged in family practice, general practice, non-specialized internal medicine (i.e., one who works out of a family practice clinic), pediatrics, obstetrics/gynecology, or the treatment of mental health/substance use disorders, or a Physician assistant / nurse practitioner regardless of specialty or practice type. Generally, these Physicians provide a broad range of services. For instance, family practitioners treat a wide variety of conditions for all family members; general practitioners provide routine medical care; internists treat routine and complex conditions in adults; and pediatric practitioners treat Children.

Private Duty Nursing (PDN) means continuous and skilled care by a registered nurse (RN) or licensed practical nurse (LPN) under the direction of a qualified practitioner for a medical condition that requires more than four continuous hours of skilled care that can be provided safely outside of an institution. It does not include care provided while confined at a Hospital, Extended Care Facility, or other Inpatient facility; care to help with Activities of Daily Living, including, but not limited to, dressing, feeding, bathing, or transferring from a bed to a chair; or Custodial Care.

Prudent Layperson means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered, and/or certified in accordance with applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

Qualified Provider means a provider duly licensed, registered, and/or certified by the state in which he or she is practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan.

Reasonable Reimbursement means the amount the Plan determines to be the reasonable charge, allowing for variance of reimbursement among provider types and geographical adjustments where market conditions suggest it appropriate.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic Treatment when a physical impairment exists and the surgery restores or improves function.

Retired Employee / Retiree means a person who was employed full-time by the employer who is no longer regularly at work and who is now retired under the employer's formal retirement program.

Specialist means a Physician, or other Qualified Provider, if applicable, who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Physicians who are not considered Specialists include, but are not limited to, those specified in the definition of Primary Care Physician above.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever a patient is in the center:

- It provides drug services as needed for medical operations and procedures performed;
- It provides for the physical and emotional well-being of the patients;
- It provides Emergency services;
- It has organized administration structure and maintains statistical and medical records.

Telehealth means the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications and that is billed by a Physician.

Telemedicine means the clinical services provided to patients through electronic communications utilizing a vendor.

Temporomandibular Joint Disorder (TMJ) means a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third-Party Administrator (TPA) means a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled means, as determined by the Plan in its sole discretion:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is qualified by education, training, or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.

Urgent Care means the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have Injuries or Illnesses that require immediate care but are not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross-section of accurate data.

Waiting Period means the period of time that must pass before coverage becomes effective for an Employee or Dependent who is otherwise eligible to enroll under the terms of this Plan. Refer to the Eligibility and Enrollment section of this Plan to determine if a Waiting Period applies.

Walk-In Retail Health Clinics means health clinics located in retail stores, supermarkets, or pharmacies that provide a limited scope of preventive and/or clinical services to treat routine family Illnesses. Such a clinic must be operating under applicable state and local regulations and overseen by a Physician where required by law.

You / Your means the Employee.

DENTAL

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CLARK COUNTY, NEVADA

GROUP DENTAL BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information in English on benefits available under this Plan, as well as with information on a Covered Person's rights and obligations under the CLARK COUNTY, NEVADA Group Dental Benefit Plan (the "Plan"). You are a valued Employee of CLARK COUNTY, NEVADA, and Your employer is pleased to sponsor this Plan to provide benefits that can help meet Your dental care needs. Please read this document carefully and contact Your Health Benefits or Personnel office if You have questions or if You have difficulty translating this document.

CLARK COUNTY, NEVADA is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of an independent Third-Party Administrator, UMR, Inc. (hereinafter “UMR”) to process claims and handle other duties for this self-funded Plan. UMR, as the Third-Party Administrator, does not assume liability for benefits payable under this Plan, since it is solely a claims-paying agent for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits.

Some of the terms used in this document begin with capital letters, even though it normally would not be capitalized. These terms have special meaning under the Plan. Most capitalized terms will be listed in the Glossary of Terms, but some terms are defined within the provisions in which they are used. Becoming familiar with the terms defined in the Glossary of Terms will help You to better understand the provisions of this Plan.

Each Individual covered under this Plan will be receiving an identification card that he or she may present to providers whenever he or she receives services. On the back of this card are phone numbers to call in case of questions or problems.

This document contains information on the benefits and limitations of the Plan and will serve as both the Summary Plan Description (SPD) and Plan Document. Therefore it will be referred to as both the SPD and the Plan Document.

This document became effective on January 1, 2022.

PLAN INFORMATION

Plan Name	CLARK COUNTY, NEVADA GROUP DENTAL BENEFIT PLAN
Name And Address Of Employer	CLARK COUNTY, NEVADA 500 S GRAND CENTRAL PKWY LAS VEGAS NV 89155
Name, Address, And Phone Number Of Plan Administrator	CLARK COUNTY, NEVADA 500 S GRAND CENTRAL PKWY LAS VEGAS NV 89155 702-455-4544
Named Fiduciary	CLARK COUNTY, NEVADA
Claims Appeal Fiduciary For Dental Claims	UMR
Employer Identification Number Assigned By The IRS	88-6000028
Type Of Benefit Plan Provided	Self-funded Health and Welfare Plan providing group dental benefits.
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for dental claims.
Name And Address Of Agent For Service Of Legal Process	KIMBERLY BUCHANAN CLARK COUNTY, NEVADA 500 S GRAND CENTRAL PKWY / DISTRICT ATTORNEY LAS VEGAS NV 89155
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual’s Effective Date and runs through December 31 of the same Benefit Plan Year.
Compliance	It is intended that this Plan comply with all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law will be deemed controlling, and any conflicting part of this Plan will be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator will perform its duties as the Plan Administrator, and in its sole discretion, will determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator will have full and sole discretionary authority to interpret all Plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator will be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third-Party Administrators for this Plan. Any interpretation, determination, or other action of the Plan Administrator or the Third-Party Administrators will be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third-Party Administrators will be based only on such evidence presented to or considered by the Plan Administrator or the Third-Party Administrators at the time they made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third-Party Administrators make, in their sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

SCHEDULE OF BENEFITS

Benefit Plan 002

Benefits for You and Your Dependents are listed below.

This coverage provides for the use of a Preferred Provider Organization (PPO). Certain benefits are paid at different levels if the service is not provided by a Participating Provider.

SUMMARY OF BENEFITS	PPO PROVIDER (In-Network)	NON-PPO PROVIDER (Out-of-Network)
Co-Pay Per Tooth Or Unit:		No Benefit
• Crowns, Inlays, And Fixed Prosthodontics	$25	
Maximums:	**Individual**	No Benefit
• Calendar Year Benefit Maximum, Including Preventive Services And Diagnostic Services, Basic Services, Major Services, And Orthodontic Services, Dependent Children Only	$2,000	
Participation Percentage	**The Plan Pays**	
• **Preventive Services And Diagnostic Services:**	100%	No Benefit
Routine Cleanings And Fluoride Treatments. Oral Exams And Bitewing And Full-Mouth X-Rays. Refer To Covered Expenses For Any Limitations.		
• **Basic Services:**		No Benefit
Fillings, Endodontics, Periodontics (Scaling And Root Planing Only), And Oral Surgery. Refer To Covered Expenses For Any Limitations.	100%	
Periodontics (Except Scaling And Root Planing). Refer To Covered Expenses For Any Limitations.	80%	
• **Major Services:**	100%	No Benefit
Inlays, Onlays And Crowns, Bridges, Dentures. Refer To Covered Expenses For Any Limitations.		
• **Orthodontic Services:**	80%	No Benefit
Orthodontic Diagnosis, Treatment, And Appliances. Refer To Covered Expenses For Any Limitations.		
Limitations And Exclusions:		
Refer To General Exclusions.	Not Payable	Not Payable

OUT-OF-POCKET EXPENSES AND MAXIMUMS

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or Usual and Customary amounts, as applicable.

ADDITIONAL OUT-OF-POCKET EXPENSES

In addition to the Deductible, if applicable, and Plan Participation percentage, the Covered Person is also responsible for the following costs:

- Co-pays.
- Any remaining charges due to the provider after the Plan's benefits are determined.
- Full charges for services that are not covered benefits under this Plan.
- Penalties, legal fees, and interest charged by a provider.
- The difference between the provider's contracted fee for the service that was actually provided and the fee for the alternate benefit that the Plan approved.

  For example, if the provider placed a resin (white) filling in Your tooth, but an amalgam (silver) filling would have been sufficient to restore the tooth, You will need to pay the difference between the cost of the resin filling and the cost of the amalgam filling.

INDIVIDUAL CALENDAR YEAR MAXIMUM BENEFIT

All Covered Expenses will count toward the Covered Person's individual dental Calendar Year Maximum Benefit that is shown on the Schedule of Benefits, as applicable.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses may not be waived by a provider under any "fee forgiveness," "not out-of-pocket," or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person's claim may be denied and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. From time to time, the Plan may request documentation from You or Your Dependents in order to make determinations for continuing eligibility. The coverage choices that will be offered to You will be the same choices offered to other, similarly situated Employees.

WAITING PERIOD (Applies to All Other Employees)

If eligible, You must complete a Waiting Period before coverage becomes effective for You and Your Dependents. A Waiting Period is a period of time that must pass before an Employee or Dependent becomes eligible for coverage under the terms of this Plan.

You are eligible for coverage on the date listed below under the Effective Date section, upon completion of 60 calendar days of continuous employment in a covered position.

The start of Your Waiting Period is the first full day of employment for the job that made You eligible for coverage under this Plan.

ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full-time 30 or more hours per week, and participants meeting the below criteria are also benefit eligible:

- 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.
- 20-hour benefited positions at UMC (University Medical Center).

But for purposes of this Plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion:

- Leased Employees.
- Independent Contractors as defined in this Plan.
- Consultants who are paid on other than a regular wage or salary basis by the employer.
- Members of the employer's Board of Directors, owners, partners, unless engaged in the conduct of the business on a full-time, regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, which may be combined with the employer's short-term disability policy, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. Employees who meet eligibility requirements during a measurement period as required by the Affordable Care Act (ACA) regulations will have been deemed to have met the eligibility requirements for the resulting stability period as required by the ACA regulations. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a Third-Party, whether by a court, governmental agency, or otherwise, without regard to whether or not the employer agrees to such reclassification, will change a person's eligibility for benefits.

An eligible Employee who is covered under this Plan and who retires under the employer's formal retirement plan will be eligible to continue participating in the Plan upon retirement, provided the individual continues to make the required contribution. See the Coordination of Benefits section for more information on how this Plan coordinates with Medicare coverage. Retirees may continue coverage under this Plan until death, non-payment of premium, or if they no longer meet the eligibility requirements, whichever occurs first. A surviving Spouse of a Retired Employee is eligible to remain on the plan until death or non-payment of premium provided such spouse was covered under the Plan at the time of the Retired Employee's death.

Employees who retire from participating Employers under the Plan, and the Retired Employee's dependents, are eligible to continue Plan coverage at the time of Retiree's retirement, on a contributory basis. To retain coverage upon retirement the Retiring Employee, or the Employee's spouse if the Employee is physically incapacitated, must enroll for continued Plan coverage within 31 days of retirement. Failure to enroll within 31 days of retirement will cause coverage to terminate.

Employees who retire from participating Employers under the Plan, and who did not elect to continue Plan coverage at the time of retirement, or the surviving spouse of such a Retired Employee who is deceased, may re-enroll in Plan coverage in January of any even numbered year as provided by Nevada Revised Statute 287.0205. Only a surviving spouse, who was a Plan Participant under the Plan at some point during the Retired Employee's lifetime, is eligible for enrollment under this provision.

Retiree Reinstatement

Retirees of a Plan Participant Employer are eligible to re-instate coverage with this Plan in January of an even numbered year, as provided by NRS 287.0205, so long as:

- The retiree was covered by the Plan on the last day of his or her active employment with the Participant Employer;
- The Participant Employer was the retiree's last public employer;
- The retiree has retired into a defined benefit retirement plan, sponsored by the Participant Employer, including but not limited to PERS; and
- The retiree complies with the requirements of NRS 287.0205 to seek reinstatement.

This provision shall be interpreted and applied in harmony with NRS 287.0205 and where NRS 287.0205 is in conflict with this provision, NRS 287.0205 will control, being interpreted to extend to the retirees of the Non-PERS participating Employers who are Participant Employers under this Plan.

Retiree / Dependent Reinstatement Enrollment:

The following enrollment process must be completed, and documentation received by Clark County Risk Management no later than January 31st, of an even numbered year.

- 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 birth certificate for each child being reinstated will be required.
- 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. Non-PERS participating Employers shall collect retiree premiums on behalf of the Plan and deliver the premium payments to the Plan on behalf of the Non-PERS retirees.

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

Note: Eligible Employees and Dependents who decline to enroll in this Plan must state so in writing. In order to preserve potential special enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or health insurance policy. Proof of such plan or policy may be required upon application for special enrollment. See the Special Enrollment Provision section of this Plan.

An **eligible Dependent** includes:

- Your legal spouse, provided he or she is not covered as an Employee under this Plan. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator. An Employee's spouse who is not a United States Citizen is not eligible for coverage, unless the individual is a lawful resident actively seeking permanent residency in the United States.

- Your Domestic Partner, as long as he or she meets the definition of Domestic Partner as stated in the Glossary of Terms, and the person is not covered as an Employee under this Plan. When a person no longer meets the definition of Domestic Partner, that person no longer qualifies as Your Dependent. Anyone enrolled as a domestic partner on 12/31/2021 is considered grandfathered into the future (until noticed otherwise). NEW domestic partnerships post on 1/1/2022 will not be eligible for coverage.

- A Dependent Child until the Child reaches his or her 26th birthday. The term "**Child**" includes the following Dependents:

  - A natural biological Child;
  - A stepchild;
  - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state, or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
  - A Child under Your (or Your spouse's) Legal Guardianship as ordered by a court. Birth to age 18 only. Coverage is only available to guardianship children for whom the Subscriber covered as a Dependent on December 31, 2010;
  - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO);
  - A natural child of the covered grandfathered Domestic Partner.

- A Dependent does not include the following:

  - A foster Child;
  - A Child of a Domestic Partner or a Child under Your Domestic Partner's Legal Guardianship;
  - A grandchild;
  - A Domestic Partner;
  - A Dependent Child if the Child is covered as a Dependent of another Employee at this company;
  - Any other relative or individual unless explicitly covered by this Plan.

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage. The Plan Administrator, at the administrator's discretion, may require documentation such as certified marriage certificates, grandfathered domestic partner registrations, divorce decrees, social security identification, tax returns, certified birth certificates, adoption decrees, or copies of certified court orders.

Eligibility Criteria: To be an eligible Totally Disabled Dependent Child, a Totally Disabled Dependent Child age 26 or over must be dependent upon the Employee for more than 50 percent of his or her support and maintenance. This financial requirement does not apply to Children who are enrolled in accordance with a Qualified Medical Child Support Order because of the Employee's divorce or separation decree.

NON-DUPLICATION OF COVERAGE: Any person who is covered as an eligible Employee will not also be considered an eligible Dependent under this Plan.

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have an obligation to notify the Plan should the Dependent's eligibility status change during the Plan Year. Please notify Your Health Benefits Department regarding status changes.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
- The Dependent Child is a Dependent of an Employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a special enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 31 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of a Totally Disabled Dependent, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Continuation of Coverage section in this document.

Employees have the right to choose which eligible Dependents are covered under the Plan.

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of the following dates:

- If You apply within Your Waiting Period, Your coverage will become effective the first day of the month following the date You complete Your Waiting Period. If Your Waiting Period ends on the first day of the month, Your coverage will not begin until the first day of the following month; or **(Applies to All Other Employees)**

- If You are an Elected Official, You and Your eligible Dependents will be covered under this Plan effective on the date You take the oath of office, so long as You comply with the Plan's Enrollment Requirements within 31 days of the date the oath of office is taken; or **(Applies to Elected Officials)**

- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 60 calendar days of the event for marriage, birth or adoption and within 31 calendar days in the case of a loss of coverage.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of the following dates:

- The date Your coverage under the Plan begins if You enroll the Dependent at that time; or

- The date You acquire Your Dependent if application is made within 60 calendar days of acquiring the Dependent for marriage, birth or adoption and within 31 calendar days in the case of a loss of coverage; or

- The date set forth under the Special Enrollment Provision if Your Dependent is eligible to enroll under the Special Enrollment Provision and application is made within 60 calendar days following the event for marriage, birth or adoption and within 31 calendar days in the case of a loss of coverage; or

- The date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

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 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.

ANNUAL OPEN ENROLLMENT PERIOD

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Covered Employees and covered Retirees will be able to make changes in coverage for themselves and their eligible Dependents.

(Applies to All Other Employees) Coverage Waiting Periods are waived during the annual open enrollment period for covered Employees, covered Retirees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If You and/or Your Dependent becomes covered under this Plan as a result of electing coverage during the annual open enrollment period, the following will apply:

- The employer will notify eligible Employees prior to the start of an annual open enrollment period; and

- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person’s coverage; and

- The Effective Date of coverage will be January 1 following the annual open enrollment period.

SPECIAL ENROLLMENT PROVISION

LOSS OF DENTAL COVERAGE

If You or Your Dependents lose other dental insurance or group dental coverage and are otherwise eligible under this Plan, and did not enroll when first eligible because You or Your Dependents had other dental coverage, then You or Your Dependents may enroll for dental coverage under this Plan if You meet the following conditions:

- You or Your Dependents were covered under a group dental plan or dental insurance policy at the time coverage under this Plan was first offered; and
- You or Your Dependents stated in writing that You declined coverage due to coverage under another group dental plan or dental insurance policy; and
- The coverage under the other group dental plan or dental insurance policy was:
  - Under a federal COBRA continuation provision and that coverage was exhausted; or
  - Under another type of coverage and that coverage terminated as a result of:
    - Loss of eligibility for the coverage due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment; or
    - The current or former employer no longer contributing toward the coverage; and
  - Not terminated due to the person's failure to pay timely premiums or for cause, such as making a fraudulent claim or an intentional misrepresentation of material fact.

You or Your Dependent must apply for coverage under this Plan no later than 60 calendar days following the event for marriage, birth or adoption and within 31 calendar days in the case of a loss of coverage after the date the other coverage ended.

You and/or Your Dependents were covered under a Medicaid plan or state child health plan and coverage for You or Your Dependents was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

NEWLY ELIGIBLE FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

A current Employee and his or her Dependents may be eligible for a special enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependents are determined to be eligible for such assistance.

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries, and other eligible persons have special opportunities to enroll for coverage under this Plan if they experience changes in family status.

If a person becomes an eligible Dependent through marriage, attestation of a grandfathered Domestic Partnership, birth, adoption, or Placement for Adoption, the Employee, spouse, and newly acquired Dependent(s) who are not already enrolled may enroll for health coverage under this Plan during a special enrollment period. The Employee must request and apply for coverage within 60 calendar days of the marriage, attestation of a grandfathered Domestic Partnership, birth, adoption, or Placement for Adoption, and within 31 calendar days in the case of a loss of coverage.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective as follows:

- In the case of marriage, on the first day of the month following the date the completed request for enrollment and supporting documentation is received by the Plan (note that eligible individuals must submit their enrollment forms prior to the Effective Dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or

- In the case of a Dependent's birth, on the date of such birth. 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 affirmatively enrolled as a Dependent in the plan; or

- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or

- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the first day of the month following the date the completed request for enrollment and supporting documentation is received by the Plan; or

- In the case of loss of coverage, the first day of the month following the date the completed request for enrollment and supporting documentation is received by the Plan.

RELATION TO SECTION 125 CAFETERIA PLAN

This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Please refer to the employer's Section 125 Cafeteria Plan for more information.

TERMINATION

For information about continuing coverage, refer to the COBRA Continuation of Coverage section of this SPD.

EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment or at annual open enrollment periods; or
- The end of the stability period in which You became a member of a non-covered class, as determined by the employer except as follows:
    - If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave for up to the end of the six (6) calendar month period that next follows the month in which the person last worked as an Active Employee, provided the applicable Employee contribution is paid when due. 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.
    - If You are temporarily absent from work due to disability leave, the date the Employer ends the continuance.
    - If You are temporarily absent from work as a furloughed Employee, the Plan Administrator may extend Plan coverage to Employees who have been furloughed by a participating entity as a result of a decline in the economy or workload. The responsible entity shall continue to remit the full cost of the premium to the Plan for the period of time the member is furloughed. A member is eligible for continued coverage for a period not to exceed 24-months as a result of his/her furlough status. A member is considered in furlough status when he/she is in an continuous unpaid status for a specified period.
    - If You are temporarily absent from work due to active military duty, refer to USERRA under the Uniformed Services Employment and Reemployment Rights Act of 1994 section; or
- The last day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other fraudulent act related to this Plan or any other group plan.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The day of the month in which Your coverage ends; or

- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state in which You reside; or

- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility and Enrollment section; or

- If Your Dependent Child qualifies for extended Dependent coverage because he or she is Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or

- The last day of the month in which Your Dependent Child no longer satisfies a required eligibility criterion listed in the Eligibility and Enrollment Section; or

- The date Dependent coverage is no longer offered under this Plan; or

- The last day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment or at annual open enrollment periods; or

- The last day of the month in which the Dependent becomes covered as an Employee under this Plan; or

- The date You or Your Dependent submits a false claim or is involved in any fraudulent act related to this Plan or any other group plan.

EXTENSION OF BENEFITS

If coverage terminates for a Covered Person 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 excludes orthodontia.

COBRA CONTINUATION OF COVERAGE

NOTE: UMR (the claims administrator) does not administer the benefits or services described within this provision. Please contact the benefit manager or Your employer with any questions related to this coverage or service.

Important: Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You and Your Dependents need to do to protect the right to receive it. When You become eligible for COBRA, You may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You or Your Dependents as required.

You may have other options available to You when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, You may qualify for lower costs on Your monthly premiums and lower out-of-pocket costs. Additionally, You may qualify for a 30-day special enrollment period for another group health plan for which You are eligible (such as a spouse's plan), even if that plan generally does not accept Late Enrollees.

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits (including dental benefits) beyond the date that they might otherwise lose coverage. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event (outlined below). When a Qualifying Event causes (or will cause) a Loss of Coverage, the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage, even if You or Your Dependent is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

If You are an Employee, You will become a Qualified Beneficiary if You lose coverage under the Plan because either one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• Your employment ends for any reason other than Your gross misconduct	up to 18 months
• Your hours of employment are reduced	up to 18 months

(There are two ways in which this 18-month period of COBRA continuation coverage may be extended. See the section below entitled "The Right to Extend the Length of COBRA Continuation Coverage" for more information.)

The spouse of an Employee will become a Qualified Beneficiary if he or she loses coverage under the Plan because any one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• The Employee dies	up to 36 months
• The Employee's hours of employment are reduced	up to 18 months
• The Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
• The Employee and spouse become divorced or legally separated	up to 36 months

The Dependent Children of an Employee will become Qualified Beneficiaries if they lose coverage under the Plan because any one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• The parent-Employee dies	up to 36 months
• The parent-Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The parent-Employee's hours of employment are reduced	up to 18 months
• The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
• The parents become divorced or legally separated	up to 36 months
• The Child loses eligibility for coverage under the Plan as a Dependent	up to 36 months

Note: A spouse or a Dependent Child newly acquired through birth or adoption during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A Dependent other than a newborn or newly adopted Child, who is acquired and enrolled after the original Qualifying Event is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

COBRA NOTICE PROCEDURES

THE NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

In order to be eligible to receive COBRA continuation coverage, covered Employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Employee and spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrator, whether to Your employer or to the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information (a form for notifying the COBRA Administrator is available upon request):

- The Qualified Beneficiary's name, current address, and complete phone number,
- The group number and the name of the Employee's employer,
- A description of the Qualifying Event (i.e., the life event experienced), and
- The date the Qualifying Event occurred or will occur.

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes to the addresses of family members. Keep copies of all notices You send to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your employer will give notice to the COBRA Administrator when coverage terminates due to the Employee's termination of employment or reduction in hours, the death of the Employee, or the Employee's becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days of when one of these events occurs.

EMPLOYEE OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of divorce or legal separation of the Employee and a spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar-day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would be a Loss of Coverage) due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, the covered Employee, or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE GROUP DENTAL COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that should be completed in order to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of his or her election in writing in order to continue group dental coverage and must make the required payments when due in order to remain covered. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group dental coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, group dental coverage will be reinstated retroactively to the date coverage was lost, provided the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will become effective on the date the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and Employee contributions. This cost may also include a 2% additional fee to cover administrative expenses (or, in the case of the 11-month extension due to disability, a 50% additional fee). The cost of continuation coverage is subject to change at least once per year.

If Your employer offers annual open enrollment opportunities for active Employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage. However, the Qualified Beneficiary will receive specific payment information, including due dates, when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA Administrator receives a check that is missing information or contains discrepancies regarding the information on the check (e.g., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary with information regarding what needs to be done to correct the mistake.

Note: Payment will not be considered made if a check is returned for non-sufficient funds.

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, written notice to the COBRA Administrator is required within 30 calendar days of the date any one of the following events occurs:

- The Qualified Beneficiary marries. Refer to the Special Enrollment Provision section of this SPD for additional information regarding special enrollment rights.

- A Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment Provision section of this SPD for additional information regarding special enrollment rights.

- A final determination is made by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.

- Any Qualified Beneficiary becomes covered by another group dental plan.

Additionally, if the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information in the timeframe outlined in the request document.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- For Employees and Dependents: 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent Children will be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)

- For Dependents only: 36 months from the Qualifying Event if coverage is lost due to one of the following events:

  - The Employee's death.
  - The Employee's divorce or legal separation.
  - The former Employee's enrollment in Medicare.
  - A Dependent Child's loss of eligibility as a Dependent as defined by the Plan.

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided written notice is given to the COBRA Administrator as soon as possible, but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA, in the event that the Social Security Administration determines the Qualified Beneficiary to be disabled either before becoming eligible for, or within the first 60 days of being covered by, COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the Qualified Beneficiary has non-disabled family members who are also Qualified Beneficiaries, those non-disabled family members are also entitled to the disability extension.

The Qualified Beneficiary must give the COBRA Administrator a copy of the Social Security Administration letter of disability determination before the end of the initial 18-month period and within 60 days of the later of:

- The date of the Social Security Administration disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA.

If the Social Security Administration determines the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Events (Dependents Only): If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family who are Qualified Beneficiaries may receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent Children who are Qualified Beneficiaries if the Employee or former Employee dies, becomes entitled to Medicare (Part A, Part B, or both) or is divorced or legally separated, or if the Dependent Child loses eligibility under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event or in the case of a newborn Child being added as a result of a HIPAA special enrollment right. Dependents acquired during COBRA continuation (other than newborns and newly adopted Children) are not eligible to continue coverage as the result of a subsequent Qualifying Event. These events will lead to the extension only when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

You or Your Dependents must provide the notice of a second Qualifying Event to the COBRA Administrator within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

There may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or other group health plan coverage (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

In general, if You do not enroll in Medicare Part A or B when You are first eligible because You are still employed, after the Medicare initial enrollment period You have an eight-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of (a) the month after Your employment ends, or (b) the month after group health plan coverage based on current employment ends.

If You do not enroll in Medicare and elect COBRA continuation coverage instead, You may have to pay a Part B late enrollment penalty and You may have a gap in coverage if You decide You want Part B later. If You elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate Your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if You enroll in the other part of Medicare after the date of the election of COBRA coverage. If You are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (as the primary payer) and COBRA continuation coverage will pay second. For more information visit https://www.medicare.gov/medicare-and-you.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group dental plan for any Employees. (Note that if the employer terminates the group dental plan under which the Qualified Beneficiary is covered, but still maintains another group dental plan for other, similarly-situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group dental plan, although benefits and costs may not be the same.)

- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled in Medicare.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan.

- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.

- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE

If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the Qualified Beneficiary will lose his or her special enrollment rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the Qualified Beneficiary since it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After COBRA continuation coverage is exhausted, the Qualified Beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange, in accordance with his or her HIPAA special enrollment rights.

DEFINITIONS

Qualified Beneficiary means a person covered by this group dental Plan immediately before a Qualifying Event. A Qualified Beneficiary may be an Employee, the spouse of a covered Employee, or the Dependent Child of a covered Employee. This includes a Child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the Child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted Children. This also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered Employee.
- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).
- A reduction in work hours of the covered Employee.
- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)
- The covered former Employee becomes enrolled in Medicare.
- A Dependent Child no longer qualifies as a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before a Qualifying Event. Loss of Coverage includes a change in coverage terms, a change in plans, termination of coverage, partial Loss of Coverage, an increase in Employee cost, and other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after a Qualifying Event, but must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA rights.

CONTINUED COVERAGE FOR DOMESTIC PARTNERS

Domestic Partners do not qualify as Qualified Beneficiaries under federal COBRA law. Therefore, under federal law, a Domestic Partner does not have the right to elect COBRA independently and separately from an eligible Employee.

However, this Plan allows Domestic Partners to elect to continue coverage under a "COBRA-like" extension, separately and independently of eligible Employees, subject to the same terms and conditions that are outlined for Qualified Beneficiaries under COBRA, when a Qualifying Event occurs.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

The Plan Administrator:
CLARK COUNTY, NEVADA
500 S GRAND CENTRAL PKWY
LAS VEGAS NV 89155

The COBRA Administrator

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in a loss of coverage. Employees on leave for military service must be treated as if they are on leaves of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leaves of absence or furloughs. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave. Reinstatement following a military leave of absence may not be subject to Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is the lesser of:

- 24 months beginning on the day that the uniformed service leave begins, or
- A period beginning on the day that the service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if giving notice is otherwise impossible or unreasonable under the circumstances.

Upon notice of intent to leave for uniformed service, Employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election of, payment for, and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Continuation of Coverage section, to the extent the COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. For periods of 31 days or longer, if an Employee elects to continue dental coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENTLY

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will be deemed eligible for the COBRA extension only because they are not eligible for a separate, independent right of election under USERRA.

PROVIDER NETWORK

The word **"Network"** means an organization that has contracted with various providers to provide dental care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the Negotiated Rates as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Plan Participation amounts, or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing to which Network a provider belongs will help a Covered Person determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons should receive services from in-network providers; however, this Plan does not limit a Covered Person's right to choose his or her own provider of dental care at his or her own expense if a dental expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

A provider may enter into an agreement to provide only certain covered dental services, but not all covered dental services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the covered dental services and products included in the participation agreement, and a non-Network provider for other covered dental services and products. The participation status of providers may change from time to time.

To find out to which Network a provider belongs, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan’s identification card. The participation status of providers may change from time to time.

The preferred provider organization is Sierra Dental.

PROVIDER DIRECTORY INFORMATION

Each covered Employee, COBRA participant, and Child or guardian of a Child who is considered an alternate recipient under a Qualified Medical Child Support Order will automatically be given or electronically provided a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in his or her household. If a covered spouse or Dependent wants a separate provider list, he or she may make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

Information on participating providers can also be accessed at the following website:

www.umr.com

ALTERNATE BENEFITS PROVISION

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

For example, if a regular amalgam (silver) filling is sufficient to restore a tooth, but the patient and the Dentist decide to use a resin (white) filling, the Plan will base its payment on the Usual and Customary charge or the maximum fee schedule for the amalgam filling. The patient will be responsible for paying the difference in cost.

PRE-TREATMENT ESTIMATE OF BENEFITS

One of the advantages of this dental Plan is that it enables a Covered Person to see the amount payable by the Plan prior to having the Dentist begin any extensive treatment. Through this process, Covered Persons can prevent any misunderstandings as to what is covered by the Plan. A Covered Person can accurately estimate what he or she will owe the Dentist. This procedure is known as "Pre-Treatment Estimate of Benefits." Here is how the process works:

Usually, before beginning any extensive treatment, the Covered Person will be advised as to what the Dentist intends to do. This plan of action is referred to as the Treatment Plan. The Dentist will submit the Treatment Plan to UMR prior to performing the services. UMR will then notify the Covered Person and the Dentist, in advance, regarding what benefits are payable under this Plan, and how much the Covered Person will be responsible for paying.

Obtaining a Pre-Treatment Estimate of Benefits is recommended whenever a Dentist's estimated charge is $300 or more. This feature is not mandatory; however, dental care can be expensive. A Covered Person may want to have an idea of how much this Plan will pay before agreeing to have the treatment performed.

Note: The Pre-Treatment Estimate of Benefits is not a guarantee of payment and is valid for 12 months after the notice date. Benefits are payable if coverage is in effect on the date the services are performed (subject to all Plan provisions) and if the claim is submitted to the Plan within the timely filing period. If additional procedures are performed, the claim will be reviewed in its entirety.

COVERED EXPENSES

The Plan will pay for the following Covered Expenses Incurred by a Covered Person, subject to any Deductibles, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits, and to all other provisions as stated in this SPD. Benefits are based on the Usual and Customary charge, fee schedule, or Negotiated Rate. Any procedure that is not specifically listed as covered is excluded.

General Overview:

This Plan provides dental benefits under several categories of dental services. Within each category, there are a number of subcategories of covered services.

PREVENTIVE SERVICES

- Cleanings (routine prophylaxis) - limited to two per calendar year.
- Topical fluoride treatments. A cleaning performed with a fluoride treatment is a separate dental service.
- Space maintainers - fixed appliances to maintain a space created by the premature loss of a primary tooth or teeth.

DIAGNOSTIC SERVICES

- Oral exams - limited to two per calendar year.
- Full-mouth X-rays - limited to one per calendar year, unless necessary due to an Injury, combined with panoramic / panorex X-rays and bitewing X-rays.
- Panoramic / panorex X-rays - limited to one per calendar year, unless necessary due to an Injury, combined with full-mouth X-rays and bitewing X-rays.
- Bitewing X-rays - limited to one per calendar year, combined with full-mouth X-rays and panoramic /panorex X-rays.
- Ancillary - emergency oral exams and palliative treatment for relief of dental pain.
- X-rays – all other dental X-rays when Medically Necessary as part of the treatment of a Covered Expense.

BASIC SERVICES

An alternate benefit may apply to specific services. Refer to the Alternate Benefits section in this SPD for more details.

- Restorative fillings – amalgam, silicate, acrylic, synthetic porcelain, and composite fillings.
- Preformed stainless steel crowns – limited to Dependent Children with deciduous primary teeth only.
- Endodontics – root canal treatments, root canal fillings, pulp vitality tests, and other related procedures.
- Periodontics – debridement and exams, and other related procedures necessary to treat a disease of the supporting tissues of the teeth. Periodontal splinting is not a covered expense.

- Periodontal maintenance.
- Oral surgery – extractions and other oral surgery including preoperative and postoperative care.
- Local anesthesia when Medically Necessary.
- General anesthesia – when administered by a Dentist due to oral or dental surgery when Medically Necessary.
- Rebase procedures for denture or bridges -limited to two per calendar year. Not covered during the first six months after initial placement.
- Reline procedures for dentures or bridges - limited to two per calendar year. Not covered during the first six months after initial placement.

Limitations for Basic Services

Reline procedures for dentures or bridges are not covered until You have been covered under the Plan for 12 consecutive months.

MAJOR SERVICES

An alternate benefit may apply to specific services. Refer to the Alternate Benefits section in this SPD for more details.

The alternate benefit of a filling may be applied if there is not enough evidence to support major decay or traumatic Injury.

If two or more teeth are missing in the same arch or two or more bridges are being performed in the same arch, an alternate benefit of a partial denture may be applied.

- Inlays or onlays.
- Crowns.
- Installation of removable or fixed bridgework.
- Installation of partial and complete dentures, including six-month post-installation care.

Limitations for Major Restorative Services

Major services are not covered until You have been covered under the Plan for 12 consecutive months.

Replacement of a bridge or denture will be covered only if the appliance was installed at least five years prior to its replacement. This provision will not apply if:

- Replacement is Medically Necessary due to the placement of an initial opposing full denture;
- Replacement is Medically Necessary due to the extraction of additional natural teeth. Such extraction must leave the bridge or partial denture unserviceable;
- The bridge or denture is damaged beyond repair while in the oral cavity. The Injury must occur while You are covered under this Plan; or
- The existing denture is a temporary denture, placed while You were covered under this Plan. Replacement by a permanent denture must be required and performed within 12 months of the date the temporary denture was placed.

Expenses Incurred for prosthodontic services performed on teeth other than permanent teeth are not covered.

Expenses Incurred at any time to replace a bridge or denture that meets, or can be made to meet, commonly held dental standards of functional acceptability are not covered.

The initial installation of a bridge or denture, replacing natural teeth that were extracted prior to Your effective date, is not covered. Such installation will be covered if Medically Necessary due to the loss or extraction of additional natural teeth after Your effective date.

ORTHODONTIC BENEFITS PROVISION

The Plan will pay Covered Expenses for Orthodontic Procedures. This benefit is subject to Medical Necessity and all other Plan provisions.

DEPENDENT CHILD LIMITATION

This provision applies only to an eligible Dependent Child who is from age 8 to 19 on the date the Orthodontic Procedure begins. This provision does not apply to You or Your spouse. Benefits will terminate under this provision for a Dependent Child on the date such Child turns age 19.

ORTHODONTIC PROCEDURE

Orthodontic Procedure means movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth. Orthodontic Procedure includes minor treatment to control harmful habits and diagnostic services (casts, consultations, exams, X-rays, and related photos taken by the Dentist).

ORTHODONTIC TREATMENT PLAN

The Treatment Plan is a Dentist's report, on a form satisfactory to the Plan, that:

- Provides a classification of the malocclusion;
- Recommends and describes necessary treatment by Orthodontic Procedures;
- Estimates the duration over which treatment will be completed;
- Estimates the total charge for such treatment; and
- Is accompanied by cephalometric X-rays, study models, and such other supporting evidence as the Plan may reasonably require.

COVERED ORTHODONTIC EXPENSES

In order to be payable, orthodontic treatment must be needed for one or more of the following conditions:

- Overbite or overjet of at least four millimeters; or
- Upper and lower arches in either protrusive or retrusive relation of at least one cusp; or
- Cross-bite; or
- An arch length difference of more than four millimeters in either the upper or lower arch.

Orthodontic services are not covered until You have been covered under the Plan for 12 consecutive months.

ADDITIONAL PROVISION

This provision will not apply to any charges for an Orthodontic Procedure if the active orthodontic appliance is placed before the Covered Person is eligible for benefits under this provision. A 12-month Waiting Period applies.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has dental coverage under more than one Plan, as defined below. It does not, however, apply to prescription benefits. The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules determine which plan will pay first (i.e., which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and the Secondary Plan does not exceed the Covered Expenses Incurred. Up to total of 100% of charges Incurred may be paid between the plans.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group dental plans, whether insured or self-insured.
- Group health plans, whether insured or self-insured.
- Specified disease policies.
- Foreign policies.
- Medical coverage related to dental care under group or individual automobile policies (including no-fault policies). See the order of benefit determination rules (below).
- Medicare or other governmental benefits, as permitted by law, not including Medicaid.

However, this Plan does not coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges will not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule that will apply:

- The plan that has no coordination of benefits provision is considered primary.

- When medical payments related to dental care are available under motor vehicle insurance (including no-fault policies), this Plan will always be considered secondary regardless of the individual's election under Personal Injury Protection (PIP) coverage with the auto carrier.

- If an individual is covered under one plan as a dependent and another plan as an employee, member, or subscriber, the plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) is considered primary. This does not apply to COBRA participants. See continuation coverage below. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any Employee plan beneficiary to be eligible for primary benefits from his or her employer's benefit plan.

- The plan that covers a person as a dependent is generally secondary. The plan that covers a person as a dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a dependent. See continuation coverage below.

- If an individual is covered under a spouse's plan and also under his or her parent's plan, the Primary Plan is the plan that has covered the person for the longer period of time. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parent's plans, the plan of the parent or spouse whose birthday falls earlier in the calendar year is the Primary Plan. If the parents and/or spouse have the same birthday, the plan that has covered the parent or spouse for the longer period of time is the Primary Plan.

- If one or more plans cover the same person as a dependent child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide dental care coverage.

    If both parents have the same birthday, the plan that has covered either of the parents the longest is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the child's dental care expenses or dental care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.

  - If the parents are not married and reside separately, or are divorced or legally separated (whether or not they have ever been married), the order of benefits is:

    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the non-custodial parent; and then
    - The plan of the spouse of the non-custodial parent.

- Active or Inactive Employee: If an individual is covered under one plan as an active employee (or dependent of an active employee), and is also covered under another plan as a retired or laid-off employee (or dependent of a retired or laid-off employee), the plan that covers the person as an active employee (or dependent of an active employee) will be primary. This rule does not apply if the rule in the third paragraph (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

- Continuation Coverage Under COBRA or State Law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies.

- Longer or Shorter Length of Coverage: The plan that has covered the person as an employee, member, subscriber, or retiree the longest is primary.

- If an active employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active employee, member, or subscriber is considered primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses may be shared equally between the plans. This Plan will not pay more than it would have paid had it been primary.

TRICARE

If an eligible Employee is on active military duty, TRICARE is the only coverage available to that Employee. Benefits are not coordinated with the Employee's dental insurance plan.

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD-PARTY ORGANIZATION

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as if it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than the Plan should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid, or from any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

The Plan has a right to subrogation and reimbursement. References to “You” or “Your” in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any Third-Party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any Third-Party for the benefits that the Plan has paid that are related to the Illness or Injury for which any Third-Party is considered responsible.

The right to reimbursement means that if it is alleged that any Third-Party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any Third-Party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor in a Workers’ Compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners’, or otherwise), Workers' Compensation coverage, other insurance carriers, or Third-Party administrators.
- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any Third-Party.
- Any person or entity that is liable for payment to You on any equitable or legal theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan’s legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any Third-Party for acts that caused benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or Injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any Third-Party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect Third-Party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any Third-Party before You receive payment from that Third-Party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible Third-Party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You, Your representative, Your estate, Your heirs, or Your beneficiaries, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, punitive, and any other alleged damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.

- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.

- If You receive any payment from any party as a result of Illness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.

- By participating in and accepting benefits from the Plan, You agree that:

  - Any amounts recovered by You from any Third-Party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
  - You and Your representative will be fiduciaries of the Plan with respect to such amounts; and
  - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.

- The Plan's rights to recovery will not be reduced due to Your own alleged negligence.

- By participating in and accepting benefits from the Plan, You agree to assign to the Plan any benefits, claims, or rights of recovery You have under any automobile policy (including no-fault benefits, Personal Injury Protection benefits, and/or medical payment benefits), under other coverage, or against any Third-Party, to the full extent of the benefits the Plan has paid for the Illness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, You acknowledge and recognize the Plan's right to assert, pursue, and recover on any such claim, whether or not You choose to pursue the claim, and You agree to this assignment voluntarily.

- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other Third-Party; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds, or any other recovery, by You, Your estate, the personal representative of Your estate, Your heirs, Your beneficiaries, or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by any Third-Party. If a parent or guardian may bring a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.

- If any Third-Party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.

- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any Third-Party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect Third-Party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

GENERAL EXCLUSIONS

The Plan does not pay for expenses Incurred for the following, even if deemed to be Medically Necessary, unless otherwise stated below. The Plan does not apply exclusions to treatment listed in this SPD as covered dental benefits based upon the source of the Injury when the Plan has information that the Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

1. **Acts of War:** Illness or Injury caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

2. **Appointments Missed:** Appointments the Covered Person did not attend.

3. **Athletic Mouth Guards.**

4. **Before Effective Date and After Termination:** Services, supplies, or expenses Incurred before coverage begins or after coverage ends under this Plan.

5. **Congenital:** Care of a congenital or developmental malformation, including congenitally missing teeth.

6. **Cosmetic:** Services or treatment for cosmetic purposes as determined by the Plan, including, but not limited to bleaching. This exclusion does not apply to Accidental Dental Injury or to orthodontic services.

7. **Denture Duplication.**

8. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical or dental reports and itemized bills.

9. **Excess Charges:** Charges or the portion thereof that are in excess of the Usual and Customary charge, the Negotiated Rate, or the fee schedule.

10. **Experimental or Investigational, or Unproven:** Services, supplies, medicines, treatment, facilities, or equipment that the Plan determines are Experimental, Investigational, or Unproven, including administrative services associated with Experimental, Investigational, or Unproven treatment.

11. **Fractures:** Treatment of fractures not including teeth or alveolar processes.

12. **Illegal Acts:** Charges for an injury or illness caused wholly, partially, directly or indirectly by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. In compliance with the Health Insurance Portability and Accountability Act, if an injury results from a medical condition or act of domestic violence, the plan will not deny benefits for the injury. A medical condition includes both physical and mental illnesses.

13. **Implants** and related services.

14. **Initial Installation of a Complete or Partial Denture,** fixed bridgework, if treatment involves replacing one or more natural teeth missing or lost prior to the date the Covered Person became covered under this Plan.

15. **Interest and Legal Fees.**

16. **Medications,** whether prescription or over-the-counter, other than those administered while in the Dentist's office as part of treatment.

17. **Military:** A military-related Illness of or Injury to a Covered Person on active military duty, unless payment is legally required.

18. **Multiple Surgical and Periodontal Procedures** in the same area. Benefits will be limited to the most extensive and inclusive procedure.

19. **Myofunctional Therapy.**

20. **Not Medically Necessary:** Services, supplies, treatment, facilities, or equipment that the Plan determines are not Medically Necessary.

21. **Occupational and/or Work Related:** Any condition for which the Plan Participant has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose, or is otherwise deemed by Statute to be care or treatment compensable under the Nevada Industrial Insurance Act commencing at NRS Chapter et seq. However, if the Plan provides benefits for any such condition, the Plan Administrator will be entitled to establish a lien upon such other benefits up to the amount paid.

22. **Orthodontic Services,** unless covered elsewhere in this document.

23. **Orthognathic Surgery,** unless covered elsewhere in this document.

24. **Preventive Control Programs** including oral hygiene instruction; plaque control; dietary planning; lab tests; anaerobic culture, except in connection with periodontal disease; sensitivity testing; and bite registrations.

25. **Professionally Recognized Standards:** Procedures that are not necessary and that do not meet professionally-recognized standards of care.

26. **Programs** for oral hygiene or plaque control.

27. **Replacement** of lost, missing, or stolen appliances regardless of any other provision of this Plan.

28. **Services At No Charge or Cost:** Services for which the Covered Person would not be obligated to pay in the absence of this Plan or that are available to the Covered Person at no cost, or for which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.

29. **Services Not Furnished By a Dentist or Dental Hygienist** who is acting under a Dentist's supervision and direction, except for X-rays ordered by a Dentist.

30. **Services Provided By a Close Relative.** See the Glossary of Terms section of this SPD for a definition of "Close Relative."

31. **Splints** unless necessary as the result of an Accidental Injury.

32. **Supplies** for plaque control or oral hygiene that can be purchased over-the-counter.

33. **Treatment** for the purpose of altering vertical dimension, restoring occlusion, splinting, or replacing tooth structure lost as a result of abrasion, attrition, or erosion, unless covered elsewhere in this document.

34. **Treatment of Disturbances** of the temporomandibular joint, craniomandibular dysfunctions, myofascial pain syndrome, or any other disorder of the joint linking the jaw to the skull and the associated muscles. This exclusion also pertains to temporomandibular joint radiographs.

Benefits not specifically included in the Covered Expenses section of this document are considered excluded.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who may contact the Plan on the Covered Person's behalf to help with claims, appeals, or other benefit issues. A minor Dependent must have the signature of a parent or Legal Guardian in order to appoint a Third-Party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: the name of the Personal Representative, the date and duration of the appointment, and any other pertinent information. In addition, the Covered Person must agree to grant his or her Personal Representative access to his or her Protected Health Information. The Covered Person should contact the Claims Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, the Covered Person will need to send the claim to the Plan within the timelines outlined below in order to receive reimbursement. The address for submitting medical claims is on the back of the group dental identification card.

A Covered Person who receives services in a country other than the United States is responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse the Covered Person for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if the paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person's/patient's ID number, name, sex, date of birth, address, and relationship to Employee
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services, or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient's account number (if applicable)
- Total billed charges
- Provider's billing name, address, and telephone number
- Provider's Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, an auto accident, or another accident (if applicable)
- Assignment of benefits (if applicable)

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third-Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. If Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veteran's Administration hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all the information that is necessary in order to process the claim. Claims received after the timely filing period will not be allowed.

HOW DENTAL BENEFITS ARE CALCULATED

When UMR receives a claim for a service that has been provided to a Covered Person, it will determine if the service is a covered benefit under this group dental Plan. If the service is not a covered benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If the service is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to the billed charges, a Negotiated Rate, or based on the Usual and Customary amounts minus any Deductible, Plan Participation rate, Co-pay, or penalties that the Covered Person is responsible for paying.

Negotiated Rate: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service. The Negotiated Rate is what the Plan will pay to the provider, minus any Deductible, Plan Participation rate, or penalties that the Covered Person is responsible for paying. If a network contract is in place, the network contract determines the Plan's Negotiated Rate.

(Applies to Benefit Plan(s) 001) Usual And Customary (U&C) is the amount that is usually charged by dental care providers in the same geographical area (or greater area, if necessary) for the same services, treatment or materials. An industry fee file is used to determine U&C fee allowances. The U&C level is at the 90th percentile of MDR. As it relates to charges made by a network provider, the term "Usual and Customary" means the Negotiated Rate as contractually agreed to by the provider and network (see above)

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties, or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears to be correct. If You have any questions or concerns about the EOB form, call the Plan at the number listed on the EOB form or on the back of the group dental identification card. The provider will receive a similar form for each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

UMR will process claims within the following timelines, although a Covered Person may voluntarily extend these timelines:

Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan may have an additional 15-day extension when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims may be denied for any of the following reasons:

- Termination of Your employment.
- A Covered Person's loss of eligibility for coverage under the dental Plan.
- Charges are Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- A Covered Person reached the Maximum Benefit under this Plan.
- Amendment of the group dental Plan.
- Termination of the group dental Plan.
- The Employee, Dependent, or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- The Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations, or penalties.
- Application of the Usual and Customary fee limits, the fee schedule, or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Procedures are considered Experimental, Investigational, or Unproven.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied, in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person may take to submit the claim for appeal (review).

If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental, Investigational, or Unproven treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim, the Covered Person or his or her Personal Representative may request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before taking any outside legal action.

- The Covered Person must file the appeal within 180 days of the date he or she received the EOB form from the Plan showing that the claim was denied. The Plan will assume the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- The Covered Person or his or her Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- The Covered Person may submit written comments, documents, records, and other information related to the claim to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records, and other information submitted that relates to the claim. This will include comments, documents, records, and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based, in whole or in part, on a dental judgment, the Plan will consult with a dental care professional with training and experience in the relevant dental field. This dental care professional may not have been involved in the original denial decision and may not be supervised by the dental care professional who was involved. If the Plan has consulted with dental or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or his or her Personal Representative must submit a written request for a second review within 30 calendar days following the date he or she received the Plan's decision regarding the first appeal. The Plan will assume the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- The Covered Person may submit written comments, documents, records, and other pertinent information to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records, and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.

- If the benefit denial was based, in whole or in part, on a dental judgment, the Plan will consult with a dental care professional with training and experience in the relevant dental field. This dental care professional may not have been involved in the original denial decision or first appeal, and may not be supervised by the dental care professional who was involved. If the Plan has consulted with dental or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on his or her rights to any other benefits under the Plan. If You have any questions regarding the voluntary level of appeal, including applicable rules, a Covered Person's right to representation (i.e., to appoint a Personal Representative), or other details, please contact the Plan.

Appeals should be sent within the prescribed time period as stated above to the following address(es).

Note: Appeal Request forms are available at www.umr.com to assist You in providing all the recommended information to ensure a full and fair review of Your Adverse Benefit Determination. You are not required to use this form.

Send dental appeals to:
UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

TIME PERIODS FOR MAKING DECISIONS ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where the Plan is unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

URGENT CLAIM APPEALS THAT REQUIRE IMMEDIATE ACTION

A request by a Covered Person or his or her authorized representative for the review and reconsideration of coverage that requires notification or approval prior to receiving medical care may be considered an urgent claim appeal. Urgent claim appeals must meet one or both of the following criteria in order to be considered urgent in nature:

- A delay in treatment could seriously jeopardize life or health or the ability to regain maximum functionality.
- In the opinion of a Physician with knowledge of the medical condition, a delay in treatment could cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

UMR must respond to the urgent claim appeal request as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receiving the request for review.

The timelines below will apply only to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

Post-Service Claims: Within a reasonable period of time, but no later than 60 calendar days after the Plan receives the request for review.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person's coverage should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud, or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (e.g., COBRA notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. (Please note that the examples listed are not all-inclusive.)

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate claims. If someone else, such as the Covered Person's spouse or another family member, files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on his or her knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek dental treatment under his or her identity. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. He or she should answer all questions to the best of his or her knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

In order to maintain the integrity of this Plan, each Covered Person is encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under the Family and Medical Leave Act of 1993 (FMLA), his or her employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided the following conditions are met:

- Contributions are paid; and
- The Employee has a written, approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the FMLA and any amendment; or
- The leave period required by applicable state law.

An Employee may choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources or Personnel office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree, or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy, at no charge, of the written procedures that the Plan uses when administering Qualified Medical Child Support Orders.

This group dental Plan also complies with the provisions of the TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.

HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care, and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan will Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care, or Health Care Operations.

The Plan Sponsor will Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care, or Health Care Operations that it performs on behalf of this Plan.

This Plan agrees that it will Disclose a Covered Person's PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will Use and Disclose a Covered Person's PHI (including Electronic PHI) only for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;

- The Plan Sponsor will promptly report to this Plan any breach or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not Use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Each Covered Person has the right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books, and records related to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of Plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees, or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Clark County Risk Management

This list includes every Employee, class of Employees, or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violation, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions, and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy, and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a person to whom the CE Discloses Protected Health Information (PHI) so that a person may carry out, assist with the performance of, or perform a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third-Party Administrators, health care clearinghouses, data processing firms, billing firms, and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse, or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Person's PHI. This includes medical or dental records, billing records, enrollment records, Payment records, claims adjudication records, and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of six years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities related to the renewal of a contract for insurance;
- Conducting or arranging for medical (or dental) review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management, and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk related to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health condition of a Covered Person, the provision of health care, or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person, or there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan, including quality assurance, claims processing, auditing, and monitoring.

Plan Sponsor means Your employer.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic, or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend, or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the relevant facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, alternatively, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals of no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or the Third-Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy, will be excluded from any benefit consideration.

The Plan will assume that the Covered Person receives the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed to the Covered Person.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Contact Your Health Benefits or Personnel office for information regarding distribution of assets upon termination of Plan.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as, a contract of employment between any Covered Person and the employer.

GLOSSARY OF TERMS

Accidental Dental Injury / Injury means damage to the mouth, teeth, and supporting tissues due directly to a blow from outside the mouth.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Calendar Year Maximum Benefit means the maximum amount of covered benefits payable during a calendar year while a person is covered under this Plan. Once the Calendar Year Maximum Benefit is met, no further covered benefits will be available for the remainder of that calendar year.

Child (Children) means any of the following individuals with respect to an Employee: a natural biological Child; a natural child of the covered grandfathered Domestic Partner; a stepchild; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Employee's or spouse's Legal Guardianship; or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Close Relative means a member of the immediate family. Immediate family includes the Employee, spouse, grandfathered Domestic Partner, mother, father, grandmother, grandfather, stepparents, step-grandparents, siblings, stepsiblings, half-siblings, Children, Children of grandfathered Domestic Partner, stepchildren, and grandchildren.

Co-pay means the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits, if applicable.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to qualifying events.

Common-Law Marriage means a partnership whereby two adult individuals are considered married because they have lived together for a certain period of time, hold themselves to be married even without a license and a formal ceremony, and meet other applicable requirements of the state in which the Common-Law Marriage was established.

Covered Expenses means any expense, or portion thereof, that is Incurred as a result of receiving a covered benefit under this Plan.

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

Deductible means an amount of money paid once per Plan Year by the Covered Person (up to a family limit, if applicable) before any Covered Expenses are paid by the Plan. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the dental care benefits to which it applies.

Dental Hygienist means a person who is licensed to practice dental hygiene and who works under the supervision and direction of a Dentist.

Dentist means a person who is licensed to practice dentistry, and who is practicing within the scope of such license. The term also includes any physician who furnishes any dental services that such physician is licensed to perform.

Dependent – see the Eligibility and Enrollment section of this SPD.

Domestic Partner / Domestic Partnership means an unmarried person of the same sex with whom the covered Employee shares a committed relationship, who is jointly responsible for the other's welfare and financial obligations, who is at least 18 years of age, who is not related by blood, who maintains the same residence, and who is not married to or legally separated from anyone else.

In order for Your Domestic Partner to qualify as a Dependent, You and Your partner must complete a certification declaring that You and Your partner:

- Are in a relationship of mutual support, care, and commitment, and are responsible for each other's welfare;
- Have maintained this relationship for the past six months and intend to do so indefinitely;
- Have shared a primary residence for the past six months and intend to do so indefinitely;
- Are not married to anyone else and do not have other Domestic Partners;
- Are financially interdependent.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as his or her Enrollment Date, as Enrollment Date is defined by the Plan.

Emergency Dental Care means care of a dental condition that is required unexpectedly and immediately because of an Injury or Illness.

Employee – see the Eligibility and Enrollment section of this SPD.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the date that coverage begins. **(Applies to Elected Officials)**
- For anyone who applies for coverage when first eligible, the first day of the Waiting Period. **(Applies to All Other Employees)**
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the first day coverage begins.

Experimental, Investigational, or Unproven means any drug, service, supply, care, or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational, or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials OR at least one or more large, controlled, national, multi-center, population-based studies;
- Items based on anecdotal and Unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care, or treatment is considered Experimental, Investigational, or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™, or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

FMLA means the Family and Medical Leave Act of 1993, as amended.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information, among other things.

Illness means a bodily disorder, disease, or physical sickness affecting the mouth, teeth, or gums.

Incurred means the date on which a service or treatment is given, a supply is received, or a facility is used, without regard to when the service, treatment, supply, or facility is billed, charged, or paid.

Independent Contractor means someone who signs an agreement with the employer as an Independent Contractor, or an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer, and who retains control over how work is completed. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor will be made consistent with Section 530 of the Internal Revenue Code.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Legal Guardianship / Legal Guardian means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Maximum Benefit means the maximum amount or the maximum number of days or treatments that are considered a Covered Expense by the Plan.

Medically Necessary / Medical Necessity means treatment, services, supplies, medicines, or facilities necessary and appropriate for the diagnosis, care, or treatment of an Illness or Injury that meet all of the following criteria as determined by the Plan:

- In accordance with *Generally Accepted Standards of Dental Practice*; and
- The health intervention is for the purpose of treating a dental condition; and
- It is the most appropriate supply or level of service, considering potential benefits and harm to the patient; and
- It is known to be effective in improving dental outcomes. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, and finally by expert opinion; and
- It is cost-effective for a specific condition, compared to alternate interventions, including the option of no intervention. The term "cost-effective" does not necessarily mean for the lowest price; and
- It is not primarily for the convenience or preference of the Covered Person, of the Covered Person's family, or of any provider; and

- It is not Experimental, Investigational, cosmetic, or custodial in nature; and
- It is currently, or at the time the charges were Incurred, recognized as acceptable medical practice by the Plan.

The fact that a Dentist has performed, prescribed, recommended, ordered, or approved a service, Treatment Plan, supply, medicine, equipment, or facility, or the fact that such service is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, Treatment Plan, supply, medicine, equipment, or facility Medically Necessary.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act, as amended.

Negotiated Rate means the amount that providers have contracted to accept as payment in full for Covered Expenses of the Plan.

Pediatric Dental Services means services provided to individuals under the age of 19.

Placed for Adoption / Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means the CLARK COUNTY, NEVADA Group Dental Benefit Plan.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means an employer who sponsors a group dental plan.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered, and/or certified in accordance with applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

Retired Employee / Retiree means a person who was employed full-time by the employer who is no longer regularly at work and who is now retired under the employer's formal retirement program.

Third-Party Administrator (TPA) means a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled means, as determined by the Plan in its sole discretion:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is qualified by education, training, or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in activities of daily living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.

Treatment Plan means the Dentist's report to the Plan that:

- Lists the dental care recommended by the Dentist for the Covered Person; and
- Shows the Dentist's normal fee for each dental procedure; and
- Includes preoperative X-rays and all other diagnostic materials needed by the Plan; and
- Is prepared on a form acceptable to the Plan.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross-section of accurate data.

Waiting Period means the period of time that must pass before coverage becomes effective for an Employee or Dependent who is otherwise eligible to enroll under the terms of this Plan. Refer to the Eligibility and Enrollment section of this Plan to determine if a Waiting Period applies.

You / Your means the Employee.

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

DATE: _____

ATTEST:

BY: _____
LYNN MARIE GOYA, County Clerk

ATTEST:

BY: _____
LYNN MARIE GOYA, County Clerk

ATTEST:

BY: _____
LYNN MARIE GOYA, County Clerk

ATTEST:

BY: _____
MARILYN SPIEGEL, Vice Chair

ATTEST:

BY: _____
JOHN ENTSMINGER, Secretary

ATTEST:

BY: _____
DEANNA HUGHES, Secretary

COUNTY OF CLARK

BY: _____
MARILYN KIRKPATRICK, Chair
Board of County Commissioners

CLARK COUNTY WATER RECLAMATION DISTRICT

BY: _____
TICK SEGERBLOM, Chair
Board of Trustees

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA

BY: _____
WILLIAM MCCURDY II, Chair
Board of Trustees

LAS VEGAS CONVENTION AND VISITORS AUTHORITY

BY: _____
JOHN MARZ, Chair
Board of Directors

LAS VEGAS VALLEY WATER DISTRICT

BY: _____
MARILYN KIRKPATRICK, President
Board of Directors

CLARK COUNTY REGIONAL FLOOD CONTROL DISTRICT

BY: _____
DEBRA MARCH, Chair
Board of Directors

ATTEST:

BY: _____
ANA DIAZ, Executive Secretary

ATTEST:

BY: _____
FERMIN LEGUEN, M.D.
District Health Officer or Designee

ATTEST:

BY: _____
TRUDY CASEY, Notary

ATTEST:

BY: _____
LYNN MARIE GOYA, County Clerk

ATTEST:

BY: _____
TANAKA WILSON

ATTEST:

BY: _____
LYNN MARIE GOYA, County Clerk

APPROVED AS TO FORM:

STEVEN B. WOLFSON, District Attorney

BY: _____
KIMBERLY BUCHANAN
Deputy District Attorney

REGIONAL TRANSPORTATION COMMISSION
OF SOUTHERN NEVADA

BY: _____
DEBRA MARCH, Chair
Board of Commissioners

SOUTHERN NEVADA HEALTH DISTRICT

BY: _____
SCOTT BLACK, Chair
Board of Health

HENDERSON DISTRICT PUBLIC LIBRARIES

BY: _____
DAVID ORTLIPP, Chair
Board of Trustees

MOUNT CHARLESTON FIRE PROTECTION DISTRICT

BY: _____
ROSS MILLER, Chair
Board of Fire Commissioners

LAS VEGAS METROPOLITAN POLICE DEPARTMENT

BY: _____
SHERIFF JOSEPH LOMBARDO

MOAPA VALLEY FIRE PROTECTION DISTRICT

BY: _____
MARILYN KIRKPATRICK, Chair
Board of Fire Commissioners