WASHOE COUNTY

PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION

Effective
January 1, 2020

CONTRACT ADMINISTRATOR

HOMETOWN HEALTH
10315 PROFESSIONAL CIRCLE
RENO, NV 89521

(775) 982-5425

INTRODUCTION

This document is both the Summary Plan Description and the Benefit Document for our benefit plan. We recommend that you take the time to review the contents of this document. In particular, we call the following to your attention:

- **PPO Plan** – The PPO Plan (Preferred Provider Organization) has a smaller calendar year deductible and co-payment features to the prescription benefit than the High Deductible Health Plan (HDHP).
- **High Deductible Health Plan (HDHP)** – Except for certain preventative care, the HDHP has a higher calendar year deductible that applies to medical and prescription drugs. The HDHP is compatible with a Health Savings Account (HSA) and Health Reimbursement Arrangement (HRA).
- Most health claims of the Plan are handled by a Contract Administrator. The name, address and phone number of that company is:

  Hometown Health
  10315 Professional Circle
  Reno, NV 89521
  (775) 982-5425 or (866) 988-5425

- Some of the terms used in the document begin with a capital letter. These terms have a special meaning under the Plan and are included in the **Definitions** section. When reading the provisions of this Plan, it may be helpful to refer to this section. Becoming familiar with the terms defined there will give you a better understanding of the benefits and provisions.
- This Plan is a self-insured program. This means that coverage is not provided by an insurance company. Your contributions and/or the County-paid contributions are used to pay claims.

Please read this document carefully. If you do not understand a benefit, exclusion, or if you have a question, contact Hometown Health at the phone number(s) shown above. Failure to request and review the terms and conditions of the group health Plan prior to enrollment may not be utilized as a basis for contending lack of awareness of, or familiarity with, or knowledge of, or being bound by the provisions of this group health Plan.

DIRECTORY OF SERVICE PROVIDERS

The following providers render services on behalf of the Plan. A Plan participant can contact the appropriate office when he or she has a question or needs help.

TYPE OF SERVICE	SERVICE PROVIDER
Medical Claims Contract Administrator Handles the processing of medical in accordance with the Washoe County Plan Document. A Covered Person can also obtain additional information about Plan coverage, treatment, procedures, preventative service, etc. from the Contract Administrator.	**Hometown Health** 10315 Professional Circle Reno, NV 89521 (775) 982-5425 or (866) 988-5425 www.hometownhealth.com
HSA/HRA Administrator	**American Fidelity Health Services** 9000 Cameron Parkway Oklahoma City, Oklahoma 73114 Phone: (866) 326-3600 Fax: (405) 523-5072 http://www.afhsa.com/
Pre-certification/Utilization Management/Case Management Provides Pre-Certification and Utilization Management services which are described on Page 1 under Utilization Management Program.	**Hometown Health Services** (775) 982-5425 or (866) 988-5425 www.hometownhealth.com
Preferred Provider Network for Medical Services Network of providers contracted to render services at discounted rates. *See Page 5 and/or Page 11 of this document for Out-of-Area provider network information*	**Hometown Health** (775) 982-5425 or (866) 988-5425 www.hometownhealth.com • Select "Find A Doctor" • Select "Self-Funded" Directory
Dental Claims Contract Administrator Handles the processing of dental claims in accordance with the Washoe County Plan Document. A Covered Person can also obtain additional information about Plan coverage, treatment, procedures, preventative service, etc. from the Contract Administrator.	**CDS Group Health** 1510 Meadow Wood Lane P.O. Box 50190 Sparks, NV 89435-0190 (775) 352-6900 / (800) 455-4236 www.cdsgrouphealth.com
Preferred Provider Network for Dental Services Network of providers contracted to render services at discounted rates. If Covered Person's dental Physician is not a Network provider, application for membership can be made with Guardian (800) 890-4774.	**Guardian Life Ins Company of America** (888) 600-9200 www.guardianlife.com
Prescription Drug Vendor Provides a Network of participating retail pharmacies where a Covered Person can obtain prescriptions by using their ID card. Provides information regarding formulary, mail order and out-of-network.	**MaxorPlus** (800) 687-0707 www.maxorplus.com
Telemedicine Service Provides access to US board-certified doctors, pediatricians and therapists by phone or video, 24 hours/day, 365 days/year	**Teladoc** (800) 835-2362 www.teladoc.com
Vision Service Plan Network of providers contracted to render services at discounted rates.	**VSP** (800) 877-7195 www.vsp.com
Washoe County Health Benefits	**Washoe County Human Resources** (775) 328-2081 www.washoecounty.us/humanresources/Benefits

SPECIAL NOTICES

NON-GRANDFATHERED PLAN

This Plan Sponsor complies with the requirements of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, together referred to as the Affordable Care Act (ACA) and all other applicable state and federal insurance laws, regulations and guidance effective on the date of publication of this Summary Plan Document. These laws, regulations and supporting guidance may change. Coverage under this Plan will remain in accordance with these laws, regulations and guidance as they are issued. The Plan participant may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under Federal law, the health benefits of most plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending physician and the patient: (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce symmetrical appearance, (3) breast prostheses, and (4) physical complications of all stages of mastectomy, including lymphedemas.

Plan participants must be notified, upon enrollment and annually thereafter, of the availability of benefits required due to the Women's Health and Cancer Rights Act (WHCRA).

NOTICE OF RIGHT TO RECEIVE A CERTIFICATE OF CREDITABLE COVERAGE

Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a "certificate of creditable coverage" or "certificate of group health plan coverage," from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates (including termination due to exhaustion of all lifetime benefits under the Plan), the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

PROHIBITION ON RESCISSIONS

The health care component plans in this Plan shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan or coverage involved, except that this Section shall not apply to a covered individual who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan or coverage. Such Plan or coverage may not be cancelled except with prior notice to the enrollee, and only as permitted under Section 2701© or Section 2742(b) of the Patient Protection and Affordable Care Act (PPACA).

GENETIC INFORMATION AND NON-DISCRIMINATION ACT (GINA)

GINA (Genetic Information and Non-Discrimination Act) applies to a group health plan on its Plan Year beginning after May 21, 2009. The Act makes it illegal for group health plans to deny coverage or charge a higher rate or premium to an otherwise healthy individual found to have a potential genetic condition or genetic predisposition towards a disease or disorder. The Plan's eligibility and coverage provisions exclude denial of benefits or increased rates due to a potential or predisposition of a genetic condition of covered employees and their families.

The Act defines genetic information as that obtained from an individual's genetic test results, as well as genetic test results of family members and the occurrence of a disease or disorder in family members.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

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

PRE-TAX CONTRIBUTIONS

Employee contributions for coverage are made on a pre-tax basis. The Internal Revenue Service (IRS) does not permit an Employee to make election changes or terminate participation outside of the Plan's Open Enrollment period unless he experiences an IRC "qualified change" or has a Special Enrollment Right as defined by the Health Insurance Portability and Accountability Act of 1996.

DEFINITIONS

Some of the terms used in this document begin with a capital letter. These terms have special meanings and are included in the Definitions section. When reading this document, it will be helpful to refer to this section. Becoming familiar with the terms defined therein will provide a better understanding of the benefits and provisions.

COBRA NOTIFICATION PROCEDURES

NOTICE RESPONSIBILITIES

It is a Plan participant's responsibility to provide the following Notices relating to COBRA Continuation Coverage:

Notice of Divorce or Separation - Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee from his spouse.

Notice of Child's Loss of Dependent Status - Notice of a Qualifying Event that is a child's loss of Dependent status under the Plan (e.g., a Dependent child reaching the maximum age limit).

Notice of a Second Qualifying Event - Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA coverage with a maximum duration of 18 (or 29) months.

Notice Regarding Disability - Notice that: (a) a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of continuation coverage, or (b) a Qualified Beneficiary as described in "(a)" has subsequently been determined by the SSA to no longer be disabled.

Notice Regarding Address Changes - It is important that the Plan Administrator be kept informed of the current addresses of all Plan participants or beneficiaries who are or may become Qualified Beneficiaries.

NOTIFICATION PROCEDURES

Notification must be made in accordance with the following procedures. Any individual who is the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee or Qualified Beneficiary may provide the Notice. Notice by one individual shall satisfy any responsibility to provide Notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Form or Means of Notification - Notification of the Qualifying Event must be provided to Human Resources.

Content - Notification must include any official documentation showing evidence that a Qualifying Event has occurred such as a copy of a divorce decree, a child's birth certificate, a copy of the Social Security Administration's disability determination, etc.

Delivery of Notification - Notification must be received by Human Resources.

Time Requirements for Notification - Should an event occur (as described in **NOTICE RESPONSIBILITIES** above), the Employee, other Qualified Beneficiary, or a representative acting on behalf of any such person must provide Notice to the designated recipient within a certain time frame.

In the case of a divorce, legal separation or a child losing dependent status, Notice must be delivered within 60 days from the later of: (1) the date of the Qualifying Event, (2) the date health plan coverage is lost due to the event, or (3) the date the Qualified Beneficiary is notified of the obligation to provide Notice through the Summary Plan Description or the Plan Administrator's General COBRA Notice. If Notice is not received within the 60-day period, **COBRA Continuation Coverage** will not be available. Refer to the **COBRA CONTINUATION COVERAGE** section.

If an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, Notice must be delivered within 60 days from the later of: (1) the date of the determination, (2) the date of the Qualifying event, (3) the date coverage is lost as a result of the Qualifying Event, or (4) the date the covered Employee or Qualified Beneficiary is advised of the Notice obligation through the Summary Plan Description or the Plan Administrator's General COBRA Notice. Notice must be provided within the 18-month COBRA coverage period. Any such Qualified Beneficiary must also provide Notice within 30 days of the date he is subsequently determined by the Social Security Administration to no longer be disabled.

The Plan will not reject an incomplete Notice as long as the Notice identifies the Plan, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete Notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following the request.

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UTILIZATION MANAGEMENT PROGRAM

The purpose of the Utilization Management Program is to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. The health care professionals in the Medical Management Department of the Contract Administrator (listed below) will focus their review on the necessity and appropriateness of hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical or surgical services.

The fact that your physician recommends surgery, hospitalization, confinement in a skilled nursing/sub-acute facility, or that your physician or other health care provider proposes any other medical services or supplies does not mean the recommended services or supplies will be considered medically necessary for determining coverage under the Plan.

The Utilization Management Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of plan benefits. Medical Management's certification that a service is medically necessary does not mean a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered, or if the services were not covered by the Plan, either in whole or in part

PRE-SERVICE REVIEW REQUIREMENTS

Hometown Health
Health Services
10315 Professional Circle
Reno, NV 89521
(775) 982-5425 or (866) 988-5425

Compliance Procedures - The procedures outlined below should be followed to avoid a possible penalty:

Inpatient Hospital Admission – Except as noted, at least three (3) working days prior to any Hospital or Skilled Nursing Facility admission which is not a Medical Emergency, the Covered Person's attending Physician must contact the Utilization Management company listed above for pre-service review and authorization. For an emergency admission, the Utilization Management company listed above must be contacted within seventy-two (72) hours after admission or on the first business day following a weekend or holiday admission.

During an Inpatient confinement, Medical Management will provide concurrent review services to ensure the most appropriate level of care for the individual's condition.

NOTE: Pre-service review will not be required for an Inpatient admission for Pregnancy delivery that does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. However, if/when the Pregnancy confinement for the mother or newborn is expected to exceed these limits, pre-service review for such extended confinement is required.

Behavioral Health Services and Substance Abuse Care – At least three (3) working days prior to any inpatient services, outpatient partial hospitalization programs, and partial residential treatment programs for behavioral health services admission or substance abuse care admission, which is not a Medical Emergency, the Covered Person's attending Physician must contact the CDS Medical Management Department for pre-service review and authorization. For an emergency admission, CDS Medical Management must be contacted within seventy-two (72) hours after admission or on the first business day following a weekend or holiday admission.

Weight Loss Surgery – Pre-service authorization is required prior to any weight loss surgery (bariatric/lap band). The Plan will provide coverage when medical necessity is determined by Medical Management.

Adequate documentation must be provided to satisfy the Obesity Guidelines established by Medical Management. Such coverage is limited to one procedure per lifetime.

Nevada Clinical Trials – Nevada law allows some clinical trials for cancer and chronic fatigue syndrome, taking place in Nevada, to be covered if certain criteria are met. Medical Management must be contacted prior to obtaining such services. See "Experimental/Investigational Treatment" in the **General Exclusions** section. NRS 689B.0306

Transplants (Organ and Tissue) – All pre-transplantation related expenses, including consultation, and the admission for transplantation services must receive pre-service review by Medical Management. It is important that you contact Medical Management prior to any pre-transplant consultation to ensure you are receiving services at the Preferred Provider.

See "Transplant-Related Expenses" in the **Eligible Medical Expenses** section.

Penalty for Non-Compliance - If the compliance procedures are not followed but it is determined that an Inpatient Admission or Outpatient Procedures and Supplies were Medically Necessary, Eligible Expenses will be payable at 50% in lieu of the Plan's normal benefit percentage. **(No benefits are payable for care which is not Medically Necessary.)**

Any additional share of expenses that becomes the Covered Person's responsibility for failure to comply with these requirements will not be considered eligible medical expenses and thus will not apply to any deductibles, coinsurance or out-of-pocket maximums of the Plan.

See "Pre-Service Claims" in the **Claims Procedures** section for more information, including information on appealing an adverse decision (i.e. a benefit reduction) under this program.

NOTE: The Plan will not reduce or deny a claim for failure to obtain a prior approval under circumstances that would make obtaining pre-service review impossible or where application of the pre-service review process could seriously jeopardize the life or health of the patient (e.g., the patient is unconscious and is in need of immediate care at the time medical treatment is required).

VOLUNTARY BACK AND NECK DISEASE MANAGEMENT PROGRAM

The Back and Neck Disease Management Program is a voluntary program through Specialty Health. The program is designed to assist individuals with managing their acute and chronic back and neck pain with the help of Specialty Health's network of providers who specialize in the management of acute and chronic back pain.

How the Program Works - An individual wishing to enroll in the Program will contact Specialty Health at (775) 398-3630. Once accepted in the Program, Specialty Health will manage your care for all back and neck services including, but not limited to, physical therapy, chiropractic services, trigger point injections, X-rays, MRIs and surgery. While in the Program all services authorized by Specialty Health, except surgery related services, will not be subject to a calendar year deductible** or co-insurance. The individual can opt-out of the program at any time. Once the individual is released from the program or opts-out out of the Program, the deductible and co-insurance will apply to services related to the back and neck going forward.

For additional information on this program, contact Specialty Health at (775) 398-3630.

** Does **not** apply to HDHP members. HDHP members must meet the Calendar Year Deductible prior to the Plan paying for the services provided under this program.

UTAH TRAVEL BENEFIT

The Utah Travel Benefit is established to offset the cost of travel for patients and/or their support person or family members when Utilization Management provides the physician and/or covered person, as an option

for **Tertiary Care** (evaluation and/or treatment), authorization to receive treatment at the University of Utah Medical Center, Intermountain Healthcare providers or Primary Children's in Utah.

Tertiary Care: Highly specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities. Examples of tertiary care services are specialist cancer care, neurosurgery (brain surgery), burn care and plastic surgery.

To qualify for the Utah Travel Benefit, the following must apply:

1. Covered Person and/or their treating physician has requested a referral to a specific facility/provider for **Tertiary Care** that is not in the primary PPO network and will require travel outside of Nevada.

2. Utilization Management has determined that the requested services are medically necessary and Tertiary Care cannot be provided in the primary PPO network.

3. Utilization Management has provided the physician and/or Covered Person, as an option, to receive Tertiary Care at the University of Utah Medical Center, Intermountain Healthcare or Primary Children's in Utah.

4. Covered Person has agreed to be in Case Management, and followed by Case Manager while in Tertiary Care.

5. Prior to travel to Utah for **Tertiary Care,** the covered person must advise the RN Case Manager of travel to receive the benefit.

Single Episode Of Care	
Travel Expenses Per Day, Per Trip	$250* per patient, support person/caregiver or parent as defined below.
Travel Expenses Maximum, Per Trip	$2,500* Per Single Episode of Care

* Per diem rates. No exclusions, no receipts necessary.

Covered Travel Expenses

1. For a covered child under the age of 19, travel expenses will be reimbursed at $250 per person for the patient and two parents or two legal guardians.

2. For a covered adult age 19 and older, travel expenses will be reimbursed for the patient and one person/caregiver.

3. Coverage will include the day prior to scheduled service and the day following the scheduled service not to exceed the $2,500 per Episode of Care.

MORE INFORMATION ABOUT PRE-SERVICE REVIEW

It is the **Employee's or Covered Person's responsibility** to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an Employee should contact the review organization to make certain that the facility or attending Physician has initiated the necessary processes.

Pre-service review and authorization is **not a guarantee of coverage**. The **Utilization Management**

Program is designed ONLY to determine whether or not a proposed setting and course of treatment is Medically Necessary and appropriate. Benefits under the Plan will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions. Nothing in the **Utilization Management Program** will increase benefits to cover any confinement or service that is not Medically Necessary or that is otherwise not covered under the Plan.

CASE MANAGEMENT SERVICES

In situations where extensive or ongoing medical care will be needed, Medical Management may, with the patient and Plan Sponsor's consent, provide case management services. Such services may include contacts with the patient, his family, the primary treating Physician, other caregivers and care consultants, and the hospital staff as necessary.

Medical Management will evaluate and summarize the patient's continuing medical needs, assess the quality of current treatments, coordinate alternative care when appropriate and approved by the Physician and Plan Sponsor, review the progress of alternative treatment after implementation, and make appropriate recommendations to the Plan Sponsor.

The Plan Sponsor expressly reserves the right to make modifications to Plan benefits on a case-by-case basis to assure that appropriate and cost-effective care can be obtained in accordance with these services.

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

SELF FUNDED PPO PLAN
MEDICAL BENEFIT SUMMARY

CHOICE OF PPO OR NON-PPO PROVIDERS

Washoe County has contracted with a Preferred Provider Organization (PPO) of health care providers. When obtaining health care services, a Covered Person has a choice of using providers who are participating in the PPO network or any other Covered Providers of his/her choice (Non-PPO Providers). However, using a Non-PPO Provider could result in higher out-of-pocket expenses.

PPO Providers - PPO Providers have agreed to provide services at negotiated rates. When a Covered Person uses a PPO Provider, his/her out-of-pocket expenses may be reduced because the Covered PPO Provider will not balance bill for expenses in excess of the PPO negotiated rate. Example: a PPO surgeon's fee for a tonsillectomy is $3,000. The PPO negotiated rate for the tonsillectomy is $1,500. Assuming the calendar year deductible has been met, the Plan would pay 80% of $1,500 resulting in a payment to the PPO surgeon of $1,200. The patient's out-of-pocket expense for a PPO tonsillectomy would be $300 (20% of $1,500). The PPO surgeon would write-off the $1,500 as a discount and will not balance bill the patient.

Non-PPO Providers - If you receive services from a Non-PPO Provider, your out-of-pocket expenses may be greater because the Non-PPO Provider's fees will be subject to the negotiated rate that would have been allowed to a PPO Provider had you used one. Example: a Non-PPO surgeon's fee for a tonsillectomy is $3,000. The PPO negotiated rate for the tonsillectomy is $1,500. Assuming the calendar year deductible has been met, the Plan would pay 80% of $1,500 resulting in a payment to the Non-PPO surgeon of $1,200. The patient's out-of-pocket expenses would be $300 (20% of $1,500) **PLUS** the Non-PPO Provider can balance bill the patient for the $1,500 that was in excess of Usual and Customary, making the patient's out-of-pocket expense for a Non-PPO tonsillectomy $1,800. The amount in excess of Usual and Customary will not go towards the Individual or Family Out-of-Pocket Maximums.

PREFERRED PROVIDER NETWORK
Hometown Health
(775) 982-5425 or (866) 988-5425
www.hometownhealth.com

A complete listing of the PPO Providers is on Hometown Health's (HHP) website at www.hometownhealth.com or you may call Hometown Health's customer service at (775) 982-5425 or (866) 988-5425. It is the responsibility of the Covered Person to verify that the provider is a PPO provider. If you require a specialty provider that is not represented in the PPO Network it is recommended that you contact Utilization Management to receive a pre-determination of benefits before receiving any services. See **Utilization Management Program** section.

Covered Persons Residing Outside of Hometown Health PPO Service Area - If you or a covered dependent permanently reside outside of the Hometown Health Self-Funded PPO network, your assigned PPO network is provided by PHCS. A listing of the PHCS Providers can be found at www.multiplan.com or you may call PHCS customer service at (800) 678-7427.
NOTE: It is the Covered Member's responsibility to notify the Plan Sponsor if you or a covered dependent permanently reside outside of the Hometown Health PPO network. Notice is also required when/if you or your covered dependent's permanent residence changes and the PHCS network is no longer applicable.

Non-PPO Provider fees will be subject to the PPO negotiated rates. However, in the following circumstances Non-PPO Provider fees will be subject to the **Usual and Customary** allowance rather than the PPO negotiated rate. See **Definitions** section for **Usual and Customary**.

Covered Persons Residing Outside of PPO Service Area - If you permanently reside more than 50 miles from a PPO Provider, your local provider's fees will be covered at the **Usual and Customary** allowance.

Emergency Care - If a Covered Person requires care for a **Medical Emergency** as defined below and is transported by an ambulance or private transportation to a Non-PPO facility, such Non-PPO fees will be subject to **Usual and Customary** instead of the PPO negotiated rate(s). If the **Medical Emergency** results in an inpatient hospitalization that is expected to exceed 3 days, **Utilization Management** will contact the Covered Person's treating physician to request that the **Covered Person** be transferred to the Plan's PPO facility once the treating physician determines his/her patient is medically stable for a safe transfer. If the Covered Person chooses not to transfer when medically stable for transfer, then the Non-PPO facility will be subject to the PPO negotiated rate(s) instead of **Usual and Customary** and may result in a greater out-of-pocket expense for the Covered Person. The treating physician is defined as the admitting physician for the inpatient stay or the physician overseeing the care of the patient during the inpatient stay.

A **Medical Emergency** is a situation which arises suddenly and which either poses a serious threat or causes serious impairment of bodily functions and which requires immediate medical attention or hospitalization. This includes conditions arising as the result of accidental bodily injury and any of the following conditions or symptoms: acute severe abdominal pains, poisoning, vomiting, acute chest pains (angina, suspected heart attack, coronary, penumothorax), shortness of breath, asthma, allergic reaction to drugs, angioneurotic edema, convulsions, coma, syncope, fainting, shock, hemorrhage, acute urinary retention, epistaxis (severe nose bleed), or high fever of at least 104 degrees.

Unavailable Services - If a Covered Person requires a specialty provider that is not represented in the PPO Network such Non-PPO specialist fees will be covered using **Usual and Customary**, rather than the PPO negotiated rate. Before seeking specialty care from a Non-PPO Provider it is recommended that you, or the physician referring you to a Non-PPO Provider, contact Utilization Management to receive a pre-determination of benefits. See the **Utilization Management Program** section for additional information.

Ancillary Services - Services of a Non-PPO ancillary provider's fees (i.e. emergency room Physician, urgent care Physician, radiologist, pathologist, on-call Physician) will be covered using **Usual and Customary** rather than the PPO negotiated rate if such services are received while a Covered Person is being treated in a PPO emergency room, PPO Urgent Care Facility, PPO Ambulatory Surgery Center or confined in a PPO hospital facility.

EXAMPLE OF HOW YOUR OUT-OF-POCKET EXPENSES can be greater if you use the services of a Non-PPO Provider. John and Peter both had the same surgery performed, except Peter went to a Non-PPO Ambulatory Surgery Center.

John had outpatient surgery at a Preferred **PPO** Ambulatory Surgical Center. John's out-of-pocket expense was $ 0.00.		Peter had outpatient surgery at a **Non-PPO** Ambulatory Surgical Center. Peter's out-of-pocket expense was $4,575.26.	
PPO Provider		**Non-PPO Provider**	
Billed Amount	$5,725.00	Billed Amount	$5,725.00
PPO Negotiated Rate (Allowed Amount)	$1,437.18	Negotiated Rate (Allowed Amount)	$1,437.18
PPO Provider Discount Not Patient Responsibility	$4,287.82	In excess of negotiated rate Patient Responsibility	$4,287.82
Allowed Amount	$1,437.18	Allowed Amount	$1,437.18
Plan Pays 100% when using a Preferred Ambulatory Surgery Center	$1,437.18	Plan Pays 80% of Negotiated rate (Allowable Amount)	$1,149.74
Patient Out-of-Pocket (Patient responsibility)	**$0.00**	**Patient Out-of-Pocket (Patient responsibility)** 20% of $1,437.18 PLUS $4,287.82 in excess of negotiated rate.	**$4,575.26**

	PPO In-Network	Non-PPO Out-of-Network
LIFETIME MAXIMUM	Unlimited	
MEDICAL DEDUCTIBLE MAXIMUM – Calendar Year		
Individual Medical Deductible	$ 350	
Family Medical Deductible	$ 700	
MEDICAL & PRESCRIPTION OUT-OF-POCKET MAXIMUM Calendar Year		
Individual Out-of-Pocket	$ 3,350	$ 6,350
Family Out-of-Pocket	$ 6,700	$ 12,700

MEDICAL DEDUCTIBLE MAXIMUM

Individual Medical Deductible - The Individual Deductible ($350) is an amount which a Covered Person must contribute toward payment of eligible medical expenses each Calendar Year.

Family Medical Deductible - If eligible medical expenses equal to the Family Maximum Deductible ($700) are incurred collectively by family members during a Calendar Year and are applied towards the Individual Deductible, then the Family Maximum Deductible is satisfied. For purposes of satisfying the Family Deductible, a "family" includes a covered Employee/Retiree, his Covered Spouse/Domestic Partner and/or Covered Dependent child(ren). No individual can have more than the $350 Individual Deductible applied towards the Family Deductible.

If both the Covered Member and a Covered Spouse/Domestic Partner are employed by Washoe County and both are eligible and enrolled in the same PPO Plan, eligible expenses will be combined when calculating the family deductible.

Deductible Carry-Over - Eligible Expenses incurred in the last 3 months of a Calendar Year and applied toward that year's Individual Deductible can be carried forward and applied toward the Covered Person's Individual Deductible for the next Calendar Year.

Common Injury Deductible - If two or more family members sustain injury simultaneously during the same accident, only the amount of one deductible per calendar year will need to be satisfied by any or all such family members on account of such accident to qualify any of them for an Allowance on covered medical expenses arising from such accident.

MEDICAL & PRESCRIPTION OUT-OF-POCKET MAXIMUM

Individual Out-of-Pocket Maximum - Except as noted, a Covered Person will not be required to pay more than $3,350 for In-Network services or $6,350 for Out-of-network services in any Calendar Year toward his share of Eligible Expenses that are not paid by the Plan. Once he has paid the Out-of-Pocket Maximum, his Eligible Expenses will be paid at 100% for the balance of the Calendar Year except for the amounts/expenses listed below under **NOTE.**

Family Out-of-Pocket Maximum - The Out-of-Pocket Maximum applies "collectively" to a Covered Family. Except as noted, a Covered Family (Employee and his/her Dependents) will not be required to pay more than $6,700 for In-network services or $12,700 for Out-of-network services in any Calendar Year toward their share of Eligible Expenses. Once the family has paid their Family Out-of-Pocket Maximum, their Eligible Expenses will be paid at 100% for the balance of the Calendar Year, except for the amounts/expenses listed below under **NOTE.**

If both the Covered Member and a Covered Spouse/Domestic Partner are employed by Washoe County and both are eligible and enrolled in the same PPO Plan, eligible expenses will be combined when calculating the family Out-of-Pocket Maximum.

NOTE: The out-of-pocket maximums do not apply to or include:

1) amounts in excess of Usual, Customary and Reasonable as determined by the Plan;
2) expenses which become the Covered Person's responsibility for failure to comply with the requirements of the Utilization Management Program;
3) expenses which become the Covered Person's responsibility for services not covered by the Plan.

SELF FUNDED PPO PLAN
SCHEDULE OF BENEFIT PERCENTAGES

IMPORTANT INFORMATION REGARDING NON-PPO ALLOWABLES (U&C) - Except where expressly stated otherwise, where rates have been negotiated with providers participating in the PPO Network, such rates will apply to PPO Providers and will be used as the Plan's Usual and Customary (U&C) allowable for Non-PPO Providers. Non-PPO charges that are in excess of U&C will not be applied towards the Out-of-Pocket Maximum and will be the Covered Person's patient responsibility.

It is important to read the entire Plan Document. The Medical Benefit Summary section provides only the highlights of the Plan and should not be relied on to determine the extent to which a service or benefit is covered or excluded. See the **ELIGIBLE MEDICAL EXPENSES, MEDICAL LIMITATIONS AND EXCLUSIONS AND GENERAL EXCLUSIONS** sections for more information.

ELIGIBLE MEDICAL EXPENSES	**Calendar Year Deductible (CYD)**	**PPO In-Network**	**Non-PPO Out-of-Network**
BILLED CHARGES ARE SUBJECT TO	**PPO Network Rates (U&C) See Important Information Above**		
Ambulance	Yes	80%	80%
Ambulatory Surgical Center (ASC)			
Preferred Providers listed below.	No	100%	N/A
All Other Ambulatory Surgical Centers	Yes	80%	80% of U&C
The 100% benefit applies to the following ASCs (Additional ASC's may be available, contact Hometown Health)			
Renown Regional Medical Center Renown South Meadows Medical Center Northern Nevada Medical Center	Digestive Health Center Reno Endoscopy Center (*Three locations Reno/Carson City)* Quail Surgical Center		
Acupuncture / Acupressure	Yes	80%	80% of U&C
Autism Spectrum Disorder,	Yes	80%	80% of U&C
Limited to 1,200 total hours of therapy per Calendar Year			
Behavioral Health Services (Mental Health and Substance Abuse)			
Outpatient Physician Visit	No/Yes	$25 co-pay	80% of U&C
Inpatient Physician Visit	Yes	80%	80% of U&C
Inpatient Facility	Yes	80%	$500 co-pay + 80% of U&C
Chiropractic Care, up to 25 visits per Calendar Year.	Yes	80%	80% of U&C
Diabetes Education	Yes	80%	80% of U&C
Diagnostic Lab & X-ray	Yes	80%	80% of U&C
Durable Medical Equipment	Yes	80%	80% of U&C
Genetic Counseling and Testing			
BRCA Counseling	No	100%	80% of U&C
BRCA1 and BRCA2 test	No	100%	80% of U&C
ApoE Counseling and test	Yes	80%	80% of U&C
Pregnancy specific counseling and tests	Yes	80%	80% of U&C
All other Genetic Counseling and Testing, not specifically listed, up to $1,000 per Calendar Year.	Yes	80%	80% of U&C
NOTE: See **Genetic Counseling and Testing and Pregnancy** under the **ELIGIBLE MEDICAL EXPENSES** for additional information.			
Hearing Aid and Related Exam, limited to one (1) hearing aid per ear and one (1) exam every 36 months.	Yes	80%	80% of U&C

SELF FUNDED PPO PLAN
SCHEDULE OF BENEFIT PERCENTAGES

ELIGIBLE MEDICAL EXPENSES	Calendar Year Deductible (CYD)	PPO In-Network	Non-PPO Out-of-Network
BILLED CHARGES ARE SUBJECT TO	**PPO Network Rates (U&C) See Important Information Page 8**		
Home Health Care, up to 100 visits per Calendar Year	Yes	80%	80% of U&C
Hospice Care	Yes	80%	80% of U&C
Hospital Services Inpatient Services	Yes	80%	$500 co-pay + 80% of U&C
Emergency Room Services	Yes	$75 co-pay + 80%	$75 co-pay + 80% of U&C
Outpatient Services	Yes	80%	80% of U&C
Inpatient Admission to a Non-PPO hospital will result in an additional co-payment of $500, unless admitted through the emergency room or you reside more than 50 miles from a PPO hospital. Hospital Emergency Room visit will result in an additional co-payment of $75 unless admitted to the hospital through the emergency room.			
Newborn Nursery	Yes	80%	$500 co-pay + 80% of U&C
Orthopedic Shoes, one pair up to $500 per Calendar Year	Yes	80%	80% of U&C
Orthotics / Shoe Inserts Age 0-17, up to $300 Lifetime	Yes	80%	80% of U&C
Age 18 and over, up to $150 Lifetime	Yes	80%	80% of U&C
Physical / Occupational Therapy	Yes	80%	80% of U&C
Physician, Primary Care (PCP) Office Visit Only	No/Yes	$25 co-pay	80% of U&C
Injection during the PCP office visit, per injection	No/Yes	$5 co-pay	80% of U&C
Laboratory test during the PCP Office Visit, per test	No/Yes	$5 co-pay	80% of U&C
X-ray taken during the PCP Office Visit, per test	No/Yes	$5 co-pay	80% of U&C
All other services rendered during the PCP Office Visit	Yes	80%	80% of U&C
Physicians, All Others	Yes	80%	80% of U&C
Primary Care Physician (PCP) includes Family Practice, General Practice, Gynecology, Internal Medicine and Pediatrics. Specialist physicians include all others unless noted.			
Prescription Drug Program through MaxorPlus Generic	No	$7 co-pay	
Preferred Brand	No	$30 co-pay	
Non-Preferred Brand	No	$50 co-pay	
Specialty Drugs	No	20% co-insurance	
MaxorPlus Specialty Copay Program for Eligible Specialty Drugs	No	Co-pay indicated on applicable manufacturer's coupon	
Maintenance Drugs (up to 90-day supply; retail or mail order) Generic	No	$14 co-pay	
Preferred Brand	No	$60 co-pay	
Non-Preferred Brand	No	$100 co-pay	

SELF FUNDED PPO PLAN
SCHEDULE OF BENEFIT PERCENTAGES

ELIGIBLE MEDICAL EXPENSES	Calendar Year Deductible (CYD)	PPO In-Network	Non-PPO Out-of-Network
BILLED CHARGES ARE SUBJECT TO	**PPO Network Rates (U&C) See Important Information Page 8**		
Preventive/Wellness	No	100%	100% of U&C
Preventative/Wellness benefits are healthcare services that are not provided as a result of illness, injury or congenital defect. Any test or procedure done that is related to a known or present condition may not be subject to this benefit and will be processed accordingly. See Appendix A – Preventative Services for additional information.			
Second Surgical Opinion	Yes	80%	80% of U&C
Skilled Nursing Facility, up to 60 days per Calendar Year	Yes	80%	80% of U&C
Speech Therapy	Yes	80%	80% of U&C
Telemedicine Services	No	100%	100% of U&C
Temporomandibular Joint Dysfunction (TMJ) Surgery	Yes	80%	80% of U&C
Non-Surgical services, up to $500 per Calendar Year	Yes	80%	80% of U&C
Medically accepted non-surgical services, including splints (removable mouth piece), will be subject to a limit of $500 per calendar year. Dental and orthodontia treatments are covered under the Dental Plan. Refer to the **Dental Plan Summary for Benefits and Limitations.**			
Urgent Care Centers	Yes	80%	80% of U&C
Weight Loss Surgery, one (1) procedure per Lifetime	Yes	80%	80% of U&C
All Other Eligible Medical Expenses	Yes	80%	80% of U&C

SELF FUNDED PPO HIGH DEDUCTIBLE PLAN
MEDICAL BENEFIT SUMMARY

CHOICE OF PPO OR NON-PPO PROVIDERS

This HDHP is compatible with a Health Savings Account (HSA) and Health Reimbursement Arrangement (HRA)

Washoe County has contracted with a Preferred Provider Organization (PPO) of health care providers. When obtaining health care services, a Covered Person has a choice of using providers who are participating in the PPO network or any other Covered Providers of his/her choice (Non-PPO Providers). However, using a Non-PPO Provider could result in higher out-of-pocket expenses.

PPO Providers - PPO Providers have agreed to provide services at negotiated rates. When a Covered Person uses a PPO Provider, his/her out-of-pocket expenses may be reduced because the Covered PPO Provider will not balance bill for expenses in excess of the PPO negotiated rate. Example: a PPO surgeon's fee for a tonsillectomy is $3,000. The PPO negotiated rate for the tonsillectomy is $1,500. Assuming the calendar year deductible has been met, the Plan would pay 80% of $1,500 resulting in a payment to the PPO surgeon of $1,200. The patient's out-of-pocket expense for a PPO tonsillectomy would be $300 (20% of $1,500). The PPO surgeon would write-off the $1,500 as a discount and will not balance bill the patient.

Non-PPO Providers - If you receive services from a Non-PPO Provider, your out-of-pocket expenses may be greater because the Non-PPO Provider's fees will be subject to the negotiated rate that would have been allowed to a PPO Provider had you used one. Example: a Non-PPO surgeon's fee for a tonsillectomy is $3,000. The PPO negotiated rate for the tonsillectomy is $1,500. Assuming the calendar year deductible has been met, the Plan would pay 80% of $1,500 resulting in a payment to the Non-PPO surgeon of $1,200. The patient's out-of-pocket expenses would be $300 (20% of $1,500) **PLUS** the Non-PPO Provider can balance bill the patient for the $1,500 that was in excess of Usual and Customary, making the patient's out-of-pocket expense for a Non-PPO tonsillectomy $1,800. The amount in excess of Usual and Customary will not go towards the Individual or Family Out-of-Pocket Maximums.

PREFERRED PROVIDER NETWORK
Hometown Health
(775) 982-5425 or (866) 988-5425
www.hometownhealth.com

A complete listing of the PPO Providers is on Hometown Health's (HHP) website at www.hometownhealth.com or you may call Hometown Health's customer service at (775) 982-5425 or (866) 988-5425. It is the responsibility of the Covered Person to verify that the provider is a PPO provider. If you require a specialty provider that is not represented in the PPO Network it is recommended that you contact Utilization Management to receive a pre-determination of benefits before receiving any services. See **Utilization Management Program** section.

Covered Persons Residing Outside of Hometown Health PPO Service Area - If you permanently reside outside of the Hometown Health Self-Funded PPO network, your assigned PPO network is provided by PHCS. A listing of the PHCS Providers can be found at www.multiplan.com or you may call PHCS customer service at (800) 678-7427.
NOTE: It is the Covered Member's responsibility to notify the Plan Sponsor if you or a covered dependent permanently reside outside of the Hometown Health PPO network. Notice is also required when/if you or your covered dependent's permanent residence changes and the PHCS network is no longer applicable.

Non-PPO Provider fees will be subject to the PPO negotiated rates. However, in the following circumstances Non-PPO Provider fees will be subject to the **Usual and Customary** allowance rather than the PPO negotiated rate. See **Definitions** section for **Usual and Customary**.

Covered Persons Residing Outside of PPO Service Area - If you permanently reside more than 50 miles from a PPO Provider, your local provider's fees will be covered at the **Usual and Customary** allowance.

Emergency Care - If a Covered Person requires care for a **Medical Emergency** as defined below and is transported by an ambulance or private transportation to a Non-PPO facility, such Non-PPO fees will be subject to **Usual and Customary** instead of the PPO negotiated rate(s). If the **Medical Emergency** results in an inpatient hospitalization that is expected to exceed 3 days, **Utilization Management** will contact the Covered Person's treating physician to request that the **Covered Person** be transferred to the Plan's PPO facility once the treating physician determines his/her patient is medically stable for a safe transfer. If the Covered Person chooses not to transfer when medically stable for transfer, then the Non-PPO facility will be subject to the PPO negotiated rate(s) instead of **Usual and Customary** and may result in a greater out-of-pocket expense for the Covered Person. The treating physician is defined as the admitting physician for the inpatient stay or the physician overseeing the care of the patient during the inpatient stay.

A **Medical Emergency** is a situation which arises suddenly and which either poses a serious threat or causes serious impairment of bodily functions and which requires immediate medical attention or hospitalization. This includes conditions arising as the result of accidental bodily injury and any of the following conditions or symptoms: acute severe abdominal pains, poisoning, vomiting, acute chest pains (angina, suspected heart attack, coronary, penumothorax), shortness of breath, asthma, allergic reaction to drugs, angioneurotic edema, convulsions, coma, syncope, fainting, shock, hemorrhage, acute urinary retention, epistaxis (severe nose bleed), or high fever of at least 104 degrees.

Unavailable Services - If a Covered Person requires a specialty provider that is not represented in the PPO Network such Non-PPO specialist fees will be covered using **Usual and Customary**, rather than the PPO negotiated rate. Before seeking specialty care from a Non-PPO Provider it is recommended that you, or the physician referring you to a Non-PPO Provider, contact Utilization Management to receive a pre-determination of benefits. See the **Utilization Management Program** section for additional information.

Ancillary Services - Services of a Non-PPO ancillary provider's fees (i.e. emergency room Physician, urgent care Physician, radiologist, pathologist, on-call Physician) will be covered using **Usual and Customary** rather than the PPO negotiated rate if such services are received while a Covered Person is being treated in a PPO emergency room, PPO Urgent Care Facility, PPO Ambulatory Surgery Center or confined in a PPO hospital facility.

EXAMPLE OF HOW YOUR OUT-OF-POCKET EXPENSES can be greater if you use the services of a Non-PPO Provider. John and Peter both had the same surgery performed, except Peter went to a Non-PPO Ambulatory Surgery Center.

John had outpatient surgery at a Preferred **PPO** Ambulatory Surgical Center. John's out-of-pocket expense was $ 0.00.		Peter had outpatient surgery at a **Non-PPO** Ambulatory Surgical Center. Peter's out-of-pocket expense was $4,575.26.	
PPO Provider		**Non-PPO Provider**	
Billed Amount	$5,725.00	Billed Amount	$5,725.00
PPO Negotiated Rate (Allowed Amount)	$1,437.18	Negotiated Rate (Allowed Amount)	$1,437.18
PPO Provider Discount Not Patient Responsibility	$4,287.82	In excess of negotiated rate Patient Responsibility	$4,287.82
Allowed Amount	$1,437.18	Allowed Amount	$1,437.18
Plan Pays 100% when using a Preferred Ambulatory Surgery Center	$1,437.18	Plan Pays 80% of Negotiated rate (Allowable Amount)	$1,149.74
Patient Out-of-Pocket (Patient responsibility)	**$0.00**	**Patient Out-of-Pocket (Patient responsibility)** 20% of $1,437.18 PLUS $4,287.82 in excess of negotiated rate.	**$4,575.26**

	PPO HDHP In-Network	Non-PPO HDHP Out-of-Network
LIFETIME MAXIMUM	Unlimited	
MAXIMUM DEDUCTIBLE – Calendar Year		
Employee (Self Only)	$2,500	
Family (Self + 1 or more family members)	$2,800	
OUT-OF-POCKET MAXIMUM – Calendar Year		
Employee (Self Only)	$5,000	$10,000
Family (Self + 1 or more family members)	$6,000	$10,000

DEDUCTIBLE MAXIMUM

If you select Employee Only Coverage you pay a $2,500 deductible per Calendar Year before the Plan provides benefits.

If you select Family coverage (*employee plus one or more eligible dependent enrolled*), no individual deductible applies and the family deductible must be met before the Plan provides benefits to any family member. The $2,800 Family Deductible amount is met as follows:

(1) When one family member has satisfied the $2,800 Family Deductible, that family member and all other family members and are eligible for benefits, or

(2) When no family member meets the family deductible on their own, but the family members collectively meet the entire family deductible, then all family members will be eligible for benefits.

*Family Deductible satisfies the IRS Minimum Family Deductible requirement.

OUT-OF-POCKET MAXIMUM

Out-of-Pocket Maximum for a Family Member - Once a covered member of the family has satisfied the $5,000 Out-of-Pocket Maximum for PPO In-Network or $10,000 for Non-PPO Out-of-Network in a Calendar Year, then Eligible Expenses will be reimbursed at 100% for that family member, even when the Family Out-of-Pocket limit has not been met. Prescription Drug, PPO In-Network and Non-PPO Out-of-Network are combined for purposes of determining the **Out-of-Pocket Maximums**.

Out-of-Pocket Maximum for Family - Once the Family has satisfied the $6,000 Out-of-Pocket Maximum for PPO In-Network or $10,000 for Non-PPO Out-of-Network in a Calendar Year, then Eligible Expenses will be reimbursed at 100% for the family for the remainder of the Calendar Year. Prescription Drug, PPO (In-Network) and Non-PPO Out-of-Network are combined for purposes of determining the **Out-of-Pocket Maximums**.

Out-of-Pocket Maximums are the monies you pay towards your plan's deductibles, coinsurance and co-pays. Out-of-Pocket Maximums do not apply to or include:

1) amounts in excess of Usual, Customary and Reasonable as determined by the Plan;
2) expenses which become the Covered Person's responsibility for failure to comply with the requirements of the **Utilization Management Program**.
3) Expenses which become the Covered Person's responsibility for services not covered by the Plan.

SELF FUNDED PPO HIGH DEDUCTIBLE HSA PLAN
SCHEDULE OF BENEFIT PERCENTAGES

IMPORTANT INFORMATION regarding Non-PPO Allowable (U&C) - Except where expressly stated otherwise, where rates have been negotiated with providers participating in the PPO Network, such rates will apply to PPO Providers and will be used as the Plan's Usual and Customary (U&C) allowable for Non-PPO Providers. Non-PPO charges in excess of U&C will not be applied towards the Out-of-Pocket Maximum and will be the Covered Person's patient responsibility.

It is important to read the entire Plan Document. The Medical Benefit Summary section provides only the highlights of the Plan and should not be relied on to determine the extent to which a service or benefit is covered or excluded. See the **ELIGIBLE MEDICAL EXPENSES, MEDICAL LIMITATIONS AND EXCLUSIONS AND GENERAL EXCLUSIONS** Sections for more information.

ELIGIBLE MEDICAL EXPENSES	**Calendar Year Deductible (CYD)**	**PPO HDHP In-Network**	**Non-PPO HDHP Out-of-Network**
BILLED CHARGES ARE SUBJECT TO	**PPO Network Rates (U&C) See Important Information Above**		
Ambulance	Yes	80%	80%
Ambulatory Surgical Center (ASC) Preferred Providers listed below.	Yes	100%	N/A
All Other Ambulatory Surgical Centers	Yes	80%	80% of U&C
The Preferred Provider, 100% ASC benefit, applies to the following ASCs after CYD has been met: Renown Regional Medical Center; Renown South Meadows Medical Center; Northern Nevada Medical Center; Digestive Health Center; Reno Endoscopy Center (*Three locations Reno/Carson City)*; Quail Surgical Center			
Acupuncture / Acupressure	Yes	80%	80% of U&C
Autism Spectrum Disorder	Yes	80%	80% of U&C
Limited to 1,200 hours of therapy per Calendar Year.			
Behavioral Health Services (Mental Health and Substance Abuse) Outpatient Physician Visit	Yes	100%	80% of U&C
Inpatient Physician Visit	Yes	80%	80% of U&C
Inpatient Facility	Yes	80%	$500 co-pay + 80% of U&C
Chiropractic Care, up to 25 visits per Calendar Year	Yes	80%	80% of U&C
Diabetes Education	Yes	80%	80% of U&C
Diagnostic Lab & X-ray	Yes	80%	80% of U&C
Durable Medical Equipment	Yes	80%	80% of U&C
Genetic Counseling and Testing			
BRCA Counseling	No	100%	80% of U&C
BRCA1 and BRCA2 test	No	100%	80% of U&C
ApoE Counseling and test	Yes	80%	80% of U&C
Pregnancy specific counseling and tests	Yes	80%	80% of U&C
All other Genetic Counseling and Testing, not specifically listed, up to $1,000 per calendar year.	Yes	80%	80% of U&C
NOTE: See **Genetic Counseling and Testing and Pregnancy** under the **ELIGIBLE MEDICAL EXPENSES** for additional information.			
Hearing Aids and Related Exams, limited to one (1) hearing aid per ear and one (1) exam every 36 months.	Yes	80%	80% of U&C

SELF FUNDED PPO HIGH DEDUCTIBLE HSA PLAN
SCHEDULE OF BENEFIT PERCENTAGES

ELIGIBLE MEDICAL EXPENSES	Calendar Year Deductible (CYD)	PPO HDHP In-Network	Non-PPO HDHP Out-of-Network
BILLED CHARGES ARE SUBJECT TO	**PPO Network Rates (U&C) See Important Information Above**		
Home Health Care, up to 100 visits per Calendar Year	Yes	80%	80% of U&C
Hospice Care	Yes	80%	80% of U&C
Hospital Services			$500 co-pay +
Inpatient Services	Yes	80%	80% of U&C
Emergency Room Services	Yes	80%	80% of U&C
Outpatient Services	Yes	80%	80% of U&C
Inpatient Admission to a Non-PPO hospital will result in an additional co-payment of $500, unless admitted through the emergency room or you reside more than 50 miles from a PPO hospital.			
Newborn Nursery	Yes	80%	80% of U&C
Orthopedic Shoes, one pair up to $500 per Calendar Year	Yes	80%	80% of U&C
Orthotics / Shoe Inserts			
Age 0-17, up to $300 Lifetime	Yes	80%	80% of U&C
Age 18 and over, up to $150 Lifetime	Yes	80%	80% of U&C
Physical / Occupational Therapy	Yes	80%	80% of U&C
Physician Services			
Primary Care Physician (PCP) - Office Visit, injections, X-ray and laboratory services during PCP Office Visit	Yes	100%	80% of U&C
Specialist Office Visit Only	Yes	100%	80% of U&C
All other services performed in a PCP or Specialist Office Visit	Yes	80%	80% of U&C
Physicians, All Others	Yes	80%	80% of U&C
Primary Care Physician (PCP) includes Family Practice, General Practice, Gynecology, Internal Medicine and Pediatrics. Specialist physicians include all others unless noted.			
Prescription Drug Program through MaxorPlus			
Generic	Yes	$ 7 co-pay	
Preferred Brand	Yes	$ 30 co-pay	
Non-Preferred Brand	Yes	$ 50 co-pay	
Specialty Drugs	Yes	20% co-insurance	
Maintenance Drugs (up to 90-day supply; retail or mail order)			
Generic	Yes	$ 14 co-pay	
Preferred Brand	Yes	$ 60 co-pay	
Non-Preferred Brand	Yes	$ 100 co-pay	
See **Prescription Drug Program** section for additional information.			

SELF FUNDED PPO HIGH DEDUCTIBLE HSA PLAN
SCHEDULE OF BENEFIT PERCENTAGES

ELIGIBLE MEDICAL EXPENSES	Calendar Year Deductible (CYD)	PPO HDHP In-Network	Non-PPO HDHP Out-of-Network
BILLED CHARGES ARE SUBJECT TO	**PPO Network Rates (U&C) See Important Information Above**		
Preventive/Wellness	No	100%	100% of U&C
Preventative/Wellness benefits are healthcare services that are not provided as a result of illness, injury or congenital defect. Any test or procedure done that is related to a known or present condition may not be subject to this benefit and will be processed accordingly. See Appendix A – Preventative Services for additional information.			
Second Surgical Opinion	Yes	80%	80% of U&C
Skilled Nursing Facility, up to 60 days per Calendar Year	Yes	80%	80% of U&C
Speech Therapy	Yes	80%	80% of U&C
Telemedicine Services	Yes	100%	100% of U&C
Temporomandibular Joint Dysfunction (TMJ) Surgery	Yes	80%	80% of U&C
Non-Surgical services, up to $500 per Calendar Year	Yes	80%	80% of U&C
Medically accepted non-surgical services including splints (removable mouth piece) will have a limit of $500 per calendar year. Dental and orthodontia procedures are covered under the Dental Plan. Refer to the **Dental Plan Summary for Benefits and Limitations.**			
Urgent Care Centers	Yes	80%	80% of U&C
Weight Loss Surgery, one (1) procedure per Lifetime	Yes	80%	80% of U&C
All Other Eligible Medical Expenses	Yes	80%	80% of U&C

ELIGIBLE MEDICAL EXPENSES

This section is a listing of those medical services, supplies and conditions which are covered by the Plan. This section must be read in conjunction with the **Medical Benefit Summary** to understand how Plan benefits are determined (application of Deductible requirements and benefit sharing percentages, etc.). All medical care must be received from or ordered by a Covered Provider.

Except as otherwise noted below or in the **Medical Benefit Summary**, Eligible Expenses are the Usual, Customary and Reasonable charges for the items listed below and which are incurred by a Covered Person - subject to the **Definitions**, **Limitations and Exclusions** and all other provisions of the Plan. In general, services and supplies must be provided by a Physician or other appropriate Covered Provider and must be Medically Necessary for the care and treatment of a covered Sickness, Accidental Injury, Pregnancy or other covered health care condition. Medically Necessary, however, does not guarantee that a service or supply is covered under the terms of the Plan.

For benefit purposes, medical expenses will be deemed to be incurred on:

- the date a purchase is made; or
- the actual date a service is rendered.

NOTE: Except where expressly stated otherwise, where rates have been negotiated with providers participating in the PPO network, such rates will apply to services of ALL providers (PPO and Non-PPO) in lieu of the Usual, Customary and Reasonable allowance.

1. **Acupuncture / Acupressure** - Needle puncture or application of pressure at specific points on the body, whether used to cure disease, to relieve pain or as a form of anesthesia for Surgery.

2. **Alcoholism** - See “Behavioral Health Services”

3. **Allergy Testing and Serum**

4. **Ambulance** - Professional ground or air ambulance service: (1) when necessary to transport a Covered Person from the place where he/she is injured or stricken by a Sickness to the nearest Hospital where treatment can be given, (2) when Medically Necessary to transport a Covered Person to medical facilities and back home, or (3) when used to transport a Covered Person to a PPO Hospital.

5. **Ambulatory Surgical Center** - Services and supplies provided by an Ambulatory Surgical Center (see **Definitions**) in connection with a covered Outpatient Surgery.

6. **Anesthesia** - Anesthetics and services of a Physician or certified registered nurse anesthetist (CRNA) for the administration of anesthesia.

7. **Attention Deficit Disorders (ADD and ADHD)** - Treatment (i.e., periodic Physician check-ups for evaluation and medication management) for attention deficit disorder (ADD) or attention deficit hyperactive disorder (ADHD).

   NOTE: See “Behavioral Health Care” for counseling coverage.

8. **Autism Spectrum Disorder -** Screening for and diagnosis of autism spectrum disorders and applied behavior analysis treatment of autism spectrum disorders under the age of 18 or, if enrolled in high school, until the person reaches the age of 22. NRS 689B.0335.

   Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care (under MaxorPlus), psychiatric care, psychological care, behavior therapy or therapeutic care that is:

a. Prescribed for a person diagnosed with an autism spectrum disorder by a licensed physician or licensed psychologist; and

b. Provided for a person diagnosed with an autism spectrum disorder by a licensed physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed physician, psychologist or behavior analyst.

As used in this section:

a. "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

b. "Autism behavior interventionist" means a person who is registered as a Registered Behavior Technician or an equivalent credential by the Behavior Analyst Certification Board, Inc., or its successor organization, and provides behavioral therapy under the supervision of:
   (1) A licensed psychologist;
   (2) A licensed behavior analyst; or
   (3) A licensed assistant behavior analyst.

c. Autism spectrum disorders" means a neurobiological medical condition including, without limitation, autistic disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified.

d. "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 autism behavior interventionist.

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

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

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

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

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

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

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

l. "Screening for autism spectrum disorders" means medically necessary assessments, evaluations or tests to screen and diagnose whether a person has an autism spectrum disorder.

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

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

NOTE: Nothing in this section shall be construed as requiring an insurer to provide reimbursement to an early intervention agency or school for services delivered through early intervention or school services.

~~**9.**~~ **Behavioral Health Services-** The Plan provides benefits for intermediate levels of care for behavioral health disorders and chemical dependency disorders in parity with medical and surgical care of the same level.

The following behavioral health practitioners are payable under the Plan: psychiatrist (MD or DO), psychologist (Ph.D.), Master's prepared counselors (e.g. MSW), licensed social associate in social work, independent social worker or clinical social worker.

Prior authorization is required for inpatient and outpatient care in a facility. For more information regarding prior authorizations, refer to *Utilization Management* (page 1).

Behavioral health services payable under this Plan include:

- Outpatient visits
- Acute inpatient admissions
- Partial day treatment
- Partial hospitalization
- Residential treatment
- Intensive outpatient therapy
- Day treatment
- Psychological testing
- Detoxification

The provider of the above services must be licensed or approved by the state in which the services are provided. All care must be provided by licensed, eligible providers – such as hospitals or residential treatment programs for inpatient care and non-residential treatment programs (including hospital centers, treatment facilities, physicians and qualified employees of the centers or facilities) for outpatient care.

10. Birthing Center - Services and supplies provided by a Birthing Center (see **Definitions**) in connection with a covered Pregnancy.

11. Blood - Blood and blood plasma (if not replaced by or for the patient), including blood processing and administration services. The Plan will also cover processing, up to eight (8) weeks of storage, and administration services for autologous blood (a patient's own blood) when such Covered Person is scheduled for a surgery that can reasonably be expected to require blood.

12. **Cardiac Rehabilitation** - A monitored exercise program directed at restoring both physiological and psychological well-being to individuals with heart disease. Services rendered must be:
    - under the supervision of a Physician;
    - in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery;
    - initiated within twelve (12) weeks after treatment for the medical condition ends; and
    - provided in a covered medical care facility as defined by the Plan.

    NOTE: Maintenance care will not be covered. See definition of "Cardiac Rehabilitation" in the **Definitions** section.

13. **Chemical Dependency** - see "Behavioral Health Services"

14. **Chemotherapy** - Professional services and supplies related to the administration of chemical agents in the treatment or control of a Sickness.

15. **Chiropractic-type Care / Spinal Manipulation** - Spinal manipulation and all related services and supplies including, but not limited to, application of a modality to one or more areas (e.g., hot or cold packs, mechanical traction, electrical stimulation, vasopneumatic devices, paraffin baths, microwave, whirlpool, diathermy and infrared).

16. **Clinical Trials for Cancer and Chronic Fatigue Syndrome** - Clinical trials that are mandated by State or Federal Law when certain criteria is met. See "Experimental/Investigational Treatment" in the **General Exclusions** section. NRS 689B.0306

17. **Contraceptive Intrauterine Devices** – A birth control device that is inserted by a Physician. See the **Prescription Drugs** section for other contraceptive coverage information.
    NOTE: Contraceptive-related services and contraceptive supplies and devices that do not require a Physician's written prescription are not covered.

18. **Diabetes Education Services** - Diabetes training and education services when requested by a Physician and Medically Necessary (as determined by the Plan Administrator or its designee) for the self-care and self-management of a person with diabetes. Services must be provided by a Certified Diabetes Educator or a Health Care Practitioner approved by the Plan Administrator or its designee and includes counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes. NRS 689B.0357

    Retraining when due to new techniques for the treatment of diabetes or when there has been a significant change in the person's clinical condition or symptoms that requires modifications of self-management techniques.

19. **Diagnostic Lab and X-ray, Outpatient -** Laboratory, X-ray and other non-surgical services performed to diagnose medical disorders, including scanning and imaging work (e.g., CT scans, MRIs), electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the United States.

20. **Dialysis Services** - Dialysis services, including the training of a person to assist the patient with home dialysis, when provided by a Hospital, freestanding dialysis center or other appropriate Covered Provider.

21. **Durable Medical Equipment** - Rental of durable medical equipment (but not to exceed the fair market 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 Sickness or Accidental Injury. The decision to rent or purchase equipment shall be at the option of the Plan. Excess charges for deluxe equipment or devices will not be covered.

Repair of purchased equipment will be covered when necessary to maintain its usability. Replacement of durable medical equipment will be covered only if: (1) needed due to a change in the patient's physical condition or (2) it is likely to cost less to buy a replacement than to repair existing equipment or rent like equipment.

"Durable medical equipment" includes such items as non-dental braces, crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, intermittent positive pressure breathing machines and dialysis equipment, etc., which: (1) can withstand repeated use, (2) are primarily and customarily used to serve a medical purpose, (3) generally are not useful to a person in the absence of Sickness or Accidental Injury, and (4) are appropriate for use in the home.

22. **Gender Reassignment –** Gender reassignment surgery consisting of any combination of the following when the following criteria is met:

    Requirement for mastectomy for female-to-male patients:

    A. Single letter of referral from a qualified mental health professional; and,
    B. Persistent, well-documented gender dysphoria; and,
    C. Capacity to make a fully informed decision and to consent for treatment; and,
    D. Age of majority in the State of Nevada; and,
    E. Significant medical or mental health concerns are reasonably well controlled

    Requirements for gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to-female):

    A. Two (2) referral letters from qualified mental health professionals, one in a purely evaluative role; and,
    B. Persistent, well-documented gender dysphoria; and,
    C. Capacity to make a fully informed decision and to consent for treatment; and,
    D. Age of majority in the State of Nevada; and,
    E. Significant medical or mental health concerns are reasonably well controlled; and,
    F. Twelve (12) months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has medical contraindication or is otherwise unable or unwilling to take hormones).

    Requirements for genital reconstructive surgery (i.e. vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female-to-male; penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male-to-female):

    A. Two (2) referral letters from qualified mental health professionals, one in a purely evaluative role; and,
    B. Persistent, well-documented gender dysphoria; and,
    C. Capacity to make a fully informed decision and to consent for treatment; and,
    D. Age of majority in the State of Nevada; and,
    E. Significant medical or mental health concerns are reasonably well controlled; and,
    F. Twelve (12) months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has medical contraindication or is otherwise unable or unwilling to take hormones); and,
    G. Twelve (12) months of living in a gender role that is congruent with their gender identity (real life experience).

Note: See Gender Reassignment under MEDICAL LIMITATIONS AND EXCLUSIONS for

services and procedures that are <u>not covered.</u>

23. **Genetic Counseling and Testing** – BRCA1 and BRCA2 genetic test for an individual identified as having an increased risk for deleterious mutations after completing genetic counseling and evaluation for testing; Apo E genetic test to help a Physician identify an individual at high risk for heart disease and to determine the most appropriate dietary and fitness program. Prenatal genetic testing for pregnant women includes amniocentesis, chorionic villus sampling (CVS), fetoscopy and alpha-fetoprotein (AFP) analysis, Early Screen for Down Syndrome, Trisomy 18 and Trisomy 13, and cystic fibrosis in pregnant women. All other genetic counseling and testing not specifically listed above is subject to an annual benefit. See **Schedule of Benefits***.*

24. Hearing Aids and Related Examinations - Hearing examinations, hearing aids and the fitting and repair of hearing aids.

NOTE: Hearing aid batteries are <u>not</u> covered.

25. Home Health Care - Services and supplies which are furnished to a Covered Person who is confined at home and is under the active medical supervision of the Physician ordering home health care and who is treating the condition for which that care is needed. Home health care services and supplies must be consistent with the patient's health condition, degree of disability and medical needs.

Home health care services and/or supplies must be provided and billed by a Home Health Care Agency. Covered home health care services and supplies include:

- services of a registered nurse (RN) or a licensed practical nurse (LPN);
- services of physical, occupational and speech therapists;
- services of a medical social service worker;
- services of home health aides who are employed by (or under an arrangement with) a Home Health Care Agency, provided the patient is also receiving nursing care and care of a therapist (see above). Services must be ordered by the Home Health Agency as a professional coordinator;
- necessary medical supplies provided by the Home Health Care Agency.

26. Hospice Care - Care of a Covered Person with a terminal prognosis (i.e., a life expectancy of six months or less) who has been admitted to a formal program of Hospice care. Eligible Expenses include Hospice program charges for:

- Inpatient hospice care;
- Physician services;
- services of a Home Health Care Agency - see "Home Health Care" (above) for additional information;
- drugs and medications; and
- homemaker services.

27. Hospital Services - Hospital services and supplies provided on an Outpatient basis and Inpatient care, including daily room and board and ancillary services and supplies.

NOTE: Comfort or convenience items provided to a Covered Person while hospitalized are not covered.

28. Infertility Testing - Testing that is performed to determine a diagnosis for infertility (i.e., to determine the cause for infertility).

29. **Marriage and Family Counseling -** See "Behavioral Health Care"

30. **Medical Foods for Inherited Metabolic Disorders -** Medical foods (also called Special Food Products as defined below) are payable for persons with Inherited Metabolic Disorders (defined below), subject to the following provisions as determined by the Plan Administrator or its designee:

    - treatment must be prescribed by a Physician;
    - documentation to substantiate the presence of an Inherited Metabolic Disorder and that the products purchased are Special Food Products may be required.

    For these purposes, "Inherited Metabolic Disorder" means genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates or fats, as diagnosed by a Physician using standard blood, urine, spinal fluid, tissue or enzyme analysis. Inherited Metabolic Disorders are also referred to as inborn errors or metabolism and includes Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance with a diagnosis of Galactosemia is not covered. NRS 689B.0353.

    A "Special Food Product" is a food product that is specially formulated to have less than one (1) gram of protein per serving and is intended to be consumed under the direction of a Physician for the dietary treatment of an inherited metabolic disease (as that term is defined in this chapter). The term does not include a food that is naturally low in protein or foods or formulas for persons who do not have Inherited Metabolic Disorders.

31. **Medical Supplies** - Medical supplies such as casts, splints, trusses, surgical dressings, catheters, colostomy bags and related supplies.

32. **Medicines** - Medicines which are dispensed and administered to a Covered Person during an Inpatient confinement or during a Physician's office visit. See the **Prescription Drugs** section for pharmacy drugs.

33. **Midwife** - Services of a certified or registered nurse midwife when provided in conjunction with a covered Pregnancy - see "Pregnancy" below.

34. **Newborn Care** - Hospital nursery and Physician services provided during the birth confinement to a covered well newborn child.

    In accordance with the Newborns' and Mothers' Health Protection Act, the Plan will not restrict benefits for a Hospital stay for a newborn (birth confinement) to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean delivery.

    NOTE: A covered newborn who is sick or injured is eligible for benefits to the same extent as any other Covered Person.

35. **Nursing Services** - Services of a registered nurse (RN), licensed vocational nurse (LVN) or licensed practical nurse (LPN) for nursing services when prescribed in writing by the attending Physician or surgeon specifically as to duration and type. Inpatient nursing care is covered only when care is Medically Necessary and not custodial and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit. Outpatient nursing care is covered only as part of "Home Health Care" or "Hospice Care", above.

    NOTE: Services of a private surgical scrub nurse are not covered.

36. **Occupational Therapy** - Short-term active, progressive Occupational Therapy performed by a licensed or duly qualified therapist as ordered by a Physician.

    Services that are restorative in nature and designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease, or injury and only if there is a reasonable

expectation that occupational therapy will achieve measurable improvement in the patient's condition in a reasonable and predictable amount of time.

NOTE: Occupational Therapy will not be covered for the management of chronic diseases, training in non-essential tasks (e.g. homemaking, gardening, recreational activities), therapy related solely to specific employment opportunities, work skills or work settings and maintenance therapy. Maintenance therapy is defined as ongoing therapy after the patient has reached maximum rehabilitative level, and patient's functionality has not shown significant improvement.

37. **Orthognathic Surgery** - Surgery to correct a receding or protruding jaw.

    NOTE: Plan coverage does not include methods of treatment which are recognized as dental procedures (e.g., extraction of teeth, night guards and/or the application of braces to the teeth).

38. **Orthotics/Shoe Inserts -** Mechanical devices to support or correct musculoskeletal deformities and/or abnormalities.

39. **Orthopedic Shoes and Braces** - Orthopedic braces and orthopedic shoes.

40. **Oxygen** - See "Durable Medical Equipment"

41. **Physical Therapy -** Short-term active, progressive Physical Therapy performed by a licensed or duly qualified therapist as ordered by a Physician. Services that are related to an injury, illness, or disease and the diagnosis is consistent with physical therapy treatment. There must be reasonable expectation that the services will produce significant improvement in the patient's condition. Documentation, when requested, must support physical therapy services that contain progress reports, a diagnosis to support the level of care provided, medical necessity of the care provided, the patient's progress toward meeting the goals of the therapy and the results achieved during the physical therapy services.

    NOTE: Services that are maintenance and palliative in nature are not covered.

42. **Physician Services** - Medical and surgical treatment by a Physician (MD or DO), including office, home or Hospital visits, clinic care and consultations. See "Second and Third Surgical Opinion" below for requirements applicable to surgery opinion consultations.

43. **Pregnancy** - Eligible Pregnancy-related expenses are covered to the same extent as any other Sickness. Pregnancy-related expenses include the following, but may include other services which are deemed to be **Medically Necessary** by the patient's attending Physician:

    - pre-natal visits and routine pre-natal and post-partum care;
    - expenses associated with a normal or cesarean delivery as well as expenses associated with any complications of pregnancy;
    - amniocentesis, chorionic villus sampling (CVS), fetoscopy and alpha-fetoprotein (AFP) analysis, Early Screen for Down Syndrome, Trisomy 18 and Trisomy 13, and cystic fibrosis in pregnant women, but only if the procedure is **Medically Necessary** as determined by her physician;
    - routine well-baby nursery expenses which are billed by the Hospital and which are incurred during the child's birth confinement and while the mother and child are both confined post-delivery;

    In accordance with the Newborns and Mothers Health Protection Act, the Plan will not restrict benefits for a Pregnancy Hospital stay for a mother and her newborn to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section. Also, the

Utilization Management Program requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the decision is made between the attending Physician and the mother.

NOTE: Pregnancy coverage will not include: (1) Lamaze and other charges for education related to pre-natal care and birthing procedures, (2) adoption expenses, or (3) expenses of a surrogate mother, unless the surrogate mother is a Covered Person under this Plan.

44. Prescription Drugs - Drugs and medicines which are dispensed and administered to a Covered Person during an Inpatient confinement.

Coverage for Outpatient drugs (i.e., pharmacy purchases) is provided through a separate program. See the **Prescription Drugs** section for additional information.

NOTE: Drugs or medications dispensed from a Physician's office are not covered.

45. Preventive Care - Screenings and services provided that are not a result of illness, injury or congenital defect. Includes, but is not limited to: evidence-based items that have a rating of "A" or "B" in recommendations provided by the U.S. Preventative Services Task Force (USPSTF) and the Health Resources and Services Administration; screenings and services identified under Nevada Revised Statute; etc. See **Appendix A** for further information

46. Prosthetics - The initial purchase, fitting, and repair of prosthetic appliances. Covered prosthetics include artificial arms, legs and accessories, and artificial eyes. To comply with the Women's Health and Cancer Rights Act, coverage also includes post-mastectomy breast prostheses. Replacement of a prosthetic appliance when authorized by Medical Management and the Prosthetic is more than 5 years old.

47. Radiation Therapy - Radium and radioactive isotope therapy.

48. Respiratory Therapy - Professional services of a licensed respiratory or inhalation 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.

49. Second and Third 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 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.

50. Skilled Nursing Facility - Inpatient care in Skilled Nursing Facility, but only when the admission to the facility or center is Medically Necessary, and is in lieu of Inpatient care at a Hospital.

51. Speech Therapy - Short-term active, progressive Speech Therapy performed by a licensed or duly qualified therapist as ordered by a Physician. Speech Therapy to restore speech to a person who has lost existing speech function as a result of disease, injury or surgery, such as seizure disorder, CVA or stroke, otitis media, brain injury, hearing loss, Parkinson's disease and paralysis of the vocal cord or larynx, carcinoma of the larynx, trachea, pharynx, lip, head, neck, and dysphasia.

NOTE: Speech Therapy is not covered for non-organic/functional speech and language disorders such as lisping, stuttering and stammering, or speech and language problems that result from non-curable developmental disorders such as, developmental delay, mental retardation or Down's Syndrome. Maintenance therapy is not covered. Maintenance therapy begins when the therapeutic

goals of a treatment plan have been met and no further functional progress is expected.

52. **Spinal Manipulation** - See "Chiropractic-type Care / Spinal Manipulation"

53. **Sterilization Procedures** - A surgical procedure for the purpose of sterilization (i.e., a vasectomy for a male or a tubal ligation for a female).

    NOTE: Reconstruction (reversal) of a prior elective sterilization procedure is not covered.

54. **Substance Abuse Care** – See "Behavioral Health Services"

55. **Telemedicine Services –** You may receive services from a Provider who is in a different location through the use of information and audio-visual communication technology. Telemedicine does not include communication through telephone, facsimile, or email. This service is available to members through TelaDoc where they can register and connect face-to-face with a board certified doctor or licensed psychologist on a smartphone, tablet, or computer through live video. Alternatively, telemedicine may be available from in-network providers. It is your responsibility to ensure the providers you use are in-network providers.

56. **TMJ / Jaw Joint Treatment** - Occlusal guards and non-dental treatment of jaw joint problems, including temporomandibular joint syndrome, cranio-mandibular disorders or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to that joint.

57. **Transplant-Related Expenses –** Any benefits paid will be treated as benefits paid to the Covered Member/recipient. Organ Transplants are only covered where the organ donor's suitability meets the OPTN/UNOS (Organ Procurement and Transplantation Network/United Network for Organ Sharing) donor evaluation and guideline criteria, when applicable. Eligible expenses include:

    - A Covered Member who is the recipient of a human organ or tissue transplant, not experimental or investigational in nature;
    - A Covered Person who is an organ donor. However, Plan benefits will be reduced by any amount paid or payable by the recipient's coverage; and
    - An organ or tissue donor who is not a Covered Person when the recipient is a Covered Person. However, Plan benefits will be reduced by any amounts paid or payable by the donor's own coverage

    In addition to the Eligible Expenses as listed in this section, eligible transplant-related expenses will include those for organ procurement and/or organ and storage costs.

    NOTE: Eligible transplant-related expenses will not include travel or lodging costs of the donor or recipient. Xenographic (cross species) transplants are not covered, except for heart valves.

58. **Urgent Care Facility** - See **Definitions**

59. **Weight-loss Surgery** - FDA approved weight loss surgery when medical criteria guidelines have been met.

MEDICAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated otherwise, no benefits will be payable for:

1. **Abortion** - Elective abortion, unless the mother's life would be endangered if the Pregnancy were allowed to continue to term.

   NOTE: Complications arising out of an abortion are covered as any other Sickness.

2. **Air Purification Units, Etc.** - Air conditioners, air-purification units, humidifiers and electric heating units.

3. **Alternative Medicine / Complementary Health Care Services** - Expenses for chelation therapy, except as may be Medically Necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.

   Expenses for prayer, religious healing, or spiritual healing, except for services provided by a Christian Science Practitioner.

   Expenses for naturopathic, naprapathic or homeopathic treatment or supplies.

   NOTE: Homeopathic office visits are covered under “Physician Services” in the **Medical Benefit Summary**.

4. **Complications of a Non-Covered Service** - Expenses for care, services or treatment required as a result of complications from a treatment or service not covered under this Plan, except for complications from an abortion.

5. **Cosmetic and Reconstructive Surgery, Etc.** - Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly. Exclusions include but are not limited to surgery for sagging or extra skin, abdominoplasty, blepharoplasty, liposuction, rhinoplasty, epikeratophakia surgery, any augmentation or reduction procedures or correction of facial or breast asymmetry (except as defined below), treatment of male-pattern baldness or hair treatment, keloid scar or other scar revision therapy, any procedures utilizing an implant which cannot be expected to substantially alter physiologic functions, earring injuries and/or earlobe repair. Complications resulting from excluded cosmetic surgery or medical procedures are <u>not</u> covered. Psychological factors (for example, for self-image, difficult social or peer relations) do not constitute a physical bodily function or Medical Necessity.

   The following are not subject to this exclusion:

   - services necessitated by an Accidental Injury or Sickness;
   - coverage required by the Women's Health and Cancer Rights Act (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including lymphedemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient;
   - surgery which is necessary to correct a congenital abnormality in a covered Dependent child;
   - removal of a mastectomy-related prosthesis only if Medically Necessary due to leakage.

6. **Custodial and Maintenance Care** - Care or confinement primarily for the purpose of meeting personal needs (bathing, walking, companionship care, homemaker services, etc.) which could be rendered at home or by persons without professional skills or training.
   Services or supplies that cannot reasonably be expected to lessen the patient's disability or to enable him to live outside of an institution.

7. **Dental Care** - Dental care including, but not limited to: treatment to the teeth, extraction of teeth, treatment of dental abscesses or granulomas, treatment of gingival tissues (other than for tumors), dental exams, orthodontia treatment, oral surgery, pre-prosthetic surgery, any procedure involving osteotomy to the jaw, any other dental product or service customarily provided by a dentist, treatment to the gums, treatment of pain or infection known or thought to be due to dental causes and in close proximity to the teeth or jaw, braces, bridges, dental plates or other dental orthoses or prostheses, and replacement of metal dental fillings. However, this exclusion will not apply to the following dental/oral-related care:

   - services of a dentist (DDS or DMD) for treatment and repair of a fractured or dislocated jaw or sound natural teeth damaged in an Accidental Injury, provided such repair is performed within six (6) months following the injury and while the person is covered hereunder;
   - facility fees and anesthesia associated with Medically Necessary dental services if the Utilization Management Organization determines that hospitalization is Medically Necessary to safeguard the health of the patient during the performance of dental services, but only when:
     - the patient is a child under age seven (7) and has been diagnosed with extensive dental decay substantiated by X-rays and narrative provided by the treating dentist; or
     - the patient has a documented illness, such as hemophilia or prior tissue or organ transplant requiring a Hospital environment to monitor vital signs; or
     - the patient has a documented mental or physical impairment requiring general anesthesia in a Hospital setting for the safety of the patient.

   Charges by the dentist or any assistant dental provider are <u>not</u> covered.

8. **Diagnostic Hospital Admissions** - Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting.

9. **Ecological or Environmental Medicine** - Chelation or chelation therapy, orthomolecular substances or use of substances of animal, vegetable, chemical or mineral origin which are not specifically approved by the FDA as effective for treatment.

10. **Educational or Vocational Testing or Training** - Testing and/or training for educational purposes or to assist an individual in pursuing a trade or occupation.

    Training of a Covered Person for the development of skills needed to cope with an Accidental Injury or Sickness, except as may be expressly included.

11. **Exercise Equipment / Health Clubs** - Exercising equipment, vibratory equipment, swimming or therapy pools. Enrollment in health, athletic, or similar clubs or programs.

12. **Fertility and Infertility Services** - Expenses for the treatment of infertility, along with services to induce Pregnancy (and complications thereof), including but not limited to services, prescription drugs, procedures or devices to achieve fertility, in-vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, zygote transfer, surrogate parenting, donor egg/semen, cryostorage of egg or sperm, adoption, ovarian transplant, infertility donor expenses and reversal of sterilization procedures.

    NOTE: This exclusion does not apply to testing that is performed to determine a diagnosis for infertility (i.e., to determine the cause for infertility).

13. **Gender Reassignment Surgery** - Services and supplies when the criteria required under Gender Reassignment in the Eligible Medical Expenses section are not met.

    Procedures that may be performed as a component of gender reassignment as cosmetic (not an all-inclusive list) will not be covered: abdominoplasty, blepharoplasty brow lift, calf implants, cheek/malar implants, chin/nose implants, collagen injections, construction of a clitoral hood, drugs for hair loss or growth, forehead lift, hair removal/hair transplantation, lip reduction, liposuction, mastopexy, neck tightening, pectoral implants, removal of redundant skin, rhinoplasty, voice therapy/voice lessons.

14. **Hair Replacement** - Replacement of nonproductive hair follicles with productive follicles from another area of the scalp or body for treatment of alopecia (baldness), or any other surgeries, treatments, drugs, services or supplies (except as noted) relating to baldness or hair loss.

15. **Hypnotherapy** - Treatment by hypnotism.

16. **Learning and Behavioral Disorders** - Except as noted, treatment for learning or behavioral disorders, mental retardation, or autism.

    NOTE: See "Autism Spectrum Disorder," "Attention Deficit Disorders (ADD and ADHD)," and "Behavioral Health Services" in the list of **Eligible Medical Expenses** for coverage information.

17. **Maintenance Care** - See "Custodial and Maintenance Care"

18. **Massage Therapy** - Massage therapy, except when performed by a Covered Physician.

19. **Modifications of Homes or Vehicles** - Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Covered Person, including without limitation, any construction or modification (e.g., ramps, elevators, chair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, hand rails, emergency alert systems, etc.).

20. **Nicotine Addiction** - Nicotine withdrawal programs, facilities, drugs or supplies.

    NOTE: See Preventative Services listed in Appendix A and Prescription Drug Program Summary for eligible expenses

21. **Non-Prescription Drugs** - Drugs for use outside of a hospital or other Inpatient facility which can be purchased over-the-counter and without a Physician's written prescription - except as may be included in the prescription coverages of the Plan. Drugs for which there is a non-prescription equivalent available.

22. **Not Medically Necessary / Not Physician Prescribed** - Services for an illness, sickness, injury or condition which are not deemed Medically Necessary by the Plan, even when ordered by a Physician or other Covered Provider.

23. **Over-the-Counter Supplies** - Supplies that can be obtained without a Physician's prescription are not covered. Such supplies include but are not limited to ace bandages, band-aids, ankle supports, wrist supports, cotton balls, Neosporin, rubbing alcohol, latex gloves, Vaseline, toothettes, instant hot/cold packs, tourniquets, cleansing towelettes, thermometers, pant liners/disposable underpads.

24. **Personal Comfort or Convenience Items** - Services or supplies that are primarily and customarily used for non-medical purposes or are used for environmental control or enhancement (whether or not prescribed by a Physician) including but not limited to: (1) vacuum cleaners, (2) motorized transportation equipment, escalators**,** (3) waterbeds or non-hospital adjustable beds, (3) hypoallergenic mattresses, pillows, blankets or mattress covers, (4) cervical pillows, (5) whirlpools, exercise equipment, or gravity lumbar reduction chairs, (6) home blood pressure kits, (7) personal computers and related equipment, televisions, telephones, or other similar items or equipment, (8)

25. food liquidizers, or (9) comfort or convenience items while hospitalized.

26. Prior Coverages - Services or supplies for which the Covered Person is eligible for benefits under the terms of the document that this Benefit Document replaces.

27. Prophylactic Surgery or Treatment – Expenses for all medical or surgical services or procedures including prescription drugs and the use of prophylactic surgery when the services, procedures, prescription of drugs, or prophylactic surgery is prescribed or performed for the purpose of avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results; or treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of physical or mental disorder.

NOTE: This provision does not apply to high risk individuals who have met the Plan's criteria for a prophylactic mastectomy or prophylactic oophorectomy and it has been authorized as medically necessary for the reduction of risk of cancer by the Plan's Utilization Management. To obtain the Plan's criteria for prophylactic mastectomy or prophylactic oophorectomy, contact Medical Management.

28. Rehabilitation Therapy (Inpatient or Outpatient) - Services provided on an Inpatient or Outpatient basis for the following:

- expenses for educational, job training, vocational rehabilitation, and/or special education for sign language;
- expenses for massage therapy, rolfing and related services;
- expenses incurred at an Inpatient rehabilitation facility for any Inpatient care provided to an individual who is unconscious, comatose or in the judgment of the Plan Administrator or its designee, is otherwise incapable of conscious participation in the therapy services and/or unable to learn and/or remember what is taught, including but not limited to coma stimulation programs and services;
- expenses for maintenance rehabilitation;
- expenses for speech therapy for functional purposes including but not limited to stuttering, stammering and conditions of psychoneurotic origin, or for childhood developmental speech delays and disorders;
- expenses for treatment of delays in childhood speech development, unless as a direct result of an injury, surgery or the result of a covered treatment.

29. Self-Procured Services - Services rendered to a Covered Person who is not under the regular care of a Physician and for services, supplies or treatment, including any periods of hospital confinement, which are not recommended, approved and certified as necessary and reasonable by a Physician, except as may be specifically included in the list of **Eligible Medical Expenses**.

30. Vision Care - Eye examinations for the purpose of prescribing corrective lenses.

- Vision supplies (eyeglasses or contact lenses, etc.) or their fitting, replacement, repair or adjustment.
- Orthoptics, vision therapy, vision perception training, or other special vision procedures, including procedures whose purpose is the correction of refractive error such as radial keratotomy or lasik surgery.

NOTE: This exclusion will not apply to: (1) services necessitated by a Sickness, or (2) up to two pair of glass lenses and one set of frames or up to two pair of contact lenses within one year following intraocular surgery or Accidental Injury.

31. Vitamins or Dietary Supplements - Prescription or non-prescription organic substances used for

32. nutritional purposes.

- Vitamins or vitamin therapy.

33. Vocational Testing or Training - Vocational testing, evaluation, counseling or training.

34. Weight Control - Services or supplies for obesity, weight reduction or dietary control, except for Bariatric Surgery when medical criteria are met. See **Weight Control** under **Eligible Medical Expenses.**

*- (See also **General Exclusions** section) -*

EXCLUSION WAIVER

The Insurance Appeals Committee has the authority to grant a waiver of an excludible expense if the service and/or supply meet the following criteria: The service and/or supplies must be Medically Necessary; less expensive than alternative treatment; with the likelihood of a negative patient response if the service or supply is not provided.

The Covered Person must request a waiver at least 30 days prior to the service and/or supply purchase. The Covered Person must provide documentation supporting the criteria. The Committee has the right consult with an independent medical advisor before rendering a decision.

PRESCRIPTION DRUG PROGRAM SUMMARY
through
MAXORPLUS

The Prescription Drug Program is provided through a separate agreement with MaxorPlus, a Pharmacy Benefit Administrator (PBA). This section provides a summary of the prescription drug coverage through MaxorPlus. Updated information regarding the formulary list, covered and non-covered drugs, participating pharmacies and helpful information on generic equivalent drugs can be found on their website.

PRESCRIPTION DRUG PROGRAM
MaxorPlus
(800) 687-0707
www.maxorplus.com

When a Covered Person presents their health plan identification card at a participating pharmacy (i.e. pharmacy with an agreement with the pharmacy network provider, TrueChoice) the Covered Person pays the co-pay for each prescription and each refill. If you use a non-participating pharmacy, you must pay full price and file a claim with MaxorPlus. Claims should be filed within 30 days of date of purchase but will be accepted up to one year from date of purchase. Reimbursement will be equal to the prescription cost less the appropriate co-pay.

	PPO	HDHP
CALENDAR YEAR DEDUCTIBLE Must be met before co-payment(s) apply	No	Yes
Retail Pharmacy Benefits / 30 day supply		
Generic Drug	$7 Co-pay	$7 Co-pay
Preferred Brand-Name Drug	$30 Co-pay	$30 Co-pay
Non-Preferred Brand-Name Drug	$50 Co-pay	$50 Co-pay

Maintenance Drugs may be filled through MaxorPlus mail service, up to 90-day supply		
	PPO	**HDHP**
Generic Drug	$14 Co-pay	$14 Co-pay
Preferred Brand-Name Drug	$60 Co-pay	$60 Co-pay
Non-Preferred Brand-Name Drug	$100 Co-pay	$100 Co-pay
For questions regarding the mail order program through MaxorPlus, or to reorder a prescription, call 800-687-8629, or reorder on the web at www.maxorplus.com.		

Specialty Drugs are required to be filled through MaxorPlus Specialty Pharmacy, 1-866-629-6779

Specialty drugs are medication that generally have unique uses, require special dosing or administration, are typically prescribed by a specialist provider and are significantly more expensive than alternative drugs.

	PPO	**HDHP**
Specialty Drugs	20% Co-insurance	20% Co-insurance
MaxorPlus Copay Assistance Program Specialty Drugs	Co-pay indicated on applicable manufacturer coupon	N/A

MaxorPlus Specialty Copay Assistance Program:

a. **Enrollment is required to participate:** Maxor Specialty Pharmacy Patient Care Advocates can assist members with enrollment with manufacturer copay assistance programs; call MaxorPlus Specialty Pharmacy at 1-866-629-6779

b. If your medication is included in the Program, the Plan will apply the manufacturer coupon value to the member portion and plan pay portion of the drug cost which will result in a less than 20% co-insurance to the member. Manufacturer coupon dictates applicable patient responsibility co-pay. Once the manufacturer coupon funds are exhausted, the patient responsibility will revert to the 20% Specialty Drug Co-insurance

NOTE: Any portion of the member's cost share known to have been paid by a coupon, rebate, or other third-party payer will be excluded from the member's deductible and out-of-pocket.

DIABETIC METER PROGRAM

Living with diabetes can be an everyday challenge. Research shows that to maintain control of your blood glucose levels and reduce your risk of diabetes-related complication, you must check your blood sugar every day using an accurate blood monitoring system while maintain a healthy and balanced lifestyle.

This program is available to you and is free of charge, except that co-payments may apply for the purchase of diabetic supplies. To obtain a free OneTouch meter, visit https://www.onetouch.com/offers or call 866-732-5941. To obtain a free Freestyle meter, visit https://www.myfreestyle.com/get-a-free-meter or call 888-522-5226

COVERED DRUGS

Covered drugs include most prescription drugs (i.e., federal legend drugs and compounded drugs which are prescribed by a Physician and which require a prescription either by federal or state law) and certain non-prescription items.

1. The following is a summary list of prescription and non-prescription drugs and supplies which are covered by this Plan. In some instances, coverage may be subject to prior authorization.
    - Legend drugs on the preferred drug list
        - Legend Smoking Deterrents
    - Retin-A - Pre-authorization is required
    - Insulin on prescription and disposable insulin syringes/needles when prescribed and dispensed at the same time as insulin and in equivalent quantities
    - Contraceptives – Prescription may be filled for a period not to exceed 12 months. (e.g. oral, shots, skin patch, vaginal ring, diaphragm, cervical cap, female condom, spermicide foam and sponges with a written prescription from a Physician)
    - Hormone Replacement Therapy
    - Diabetic Supplies - Alcohol swabs, lancets, lancet devises, test strips
    - Depo-Provera injection
    - Epi-Pen, Epi-Pen, Jr.

EXPENSES NOT COVERED

Examples of prescription drugs and services not included are:

1. **Administration** - Any charge for the administration of a covered drug.
2. **Blood, Blood Plasma and Biological Sera**
3. **Devices** - Devices of any type, even though such devices may require a prescription. These include but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.
4. **Excess Refills** - Refills beyond the number specified by a Physician or refills more than one (1) year from the date of the initial prescription order.
5. **Experimental and Non-FDA Approved Drugs** - Experimental drugs and medicines, even though a charge is made to the Covered Person. Drugs not approved by the Food and Drug Administration.
6. **Immunizations Agents** - Serums, toxoids, vaccines.
7. **Investigational Drugs** - A drug or medicine labeled: “Caution - limited by federal law to investigational

use."

8. **No Charge** - A prescribed drug which may be properly received without charge under a local, state or federal program or for which the cost is recoverable under any workers' compensation or occupational disease law.

9. **Non-Home Use** - Drugs intended for use in a health care facility (Hospital, Skilled Nursing Facility, etc.) or dispensed in or from a Physician's office.

10. **Non-Prescription Drugs** - A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

11. **Outside United States** - Prescriptions purchased outside of the United States.

12. **Smoking Cessation/Deterrent Drugs** - Any type of non-prescription drug or supply for smoking cessation (e.g., nicotine gum, smoking deterrent patches, etc.).

ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE PART D

Prescription drug coverage is available to everyone with Medicare through the Medicare prescription drug plans. Because this Plan's prescription drug coverage is, on average, at least as good as standard Medicare prescription drug coverage, the Plan suggests that you do not enroll in any Medicare D prescription plan at this time. Because this prescription drug plan is considered "Creditable" you can choose to join a Medicare prescription drug plan later with no penalty.

DENTAL BENEFIT SUMMARY

Washoe County provides one Dental Benefit Plan for ALL benefited Employees and their covered dependents regardless of their selection of Medical Plans.

Dental benefits are available through the Retiree Health Benefits Program as an *optional* benefit, with the entire premium payment made by the retiree.

Dental Claims Contract Administrator:

CDS Group Health
1510 Meadow Wood Lane
P.O. Box 50190
Sparks, NV 89435-0190
(775) 352-6900 or (800) 455-4236
www.cdsgrouphealth.com

The Dental Claims Contract Administrator listed above handles the processing of dental claims in accordance with the Washoe County Plan Document. A Covered Person can also obtain additional information about the dental Plan coverage, treatment, procedures, preventative service, etc. from the Contract Administrator.

CHOICE OF DPPO OR NON-DPPO PROVIDERS

The Plan Sponsor has contracted with a Dental Preferred Provider Organization (DPPO) called DentalGuard Preferred Select Network. You can obtain a list of the dental providers by going to their website at www.guardiananytime.com.

When obtaining dental care services, a Covered Person has a choice of using a dental provider who is participating in the DPPO network or any other Covered Provider of his/her choice. Because DPPO providers have agreed to provide dental services at negotiated rates, when a Covered Person uses a DPPO provider his/her out-of-pocket costs may be reduced because he/she will not be billed for expenses in excess of "Usual, Customary and Reasonable" or in excess of the negotiated rates.

SCHEDULE OF DENTAL BENEFITS

MAXIMUM BENEFIT	
Dental Calendar Year Maximum, per person	$3,000
Orthodontia Lifetime Maximum, per person	$1,500
CALENDAR YEAR DEDUCTIBLE Individual Deductible	 $50
There is no deductible on Preventive services. The above dental deductible is applied to Basic, Major or Orthodontic services only and must be met by each covered person in each calendar year before benefits are payable for covered expenses each calendar year.	
ELIGIBLE DENTAL EXPENSES	**Benefit**
Preventive Services (Deductible waived)	100%
- routine oral examinations and cleanings are limited to 4 exams/cleanings per Calendar Year; - fluoride is limited to 2 applications per Calendar Year, for children under age 18; - routine bitewings are limited to 2 sets per Calendar Year; - Panoramic (full-mouth) X-rays are limited to once per 3-year period;	
Basic Services	80%
Major Services	50%
Orthodontic Services	50%

DENTAL PRE-TREATMENT ESTIMATE

If extensive dental work is needed, the Plan Administrator recommends that a pre-treatment estimate be obtained prior to the work being performed. Emergency treatments, oral examinations including prophylaxis, and dental X-rays will be considered part of the "extensive dental work" but may be performed before the pre-treatment estimate is obtained.

A pre-treatment estimate is obtained by having the attending dentist complete a statement listing the proposed dental work and charges. The form is then submitted to the Contract Administrator for review and estimate of benefits. The Contract Administrator may require an oral exam (at Plan expense) or request X-rays or additional information during the course of its review.

A pre-treatment estimate serves two purposes. First, it gives the patient and the dentist a good idea of benefit levels, maximums, limitations, etc., that might apply to the treatment program so that the patient's portion of the cost will be known and, secondly, it offers the patient and dentist an opportunity to consider other avenues of restorative care that might be equally satisfactory and less costly.

Most dentists are familiar with pre-treatment estimate procedures and the dental claim form is designed to facilitate pre-treatment estimates.

If a pre-treatment estimate is not obtained prior to the work being performed, the Plan Administrator reserves the right to determine Plan benefits as if a pre-treatment estimate had been obtained.

NOTE: A pre-treatment estimate is not a guarantee of payment. Payment of Plan benefits is subject to Plan provisions and eligibility at the time the services are actually incurred. The pre-treatment estimate is valid for ninety (90) days from the date of issue.

ELIGIBLE DENTAL EXPENSES

1. Eligible dental expenses are the Usual, Customary and Reasonable charges for the dental services and supplies listed below, which are: (1) incurred while a person is covered under the Plan, and (2) received from a licensed dentist, a qualified technician working under a dentist's supervision or any Physician furnishing dental services for which he/she is licensed.

2. For benefit purposes, dental expenses will be deemed incurred as follows:
   - for an appliance or modification of an appliance, on the date the final impression is taken;
   - for a crown, inlay, onlay or gold restoration, on the date the tooth is prepared;
   - for root canal therapy, on the date the pulp chamber is opened; or
   - for any other service, on the date the service is rendered.

   NOTE: Many dental conditions can be properly treated in more than one way. The Plan is designed to help pay for dental expenses, but not for treatment which is more expensive than necessary for good dental care. If a Covered Person chooses a more expensive course of treatment, the Plan will pay benefits equivalent to the least expensive treatment that would adequately correct the dental condition.

PREVENTIVE SERVICES

1. **Exams & Cleanings, Routine** - Routine oral examinations and routine cleaning and polishing of the teeth.

2. **Fluoride** - Topical application of stannous or sodium fluoride.

3. **Prophylaxis** - see "Exams & Cleanings, Routine"

4. **X-rays, Routine** - Routine full mouth X-rays, routine bitewing X-rays and supplementary periapical X-rays as necessary. “Full mouth X-rays” means a panorex plus bitewings or fourteen (14) periapical films plus bitewings.

BASIC SERVICES

1. **Anesthesia** - General anesthesia when administered in connection with oral Surgery.

   NOTE: Hypnosis and relative analgesia are <u>not</u> covered unless the patient is completely anesthetized to a state of unconsciousness as with a general anesthetic.

2. **Endodontia** - Endodontic services including but not limited to: root canal therapy (but not on a primary tooth), pulpotomy, apicoectomy and retrograde filling.

3. **Extraction** - See "Oral Surgery"

4. **Fillings, Non-Precious** - Amalgam, silicate, composite and plastic restorations, including pins to retain a filling restoration when necessary.

   Replacement of a filling if the existing restoration is at least twenty-four (24) months old.

5. **Injections** - Injection of antibiotic drugs.

6. **Night Guard/Occlusal Guard -** For the treatment of bruxism (grinding or clenching teeth) up to a maximum of $250 once every 5 years (including adjustment or repairs).

7. **Non-Routine Exams/Visits** - Office visits other than those covered as “Preventive Services.”

8. **Oral Surgery** - Extraction of teeth, including simple extractions and surgical extraction of bone or tissue-impacted teeth. Biopsy of oral tissue (but not including laboratory costs), and other surgical and adjunctive treatment of disease, injury and defects of the oral cavity and associated structures.

9. **Palliatives** - Emergency treatment for the relief of dental pain.

10. **Periodontia** - Periodontal scaling and root planing and surgical procedures (i.e., gingivectomy, osseous surgery and mucogingival surgery). Any allowance for periodontal surgery includes postoperative care for six (6) months following the surgery.

11. **Repairs & Adjustments** - Repair of bridgework or dentures, the relining of dentures (see NOTE) and prosthetic adjustments.

    NOTE: Relines are limited to laboratory relines. Office relines are considered to be temporary and are not covered.

12. **Sealants** - Application of sealants to the pits and fissures of the teeth, with the intent to seal the teeth and reduce the incidence of decay. Coverage is limited to application on the occlusal (biting) surface of permanent molars which are free of decay or prior restoration.

    Any allowance made for sealants includes any necessary repair or replacement within thirty-six (36) months from time of application.

13. **Space Maintainers** - Fixed and removable appliances to maintain (not change) the space left by a prematurely lost primary or "baby" tooth and to prevent abnormal movement of the surrounding teeth.

14. **X-Rays, Non-Routine** - X-rays other than those covered as “Preventive Services.”

MAJOR SERVICES

1. **Crowns** - A crown restoration when a tooth cannot be satisfactorily restored with a filling restoration. Coverage for a crown includes a post and core when necessary. The maximum allowance for a crown on a primary tooth will be the allowance for a stainless steel crown.

   Replacement of a crown, if the existing crown is at least five (5) years old.

2. **Implants** - Placement of an implant to replace a missing tooth.

3. **Inlays, Onlays & Gold Restorations** - An inlay, onlay or gold restoration when a tooth cannot be satisfactorily restored with a less costly filling (amalgam, etc.) restoration.

   Replacement of an inlay, onlay or gold restoration, if the existing restoration is at least five (5) years old.

4. **Prosthetics** - Initial placement of a full or partial denture or bridge.

   Addition of teeth to a partial denture or bridge.

   Replacement of an existing full or partial denture or bridgework, but only if the existing denture or bridgework cannot be made serviceable and is at least five (5) years old.

   NOTE: Fixed bridges are not covered for a child under sixteen (16) years of age. An allowance will be made for a partial denture.

ORTHODONTIA SERVICES

1. **Consultation**
2. **Initial banding or placement of orthodontia appliance(s)**
3. **Models, X-rays and other diagnostic services**
4. **Periodic adjustments**
5. **Retainers**

DENTAL LIMITATIONS AND EXCLUSIONS

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

1. **Cosmetic Dentistry** - Treatment rendered purely for cosmetic purposes.

2. **Discoloration Treatment** - Teeth whitening or any other treatment to remove or lessen discoloration, except in connection with endodontia.

3. **Excess Care** - Services which exceed those necessary to achieve an acceptable level of dental care. If it is determined that alternative procedures, services, or courses of treatment could have been performed to correct a dental condition, Plan benefits will be limited to the least costly procedure(s) which would produce a professionally satisfactory result.

   Duplicate prosthetic devices or appliances.

4. **Experimental Procedures** - Services which are considered experimental or which are not approved by the American Dental Association.

5. **Hospital Expenses**

6. **Implant Removal** - The removal of implants.

7. **Lost or Stolen Prosthetics or Appliances** - Replacement of a prosthetic or any other type of appliance which has been lost, misplaced, or stolen.

8. **Medical Expenses** - Any dental-related services to the extent to which coverage is provided under the terms of the medical benefits of this Plan.

9. **Myofunctional Therapy** - Muscle training therapy or training to correct or control harmful habits.

10. **Non-Professional Care** - Services rendered by someone other than:
    - a dentist (DDS or DMD);
    - a dental hygienist, X-ray technician or other qualified technician who is under the supervision of a dentist; or
    - a Physician furnishing dental services for which he/she is licensed.

11. **Oral Hygiene Instruction and Supplies, Etc.** - Dietary or nutritional counseling or related supplies, personal oral hygiene instruction or plaque control. Oral hygiene supplies including but not limited to: toothpaste, toothbrushes, waterpiks, and mouthwashes.

13. **Orthognathic Surgery** - Surgery to correct a receding or protruding jaw.

14. **Personalization or Characterization of Dentures** - Excess charges for the personalization or characterization of dentures.

15. **Prescription Drugs** - See the **Prescription Drugs** section

16. **Prior to Effective Date / After Termination Date** - Courses of treatment which were begun prior to the Covered Person's effective date, including crowns, bridges or dentures which were ordered prior to the effective date and Expenses incurred after termination of coverage.

17. **Replanted / Transplanted Teeth** - Restorations on replanted or transplanted teeth.

18. **Splinting** - Appliances or restorations for splinting teeth.

19. **Temporary Restorations and Appliances** - Excess charges for temporary restorations and appliances. The Eligible Expenses for the permanent restoration or appliance will be the maximum covered charge. (MAJOR)

20. **TMJ Treatment** - Procedures, restorations or appliances for the treatment of temporomandibular joint dysfunction syndrome. See Eligible Expenses under Medical

*- (See also **General Exclusions** section) -*

GENERAL EXCLUSIONS

The following exclusions apply to all health benefits and no benefits will be payable for:

1. **Court-Ordered Care, Confinement or Treatment** - Any care, confinement or treatment of a Covered Person in a public or private institution as the result of a court order, unless the confinement would have been covered in the absence of the court order.

2. **Criminal Activities** - Any injury, illness or sickness which is incurred while taking part or attempting to take part in a felony **Criminal Act** (see definition), including but not limited to, burglary, robbery, assault, criminal trespass, participation in a riot or civil disturbance, or while engaged in an illegal occupation. It is not necessary that a criminal charge be filed, or, if filed, that a conviction results. Proof beyond a reasonable doubt is not required to be deemed a Criminal Act. Such exclusion does not apply to injuries and/or illness sustained due to a medical condition (physical or mental) or victims of domestic violence. NRS 689B.287

3. **Drugs in Testing Phases** - Medicines or drugs which are in the Food and Drug Administration Phases I, II, or III testing, drugs which are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

   Except as specifically authorized by the United States Food and Drug Administration, any treatment using dimethyl sulfoxide (DMSO), laetrile or gerovital.

4. **Excess Charges** - Charges in excess of the Usual, Customary and Reasonable fees for services or supplies provided.

5. **Experimental / Investigational Treatment** - Expenses for treatments, procedures, devices, or drugs which the Plan Administrator determines, in the exercise of its discretion, are experimental, investigational, or done primarily for research. Treatments, procedures, devices, or drugs shall be excluded under this Plan unless:

   - approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law; and
   - reliable evidence shows that the treatment, procedure, device or drug is not the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses; and
   - reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses.

     "Reliable evidence" shall include anything determined to be such by the Plan Administrator, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the medical professional community in the United States, including the *CMS Medicare Coverage Issues Manual*.

   As an exception to the above, NRS 689B.0306 mandates the following criteria be met in cases of cancer and chronic fatigue syndrome:

   - a policy of health insurance must provide coverage for medical treatment in a clinical study if:
     - treatment is a phase I, II, III, or IV for cancer;
     - treatment is a phase II, III, or IV for chronic fatigue syndrome;
     - study is approved by Agency of Nat'l Institute of Health, a cooperative group (see bill for exact definition), FDA for new investigational drug, US Dept. of Veterans Affairs, US Dept. of Defense;

- health care provider and facility have experience to provide the care;
- no other treatment considered a more appropriate alternative;
- reasonable expectation based on clinical data that treatment will be at least as effective as other treatments;
- study is conducted in Nevada;
- participant signs a statement of consent that he has been informed of: (1) the procedure to be undertaken, (2) alternative methods of treatment, and (3) associated risks of treatment;

▪ coverage for medical treatment is limited to:
- a drug or device approved for sale by the FDA;
- reasonably necessary required services provided in treatment or as a result of complications to the extent that they would have otherwise been covered;
- initial consultation; and
- clinically appropriate monitoring;

▪ treatment not required to be covered if provided free by sponsor;

▪ coverage does not include:
- portions customarily paid by other government or industry entities;
- a drug or device paid for by manufacturer or distributor;
- excluded health care services;
- services customarily provided free in a study;
- extraneous expenses related to study;
- expenses for persons accompanying participant in study;
- any item or service provided for data collection not directly related to study;
- expenses for research management of study.

To determine how to obtain a pre-certification of any procedures that might be deemed to be experimental and/or investigational, see the **Utilization Management Program**.

6. **Forms Completion** - Charges made for the completion of claim forms or for providing supplemental information.

7. **Government-Operated Facilities** - Services furnished to the Covered Person in any veterans hospital, military hospital, institution or facility operated by the United States Government or by any state government or any agency or instrumentality of such governments.

   NOTE: This exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other federal government hospital to dependents of active duty armed service personnel or armed service retirees and their dependents. This exclusion does not apply where otherwise prohibited by law.

8. **Late-Filed Claims** - Claims which are not filed with the Contract Administrator for handling within one (1) year from the date of service. See **Claims Procedures** section for additional information.

9. **Military Service** - Conditions that are determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

10. **Missed Appointments** - Expenses incurred for failure to keep a scheduled appointment.

11. **No Charge / No Legal Requirement to Pay** - Services for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. Where Medicare coverage is involved and this Plan is a "secondary"

coverage, this exclusion will apply to those amounts which a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts.

NOTE: The above exclusion does not apply to any benefit or coverage which is available through the Medical Assistance Act (Medicaid).

12. **Not Listed Services or Supplies** - Any services, care or supplies which are not specifically listed in the Benefit Document as Eligible Expenses will not be covered unless the expense is substantiated and determined to be Medically Necessary and is approved for coverage by the Plan Administrator.

13. **Other Coverage** - Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (federal or state, dominion or province or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Payer or Medicaid Priority rules.

    Services or supplies received from a health care department maintained by or on behalf of an employer, mutual benefit association, labor union, trustees or similar person(s) or group.

14. **Outside United States** - Charges incurred outside of the United States if the Covered Person traveled to such a location for the primary purpose of obtaining such services or supplies.

15. **Postage, Shipping, Handling Charges, Etc.** - Any postage, shipping or handling charges which may occur in the transmittal of information to the Contract Administrator. Interest or financing charges.

16. **Prior Coverages** - Services or supplies for which the Covered Person is eligible for benefits under the terms of the document that this Benefit Document replaces.

17. **Prior to Effective Date / After Termination Date** - Charges incurred prior to an individual's effective date of coverage under the Plan or after coverage is terminated, except as may be expressly stated.

18. **Relative or Resident Care** - Any service rendered to a Covered Person by a relative (i.e., a spouse, or a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

19. **Sales Tax, Etc.** - Sales or other taxes or charges imposed by any government or entity. However, this exclusion will not apply to surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) or similar surcharges imposed by other states.

20. **Self-Inflicted Injury** - Any expenses resulting from voluntary self-inflicted injury or voluntary attempted self-destruction, except that, this exclusion will not apply where such self-inflicted injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g., depression).

21. **Telecommunications** - Advice or consultation given by or through any form of telecommunication.

22. **Travel** - Travel or accommodation charges, whether or not recommended by a Physician, except for ambulance charges or as otherwise expressly included in the list of **Eligible Medical Expenses**.

23. **War or Active Duty** - Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications therefrom, or service (past or present) in the armed forces of any country, to the extent not prohibited by law.

24. **Work-Related Conditions** - Any condition which is covered or subject to any workers' compensation law or federal employer compensation or liability acts, even if the Covered Person or the Employer is not in compliance therewith or has rejected or not applied for such coverage.

COORDINATION OF BENEFITS

Health care benefits provided under the Plan, are subject to Coordination of Benefits (COB) as described below, unless specifically stated otherwise.

NOTE: The Prescription Drug Program under this Plan does not contain a COB Provision.

DEFINITIONS

As used in this COB section, the following terms will be capitalized and will have the meanings indicated:

1. **Other Plan** - Any of the following that provides health care benefits or services:
   - group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured). A "closed panel plan" is a plan that, except in an emergency, provides coverage only in the form of services obtained through a panel of providers that have contracted with or are employed by the plan;
   - medical care components of group long-term care contracts, such as skilled nursing care;
   - medical benefits under group or individual automobile contracts;
   - auto insurance which is subject to a state "no-fault" automobile insurance law. A Covered Person will be presumed to have at least the minimum coverage requirement of the state of jurisdiction, whether or not such coverage is actually in force;
   - Medicare or other governmental benefits, as permitted by law.

   An "Other Plan" does not include: (1) individual or family insurance, (2) closed panel or other individual coverage (except for group-type coverage), (3) school accident type coverage, (4) benefits for non-medical components of group long-term care policies, (5) Medicare supplement policies, (6) Medicaid policies or coverage under other governmental plans, unless permitted by law.

   NOTES: An "Other Plan" includes benefits that are actually paid or payable or benefits which would have been paid or payable if a claim had been properly made for them.

   If an Other Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

2. **This Plan** - The coverages of this Plan.

3. **Allowable Expense** - A health care service or expense, including deductibles and co-payments, that is covered at least in part by any of the plans (i.e., This Plan or Other Plan(s)) covering the Claimant. When a plan provides benefits in the form of services (an HMO, for example), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

   Any expense or service that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:
   - If a Claimant is confined in a private hospital room, the difference in cost between a semi-private room in the hospital and a private room will not be an Allowable Expense unless the private room accommodation is medically necessary in terms of generally accepted medical practice or unless one of the plans routinely provides coverage for private rooms;
   - If a person is covered by two (2) or more plans that compute benefits on the basis of usual and customary allowances, any amount in excess of the highest usual and customary allowance is not an Allowable Expense;

- If a person is covered by two (2) or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the lowest of the negotiated fee is not an Allowable Expense;
- If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary and another plan that provides its benefits or services on the basis of negotiated fees, the negotiated fees shall be the Allowable Expense for This Plan.

NOTE: Any expense not payable by a primary plan due to the individual's failure to comply with any utilization review requirements (e.g., precertification of admissions, second surgical opinion requirements, etc.) will not be considered an Allowable Expense.

4. **Claim Determination Period** - A period which commences each January 1 and ends at 12 o'clock midnight on the next succeeding December 31, or that portion of such period during which the Claimant is covered under This Plan. The Claim Determination Period is the period during which This Plan's normal liability is determined (see "Effect on Benefits under This Plan").

5. **Custodial Parent** - A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

EFFECT ON BENEFITS UNDER THIS PLAN

When Other Plan Does Not Contain a COB Provision - If an Other Plan does not contain a COB provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be "primary" and This Plan will pay its benefits AFTER such Other Plan(s). This Plan's liability will be the lesser of: (1) its normal liability or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

When Other Plan Contains a COB Provision - When an Other Plan also contains a COB provision similar to this one, This Plan will determine its benefits using the "Order of Benefit Determination Rules" below. If, in accordance with those rules, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits AFTER an Other Plan(s), it will pay the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan(s).

NOTE: The determination of This Plan's "normal liability" will be made for an entire Claim Determination Period (i.e. Calendar Year). If this Plan is "secondary," the difference between the benefit payments that This Plan would have paid had it been the primary plan and the benefit payments that it actually pays as a secondary plan is recorded as a "benefit reserve" for the Covered Person and will be used to pay Allowable Expenses not otherwise paid during the balance of the Claim Determination Period. At the end of the Claim Determination Period, the benefit reserve returns to zero.

ORDER OF BENEFIT DETERMINATION RULES

Under Order of Benefits Rules, whether this Plan is the "primary" plan or a "secondary" plan is determined in accordance with the following rules, in the order specified below.

Medicare as an "Other Plan" - Medicare will be the primary, secondary or last payer in accordance with federal law. When Medicare is the primary payer, this Plan will determine its benefits based on Medicare Part A and Part B benefits that were paid. For those employees hired post 97/98, Medicare Part A and B will become the primary payer upon retirement or when the claimant obtains Medicare eligibility at age 65, regardless of whether or not they enroll in Medicare. If claimant does not enroll in Medicare upon

eligibility, this Plan will pay 20% of eligible benefits. This provision also applies to the retiree's dependents upon reaching Medicare eligibility.

Non-Dependent vs. Dependent - The benefits of a plan which covers the Claimant other than as a dependent (i.e., as an employee, member, subscriber or retiree) will be determined before the benefits of a plan which covers such Claimant as a dependent. However, if the Claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan - When the Claimant is a dependent child, the primary plan is the plan of the parent whose birthday is earlier in the year if: (1) the child's parents are married, (2) the parents are not separated, whether or not they have ever been married, or (3) 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 covered either of the parents longer is primary.

When the Claimant is a dependent child and 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 commencing after the plan is given notice of the court decree.

When the Claimant is a dependent child whose father and mother are not married, are separated (whether or not they have ever been married) or are divorced, 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 vs. Inactive Employee - The plan that covers the Claimant as an employee, who is neither laid off nor retired, is primary. The plan that covers a person as a dependent of an employee, who is neither laid off nor retired, is primary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage (COBRA) Enrollee - If a Claimant is a COBRA enrollee under This Plan, an Other Plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary and This Plan is secondary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer vs. Shorter Length of Coverage - If none of the above rules establish which plan is primary, the benefits of the plan which has covered the Claimant for the longer period of time will be determined before those of the plan which has covered that person for the shorter period of time.

NOTE: If the preceding rules do not determine the primary plan, the Allowable Expenses shall be shared equally between This Plan and the Other Plan(s). However, This Plan will not pay more than it would have paid had it been primary.

OTHER INFORMATION ABOUT COORDINATION OF BENEFITS

Right to Receive and Release Necessary Information
For the purpose of enforcing or determining the applicability of the terms of this COB section or any similar provision of any Other Plan, the Contract Administrator may, without the consent of any person, release to or obtain from any insurance company, organization or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish to the Contract Administrator such information as may be necessary to enforce this provision.

Facility of Payment
A payment made under an Other Plan may include an amount that should have been paid under This Plan. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though 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 it should have paid under this COB section, the Plan may recover the excess from one or more of the persons it has paid or for whom it has paid—or any other person or organization that may be responsible for the benefits or services provided for the Claimant. The "amount of the payments made" includes the reasonable cash value of benefits provided in the form of services.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed. The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.

5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
7. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
8. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
9. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
10. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset
If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status
In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court- appointed guardian.

Language Interpretation
The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability
In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

ELIGIBILITY AND EFFECTIVE DATES

Choice of Coverage and Annual Re-Election
The coverages of the Plan include optional schedules from which an Employee must choose at point of initial enrollment in the Plan. An Employee must enroll himself/herself and his Dependents (if any are to be enrolled) in the same option(s).

Coverage becomes effective on the 91st day of continuous, full time or permanent part-time employment. The employee must enroll via ESS in a timely manner, but no later than 31 days after this effective date. If enrollment is not completed within that time frame, the employee will be enrolled with **employee only** coverage in the County-sponsored self-funded medical plan as of his/her effective date and will not be allowed to change plans until Open Enrollment or unless another qualifying event occurs.

Once in each Plan Year, the Plan Sponsor will hold an Open Enrollment period. At that time, covered Employees and their covered Dependents may change between the coverage options. The newly-elected option will become effective on the date specified by the Plan Sponsor following the Open Enrollment.

Eligibility Requirements - Employees
An individual eligible to participate in the Plan as an "Employee" includes:

- an individual in active permanent employment for the Employer performing all customary duties of his occupation at his usual place of employment (or at a location to which the business of the Employer requires him/her to travel) and regularly scheduled to work at least twenty one (21) hours per week;
- a County retiree who receives monthly payments under the State of Nevada Public Employees' Retirement System (PERS) and who elected to continue coverage at retirement;
- a surviving spouse of a deceased retiree who elects to continue coverage on a contributory basis (see “Survivor Privilege” in the **Extension of Coverage Provisions**); and
- a current elected official.

An Employee will be deemed in "active employment" on each day he is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided he/she was actively at work on the last preceding regular working day. An Employee will also be deemed in "active employment" on any day on which he/she is absent from work during an approved FMLA leave or solely due to his own health status (see "Non-Discrimination Due to Health Status" in the **General Plan Information** section). An exception applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on his first scheduled workday, he/she will not be considered as having commenced active employment.

See **Extension of Coverage** section(s) for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

Effective Date - Employees
An eligible Employee’s coverage is effective, subject to timely enrollment, on his ninety-first (91st) day of continuous full-time or part-time employment.

Eligibility Requirements - Dependents
An eligible Dependent of an Employee is:

- a legally married spouse - legally married means a legal union (as defined by the Employee’s state of residence). In no instance will an eligible spouse include a common law spouse;

- a domestic partner. The domestic partnership must be established in Nevada by filing a Declaration of Domestic Partnership with the Secretary of State. All of the following requirements must be met:
  - both persons must be at least 18 years of age;
  - have not terminated that domestic partnership;
  - both persons are competent to consent to the domestic partnership;
  - both persons are not related by blood in a way that would prevent them from being married to each other in this state;
  - neither person is married or a member of another domestic partnership;
  - both persons share a common residence; and
  - both persons sign a declaration that they have chosen to share one another's lives in an intimate and committed relationship of mutual caring.
- a child under age 26. The child need not: (1) reside with the Employee or any other person, (2) be a student, (3) be a tax-code dependent of the Employee or financially dependent on the Employee or any other person, (4) be unmarried, or (5) be unemployed.

  A "child" will include:

  - a natural child;
  - a stepchild;
  - a child placed under the court-appointed legal guardianship of the Employee;
  - a child who is adopted by the Employee or placed with him for adoption prior to age 18. "Placed for adoption" means the assumption and retention by the Employee of a 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 begun. Placement ends when the legal support obligation ends;
  - notwithstanding any residency or main support and care requirements, a child for whom the Employee or covered Dependent spouse is required to provide coverage due to a Medical Child Support Order (MCSO) which the Plan Administrator determines to be a Qualified Medical Child Support Order in accordance with its written procedures (which are incorporated herein by reference and which can be obtained without charge). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and having the force and effect of state law;
  - a disabled dependent. The covered employee's dependent child is eligible for coverage at any age provided the dependent is permanently mentally or physically disabled, so incapacitated as to be incapable of self-sustaining employment, and depends upon the enrollee for 50% or more support. The disabling condition must have occurred prior to the dependents 26th birthday. The enrollee must provide written proof of incapacity (including documentation from a physician). Neither a reduction in work capacity nor an inability to find employment is, of itself, evidence of incapacitation. Coverage may continue for as long as the incapacitation exists and the covered employee remains covered under the Plan.

    Proof of disability must be provided within thirty-one (31) days of the child's attainment of the limiting age; see **Extension of Coverage** (page 60) for full requirements and details.

    New employees or covered employees, during a period of **Open Enrollment** (page 55), who wish to enroll a permanently disabled dependent must submit the written proof of incapacity as described above. The disabling condition must have occurred prior to the dependent's 26th birthday.

An eligible Dependent does not include:

- a grandchild
- a spouse following legal separation or a final decree of dissolution or divorce;
- a spouse who is eligible for Medicare coverage by reason of age and who has elected Medicare coverage in lieu of Plan coverage;
- any person who is on active duty in a military service, to the extent permitted by law;
- any person who is eligible and has enrolled as an Employee under the Plan;
- any person who is covered as a Dependent of another Employee under the Plan.

These eligibility requirements may be waived or modified pursuant to the **Extension of Coverage** section herein.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.

Proof of Dependent Status
Specific documentation to substantiate Dependent status may be requested at any time and may include any of the following:

- marriage - a copy of the certified marriage certificate or passport;
- domestic partnership - a copy of the Declaration of Domestic Partnership with the Nevada Secretary of State;
- birth - a copy of the live birth confirmation;
- adoption or placement for adoption - a copy of the court order signed by the judge. Final adoption decree and/or birth record must be submitted to the County's Human Resource Office within thirty-one (31) days of issuance;
- permanent legal guardianship - a copy of the permanent legal guardianship court order, signed by the judge, and a copy of the certified birth certificate.

Effective Date - Dependents
A Dependent who is eligible and enrolled when the Employee enrolls, will have coverage effective on the same date as the Employee. Dependents acquired later may be enrolled within thirty-one (31) days of their eligibility date and coverage will be effective on the first day of the event or acquired. (see the "Special Enrollment Rights" provision for details as well as instances when the loss of other coverage and other circumstances can allow a Dependent to be enrolled). Otherwise, a Dependent can be enrolled only in accordance with the "Open Enrollment" provision.
NOTE: In no instance will a Dependent's coverage become effective prior to the Employee's coverage effective date.

Notification of Family and Status Changes
It is an enrolled Employee's responsibility to notify Washoe County Human Resources promptly whenever he/she has a change in status as described below:

- he/she has a Dependent or Dependents who are no longer eligible for coverage under the Plan (i.e. divorce, legal separation);
- he/she wishes to add or discontinue Plan coverage for a spouse/domestic partner;
- he/she or any covered Dependent becomes eligible for Medicare's Part A, B, C and D Prescription plan.

NOTE: Failure to report a family and/or status change to the County's Human Resource's Office could result in loss of contributions. A maximum of two (2) months of contributions will be reimbursed for overpayment due to non-notification of a family and/or status change.

Newborn Children - Limited Automatic 31-Day Benefit Period for Ill or Injured Children
An Employee's ill or injured newborn child or the ill or injured newborn child of an Employee's legal spouse will be eligible for benefits for Eligible Expenses which are incurred within the first thirty-one (31) days after the child's birth. Benefits for such child will be available for the 31-day period only. After the 31-day period, coverage for the child will be available only if, within the thirty-one (31) days after the child's birth, the Employee has notified the Plan Sponsor or the Contract Administrator of the birth, has enrolled the child, and has agreed to make any required contributions for coverage from the moment of birth. NRS 689B.033. **NOTE:** During the limited 31-day benefit period, an ill or injured newborn child is not a Covered Person. Any extended coverage periods or coverage continuation options which are available to Covered Persons WILL NOT APPLY to a newborn child who is provided with these thirty-one (31) days of limited benefits and who is not enrolled within such 31-day period.

Special Enrollment Rights
Entitlement Due to Loss of Other Coverage - An individual who did not enroll in the Plan when previously eligible will be allowed to apply for coverage under the Plan at a later date if:

- he/she was covered under another group health plan or other health insurance coverage (including Medicaid) at the time coverage was initially offered or previously available to him. "Health insurance coverage" means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;
- the individual lost the other coverage as a result of a certain event such as, but not limited to, the following:
  - loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment;
  - loss of eligibility when coverage is offered through an HMO or other arrangement in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual);
  - loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
  - loss of eligibility when a plan no longer offers any benefits to a class of similarly situated individuals. For example, if a plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility, even if the plan continues to provide coverage to other employees;
  - loss of eligibility when employer contributions toward the employee's or dependent's coverage terminates. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer;
  - loss of eligibility when COBRA continuation coverage is exhausted; and
- the Employee requested Plan enrollment within thirty-one (31) days of termination of the other coverage.

If the above conditions are met, Plan coverage will be effective on the date of the event.

Loss of other coverage for failure to pay premiums on a timely basis or for cause (e.g., making a fraudulent claim or making an intentional misrepresentation of a material fact with respect to the other coverage) will not be a valid loss of coverage for these purposes.

Entitlement Due to Acquiring New Dependent (s) - If an Employee acquires one (1) or more new eligible Dependents through marriage, birth, adoption, or placement for adoption (as defined by federal law),

application for their coverage may be made within thirty-one (31) days of the date the new Dependent or Dependents are acquired (the "triggering event") and Plan coverage will be effective as follows:

- where Employee's marriage is the "triggering event" - the spouse's coverage (and the coverage of any eligible Dependent children the Employee acquires in the marriage) will be effective on the date of the event;
- where birth, adoption or placement for adoption is the "triggering event" - the child's coverage will be effective on the date of the event (i.e., concurrent with the child's date of birth, date of placement or date of adoption). The "triggering event" date for a newborn adoptive child is the child's date of birth if the child is placed with the Employee within thirty-one (31) days of birth.

NOTE: For a newly-acquired Dependent to be enrolled under the terms of this provision, the Employee must be enrolled or must be eligible to enroll (i.e., must have satisfied any waiting period requirement) and must enroll concurrently. If the newly-acquired Dependent is a child, the spouse and other eligible children are also eligible to enroll.

The Children's Health Insurance Program Reauthorization Act 2009
Employees and Dependents who are eligible but not enrolled for the Employer's group health plan may enroll for coverage hereunder in the following instances:

Loss of Medicaid or CHIP Eligibility: If the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, the Employee may request coverage under the Employer's group health plan coverage within sixty (60) days after Medicaid or CHIP coverage terminates.

Eligibility for State Premium Assistance: Where a state has chosen to offer premium assistance subsidies for qualified employer-sponsored benefits (see NOTE) and if the Employee or Dependent becomes eligible for such subsidy under Medicaid or CHIP, then the Employee may request coverage under the Employer's group health plan within sixty (60) days after eligibility for the subsidy is determined.

NOTE: CHIP allows states to elect to offer premium assistance subsidies to qualified individuals. Such subsidies are not mandated.

Court or Agency Ordered Coverage - If an Employee or an Employee's spouse is required to provide coverage for a child under a Medical Child Support Order, coverage for the child shall be effective as of the date specified in such order provided that such order is qualified according to the Plan Administrator's written procedures and provided that a request for coverage is made on a form acceptable to the Plan Administrator within thirty-one (31) days from the date such order is determined to be qualified. A request to enroll the child may be made by the Employee, the Employee's spouse, the child's other parent, or by a state agency on the child's behalf.

If the Employee is not enrolled when the Plan is presented with an MCSO that is determined to be qualified, and the Employee's enrollment is required in order to enroll the child, both must be enrolled. The Employer is entitled to withhold any applicable payroll contributions for coverage from the Employee's pay.

Open Enrollment
If an individual (new hire) does not enroll when first eligible, he/she will be automatically enrolled in the HDHP self-funded plan with "employee only" coverage. He/she may later change or add dependents during the following Open Enrollment period which will be held annually. Plan coverage will be effective on the January 1 following the end of the Open Enrollment period. See "Special Enrollment Rights" for exceptions to this provision.

The Open Enrollment period is also a time when Employees are given the opportunity to change their enrollment from one County sponsored plan to another.
Reinstatement for Active Employees on Approved Leave without Pay

If a Covered Employee is granted a leave of absence **without pay** during an entire pay period for reasons other than those provided under the FMLA, or when the allowed 12 weeks under FMLA have expired, the employee may continue his health care benefits by paying the required premium pursuant to Employer's policy. The employee should contact Human Resources regarding payment arrangement.

If an Employee elects not to continue his health care benefits by not paying the premium, coverage will terminate as of the last day of work or FMLA covered work week. However, in the situation where insurance benefits for any Employee *on approved* leave without pay have been terminated, those insurance benefits will be reinstated effective the day they return to active employment.

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain Employees who return to active employment following active duty service as a member of the United States armed forces will be reinstated under the Plan immediately upon returning from military service. Additional information concerning the USERRA can be obtained from the Plan Administrator.

Transfer of Coverage
If a Covered Person changes status from Employee to Dependent or vice versa, and the person remains eligible and covered without interruption, then Plan benefits will not be affected by the person's change in status.

If a husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of his eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Except as noted, such new coverage will be deemed a continuation of prior coverage and will not reduce or increase coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

Dual Coverage Not Permitted

Active Employees: If the person qualifies as both an employee and a dependent, the person will be considered for employee coverage, not dependent coverage. No individual may be covered under a County sponsored Plan both as an employee and as a dependent.

Dependents: A dependent child may not be covered as the dependent of more than one employee or retiree.

Retirees: A person who retirees and is eligible to participate in the Plan as a primary insured may not elect to be a dependent of his spouse who is a primary insured in the Plan.

TERMINATION OF COVERAGE

Employee Coverage Termination
An Employee's coverage under the Plan will terminate upon the earliest of the following:

- termination of the Plan;
- thirty-one (31) days after the date the Employee begins active duty service in the armed services of any country or organization, except for reserve duty of less than thirty-one (31) days. See the "Extension of Coverage During U.S. Military Service" in the **Extensions of Coverage** section for more information;
- at midnight of the day the covered Employee leaves or is dismissed from the employment of the Employer, ceases to be eligible, or ceases to be engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the terms of any **Extension of Coverage** provision;
- the date the Employee dies.

Dependent Coverage Termination
A Dependent's coverage under the Plan will terminate upon the earliest of the following:

- termination of the Plan or discontinuance of Dependent coverage under the Plan;
- termination of the coverage of the Employee;
- at midnight on the day the Dependent ceases to meet the eligibility requirements of the Plan, except when coverage is extended under the terms of any **Extension of Coverage** provision. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee;
- Employee last made the required contribution for such coverage, if Dependent's coverage is provided on a contributory basis (i.e., Employee shares in the cost). However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has replacement coverage which will take effect immediately upon termination and provided that the change is consistent with Cafeteria Plan rules.

*(See **COBRA Continuation Coverage**)*

QUALIFYING LIFE AND WORK EVENT TIMELINE

ADDING DEPENDENTS

Qualifying Event	Notification Period	Effective Date of Change	Accepted Supporting Documents
Marriage/Domestic Partnership	Within 31 days of date of marriage	Date of marriage	Copy of marriage certificate or Declaration of Domestic Partnership filed with the Secretary of Nevada.
Birth	Within 31 days of date of birth	Date of birth	Copy of live birth confirmation
Adoption or placement for adoption	Within 31 days of date of adoption or placement for adoption	Date of the child's adoption or placement for adoption	Copy of adoption decree signed by the judge
Dependent loses coverage	Within 31 days of loss of coverage	Date following last day of coverage	Certificate of creditable coverage or COBRA offering. Additional documentation may be required if surnames differ
Gain dependent status	Within 31 days of gaining child status	First day of the event i.e. loss or gain of coverage	As applicable: • Copy of birth certificate • Certificate of creditable coverage • Permanent legal guardianship papers • Copy of participant's marriage certificate • Proof of disabled dependent child documents
Change required under terms of a Qualified Medical Child Support Order (QMCSO)	Upon receipt of QMCSO from Court	Date of QMCSO	Receipt of QMCSO

REMOVING DEPENDENTS

Qualifying Event	Notification Period	Effective Date of Change	Accepted Supporting Documents
Divorce/Annulment/ Dissolution of Domestic Partnership	Within 31 days from the stamp date of the Court	Date of divorce	Copy of the divorce decree/annulment signed by the judge/domestic partnership termination form
Dependent gains other coverage	Within 31 days of gaining coverage	First day the dependent becomes covered under other coverage	Copy of the confirmation of coverage letter or letter from employer or new health plan carrier
Loss of dependent eligibility status	Within 31 days of losing eligibility status	First day of the event, i.e. loss or gain of coverage	As applicable: ▪ Copy of confirmation of coverage letter from new health plan carrier ▪ Copy of military orders ▪ Copy of a divorce decree if it stipulates that participant must provide health care coverage for a dependent
Death of covered person	Within 31 days of date of death	Date of death	Copy of death certificate
Cancellation of coverage for a dependent who becomes entitled to coverage under Medicaid or Medicare	Within 31 days of date of coverage under Medicaid or Medicare	Date Medicaid or Medicare becomes effective	▪ Certificate of creditable coverage from Medicaid ▪ Copy of Medicare Card

QUALIFYING LIFE AND WORK EVENT TIMELINE*, continued*

MISCELLANEOUS CHANGES

Qualifying Event	Notification Period	Effective Date of Change	Accepted Supporting Documents
Change of Employee's residence	Within 31 days of date of change	Date of Address Change	None
Becoming eligible for Medicare Parts A and/or B	Within 31 days of receipt of notice of eligibility for Medicare	Date Medicare becomes effective	Copy of Medicare card
Life insurance beneficiary change	Not applicable	Date form is executed	None
Extension of Coverage for Disabled Dependent Child	Within 31 days of child's attainment of limiting age	Not applicable	Certification of Dependent Disability. Physician letter, medical records and/or income tax returns may be requested.

CHANGING MEDICAL PLANS

Qualifying Event	Notification Period	Effective Date of Change	Required Supporting Documents
Employee's retirement	Within 31 days of retirement date	Date of retirement	Retiree Health Benefits Program Application
Change of Employee's residence	Within 31 days of date of change	Date of Address Change	NOTE: Change of health plan permitted for HMO members moving outside of the HMO provider network area
Open Enrollment	Mid Oct – Mid Nov	January 1	Certification through ESS

EXTENSION OF COVERAGE PROVISIONS

Coverage may be continued beyond the **Termination of Coverage** date in the circumstances identified below. Unless expressly stated otherwise, however, coverage for a Dependent will not extend beyond the date the Employee's coverage ceases.

Extension of Coverage for Disabled Dependent Children
If an already covered Dependent child is

- incapable of self-sustaining employment due to a physical handicap or mental retardation; and:
- dependent on the Covered Employee and/or spouse for support and maintenance;

then such child's status as a "Dependent" will not terminate solely by reason of his having attained the limiting age and he will continue to be considered a covered Dependent under the Plan so long as he remains in such condition, and otherwise conforms to the definition of "Dependent."

The Covered Employee must provide written proof of incapacity (including documentation from a physician) within thirty-one (31) days of the child's attainment of the limiting age, and thereafter as may reasonably be required, but not more frequently than once a year after the two-year period following the child's attainment of such age. The Plan may require proof of support and maintenance (e.g., a copy of income tax returns showing the child was claimed as a dependent on IRS tax forms in compliance with the IRS Code 152 (a) [without regard to the gross income test]). NRS 689B.035

Extensions of Coverage During Absence From Work
If an Employee fails to continue in active employment but is not terminated from employment (e.g., he is absent due to an approved leave, a temporary layoff, etc.), he may be permitted to continue health coverages for himself and his dependents though he could be required to pay full cost of coverage during such absence. Any such extended coverage allowances will be provided on a non-discriminatory basis.

Except where the Family and Medical Leave Act (FMLA) may apply, any coverage which is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

- the date coverage terminates as specified in the Employer's personnel policies or other employee communications, if any. Such documents are incorporated into the Plan by reference;
- the end of the period for which the last contribution was paid, if such contribution is required;
- the date of termination of this Plan.

To the extent that the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), it intends to comply with the Act. The Employer is subject to FMLA if it engages in commerce or in any industry or activity affecting commerce and employs fifty (50) or more employees for each working day during each of twenty (20) or more calendar workweeks in the current or preceding Calendar Year.

In accordance with the FMLA, an Employee is entitled to continued coverage if he: (1) has worked for the Employer for at least twelve months, (2) has worked at least 1,250 hours in the year preceding the start of the leave, and (3) is employed at a worksite where the Employer employs at least fifty employees within a 75-mile radius.

Except as noted, continued coverage under the FMLA is allowed for up to 12 workweeks of unpaid leave in any 12-month period. Such leave must be for one or more of the following reasons:

- the birth of an Employee's child and in order to care for the child
- the placement of a child with the Employee for adoption or foster care
- to care for a spouse, child or parent of the Employee where such relative has a serious health condition

- employee's own serious health condition that makes him unable to perform the functions of his or her job

The Employee has a "qualifying exigency" (as defined by DOL regulations) arising because the Employee's spouse, son, daughter or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation (a specific military operation).

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. The above is a summary of FMLA requirements. An Employee can obtain a more complete description of his FMLA rights from the Plan Sponsor's Human Resources department. Any Plan provisions that are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

NOTE: An eligible Employee will be entitled to take up to a combined total of 26 workweeks of FMLA leave during a single 12-month period where the Employee is a spouse, son, daughter, parent or next of kin (i.e., nearest blood relative) of a covered "service member". A "covered service member" is a member of the Armed Forces (including the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is an outpatient, or is on the temporary disability retired list, for a "serious injury or illness" (an injury incurred in line of duty on active duty in the Armed Forces that may render the service member medically unfit to perform his duties).

Extension of Coverage During a Leave of Absence Due To Worker's Compensation
If an employee is injured on the job and is temporarily totally disabled as a result of that injury, the County will pay the employee's health care premiums up to one year or cessation of the disability, whichever occurs first. To be eligible for this benefit, the employee must exhaust all of his sick leave, vacation and compensatory time and be on leave without pay status. The employee will still be responsible for full payment of his dependent's health care premiums.

If the employee chooses not to exhaust all of his leave time as indicated above, the employee will be responsible for payment of all premiums due, except for the 12 week period of approved FMLA leave. See "THE FAMILY MEDICAL LEAVE ACT of 1993" and "COUNTY POLICY - LEAVE OF ABSENCE" above.

Extension of Coverage During U.S. Military Service
Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

An Employee who is ordered to active military service is (and the Employee's eligible Dependent(s) are) considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the stipulations set forth herein.

Notice Requirements - To be protected by USERRA and to continue health coverage, an Employee must generally provide the Employer with advance notice of his military service. Notice may be written or oral, or may be given by an appropriate officer of the military branch in which the Employee will be serving. Notice will not be required to the extent that military necessity prevents the giving of notice or if the giving of notice is otherwise impossible or unreasonable under the relevant circumstances. If the Employee's ability to give advance notice was impossible, unreasonable or precluded by military necessity, then the Employee may elect to continue coverage at the first available moment and the Employee will be retroactively reinstated in the Plan to the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premiums from date of termination of Plan coverage. No administrative or reinstatement charges will be imposed.

If the Employee provides the Employer with advance notice of his military service but fails to elect continuation of coverage under USERRA, the Plan Administrator will continue coverage for the first thirty (30) days after Employee's departure from employment due to active military service. The Plan Administrator will terminate coverage if Employee's notice to elect coverage is not received by the end of the 30-day period. If the Employee subsequently elects to continue coverage while on active military service and within the time set forth in the subsection entitled "Maximum Period of Coverage" below, then the Employee will be retroactively reinstated in the Plan as of the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premium charges from the date Plan coverage terminated.

Cost of USERRA Continuation Coverage - The Employee must pay the cost of coverage (herein "premium"). The premium may not exceed 102% of the actual cost of coverage, and may not exceed the active Employee cost share if the military leave is less than 31 days. If the Employee fails to make timely payment within the same time period applicable to those enrollees of the plan continuing coverage under COBRA, the Plan Administrator will terminate the Employee's coverage at the end of the month for which the last premium payment was made. If the Employee applies for reinstatement to the Plan while still on active military service and otherwise meets the requirements of the Plan and of USERRA, the Plan Administrator will reinstate the Employee to Plan coverage retroactive to the last day premium was paid. The Employee will be responsible for payment of all back premium charges owed.

Maximum Period of Coverage - The maximum period of USERRA continuation coverage is the lesser of:

- 24 months
- the duration of Employee's active military service.

Reinstatement of Coverage Following Active Duty - Regardless of whether an Employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the Employee returns to active employment if the Employee was released under honorable conditions.

The Employee must return to employment:

- on the first full business day following completion of military service for military leave of 30 days or less; or
- within 14 days of completion of military service for military leave of 31-180 days; or
- within 90 days of completion of military service for military leave of more than 180 days.

When coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the Employee had not taken military leave and coverage had been continuous. No waiting period can be imposed on a returning Employee or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

Survivors of Active Employees

A surviving spouse, domestic partner and/or dependent of an active employee who dies with ten (10) or more years of service credit are eligible to remain with their current Plan coverage. Surviving dependents of an active employee who dies include the covered spouse, domestic partner and covered dependents of the employee at the time of his/her death. If the active employee had less than ten (10) years of service, thirty-six (36) months of COBRA coverage will be available to survivors.

When a **covered employee dies**, coverage for any enrolled dependent(s) will be continued without premium for **medical benefits only** for a period of one year. An application for this coverage is required. At the end of that time, the dependents may elect to continue benefits under the COBRA extension for an additional two (2) years (combined extension of benefits would be the three (3) year maximum under COBRA).

If a dependent child is the survivor and there is no spouse or domestic partner, the child pays the surviving spouse premium rate until their 26th birthday. If a covered surviving spouse remarries or enters into a domestic partnership, the survivor remains eligible for coverage, but their new spouse, domestic partner or step-children are not eligible for coverage.

Any surviving spouse, domestic partner or dependent child not enrolled in this Plan at the time of the active employee's death may not enroll in this Plan after the active employee's death (as a survivor of an active employee). After the death of the active employee, the enrolled surviving spouse or domestic partner may not enroll eligible dependent children on the Plan who were not covered on the date of the active employee's death.

Survivors of Active Police/Fire Members killed in the line of duty
Per NRS 287.021, survivors of police officers or firemen killed in the line of duty include a spouse, domestic partner and/or dependent child(ren), whether or not they are currently covered under this Plan. The survivors may elect to accept or continue this Plan's coverage if the active employee would have been eligible to participate in the Plan on the date of death. To elect or continue benefits under this Plan as a survivor of an active Police/Fire member killed in the line of duty, the survivor must enroll or re-enroll in this Plan within 60 days of the date of death of the active member by submitting a completed enrollment form to Human Resources. Coverage as a survivor of an active Police/Fire member killed in the line of duty will then be effective the date of the active employee's death. Coverage is paid for by the County and continues for the life-time of the surviving spouse, domestic partner and for dependent children up to the age of 19 or age 23 if a full time student.

Survivors of Retirees
When a covered retiree dies, coverage for any enrolled dependent(s) may continue indefinitely with payment of the required premium.

Survivors of retirees include the spouse, domestic partner and dependent children covered under this Plan on the date of the retiree's death. In some cases (see NRS 286.676), certain employees will be deemed to have retired on their date of death and their survivor can continue coverage. Survivors of retirees have the option either to continue or cancel coverage. To continue coverage under this Plan as a survivor of a retiree, the survivor must re-enroll in this Plan within 60 days of the date off death of the covered retiree by submitting a completed Enrollment/Change form to the County's Human Resource's Office. Coverage as a survivor of a retiree will then be effective on the date of the retiree's death.

Any surviving spouse, domestic partner or dependent child not enrolled in this Plan at the time of the Participant's death may not enroll in this Plan after the Participant's death (as a survivor of a retiree). After the death of the retiree, the enrolled surviving spouse or domestic partner may not enroll eligible dependent children on the Plan who were not covered on the date of the retiree's death. If a covered surviving spouse remarries or enters into a domestic partnership, the survivor remains eligible for coverage, but their new spouse or step-children are not eligible for coverage.

Retirees
In accordance with the County policies, all employees who retire from County employment and immediately begin drawing monthly payments under the State of Nevada Public Employees Retirement Systems (PERS) are eligible for the County's Retiree Health Benefits Program (RHBP). The RHBP provides the same benefits as those of active employees with the exception of dental coverage. However, retirees may elect dental coverage upon retirement and pay the premium for that optional coverage.

Depending on the retiree's original hire date and years of service with the County, the County may pay a portion of the retiree's premium for the selected plan in the RHBP. The remainder of the retiree's premium and the entire premium for dependent coverage are the retiree's responsibility as well as the dental premium if elected.
For employees hired after January 13, 1981, the employee must retire and draw the PERS pension benefits immediately upon ceasing County employment to qualify for the County's RHBP and any County

contribution towards the retiree's premium. Coverage will be transferred from the employee plans to the retiree plans without a break in coverage. Retirees retain the same medical plan and dependent coverage in the RHBP as they had as an employee; however, they can remove dependents as allowed with termination but cannot add dependents when transferring to the RHBP. Dependents can be added during Open Enrollment periods, or at qualifying events.

Employees hired prior to January 13, 1981, have the ability to terminate County employment and later "reinstate" coverage in the County's RHBP, with the County paying a portion of their premium based on years of County service, when they draw their PERS pension (within 30 days of their retirement) or in January of any "even numbered" year per NRS 287.0475.

Retirees may remain on the County's RHBP as long as they continue to receive pension benefits through PERS. A retiree may elect to terminate the County's retiree insurance by giving written notice. Should a Retiree choose to terminate coverage on the County's RHBP, any and all obligation the County had for any payment toward the retiree's premium would cease.

Effective July 1, 2010
Employees hired on or after July 1, 2010 will receive no health care contribution by Washoe County; however, they may participate in the County's retiree health insurance program upon retirement, but will be responsible for 100% of the premium. Medicare Parts A (hospital) and B (medical) will become the primary payer upon eligibility (age 65), and the Washoe County plan will become the secondary payer regardless of whether the retiree enrolls in the Medicare program or not. If the retiree does enroll in the Medicare Program, Coordination of Benefit rules will apply.

Effective July 1, 2011
For all employees hired post 97/98, Medicare Part A and B will become the primary payer upon retirement to the Washoe County plan upon retiree's eligibility for Medicare, regardless of whether or not they enroll in Medicare. If the retiree enrolls in Medicare, Coordination of Benefit rules will apply. If the retiree does not enroll in Medicare upon eligibility, this Plan will pay 20% of eligible benefits. This provision also applies to the retiree's dependents upon reaching Medicare eligibility.

CLAIMS PROCEDURES

ADMINISTRATIVE PROCESSES AND SAFEGUARDS

The Plan requires that claims determinations be made in accordance with governing documents of the Plan and that they be applied consistently with respect to similarly situated Claimants. The claims procedures will not be administered in a way that unduly inhibits or hampers the initiation or processing of claims or claims appeals.

AUTHORIZED REPRESENTATIVE MAY ACT FOR CLAIMANT

Any of the following actions which can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf. The Claimant may be required to provide reasonable proof of such authorization. For an urgent claim, a health care professional, with knowledge of a Claimant's medical condition, will be permitted to act as the authorized representative of the Claimant. "Health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

BENEFIT DETERMINATIONS

Upon the Contract Administrator's receipt of a written claim for benefits and pursuant to the procedures described herein, the Contract Administrator will review the claim submission, proof of claim, and all associated and/or applicable information provided by the Claimant and gathered independently by the Contract Administrator in light of the Benefit Document through which benefits of the Plan are paid. Further, the Contract Administrator will assure that all benefit determinations are applied consistently to similarly-situated Plan participants by maintaining appropriate claim and benefit records which shall be reviewed periodically and on a case-by-case basis to determine past practices in similar claim situations. Should the Contract Administrator at any time during its review period determine that additional information is required from the Employee or Claimant; the Contract Administrator will request such necessary information from the Employee. The Contract Administrator will make every effort to make its benefit determination in as reasonable a time frame as possible.

TIMELY FILING OF CLAIMS

Except for Pre-Service claims (see **"Submitting a Claim**" below), proof of loss for a claim must be submitted to the Contract Administrator within twelve (12) months after the date a service is rendered. The 12-month time limit applies to an original claim submission and to any adjustments or re-processing requests on a previously-submitted claim. It is the Claimant's responsibility for timely submission of all claims. Proof of loss for a claim has not been "furnished" unless and until the Contract Administrator has received all information they reasonably deem necessary to allow processing of the claim. This includes responding to reasonable requests for completion of forms, providing additional information about the claim, or providing documents in support of the claim. If satisfactory proof of loss is not furnished within the 12-month period the date of service and expenses are incurred, benefits will not be available.

Failure to furnish proof within the time required will not invalidate nor reduce any claim if it can be shown that it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

NOTE: In accordance with federal law, the Centers for Medicare and Medicaid Services (CMS) have one (1) year to submit claims when CMS has paid as the primary plan and the Plan should have been primary.

SUBMITTING A CLAIM

A claim is a request for a benefit determination which is made, in accordance with the Plan's procedures, by a Claimant or his authorized representative. A claim must be received by the Contract Administrator for handling on behalf of the Plan so that the claim review and benefit determination process can begin. A claim must name the Plan, a specific Claimant, a specific health condition or symptom or diagnostic code, and a specific treatment, service or supply (or procedure/revenue codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services are received, and provider name, address, phone number and tax identification number.

There are two types of claims: (1) Pre-Service Claims, and (2) Post-Service Claims:

1. **Pre-Service Claims**
   A Pre-Service Claims is a written or oral request for health care services where the terms of the Plan's condition of benefits, in whole or in part, requires pre-service review of the proposed care, as outlined in the **Utilization Management Program**, prior to receiving the medical care. A pre-service review is only for the purposes of assessing the Medical Necessity and appropriateness of care and delivery setting. A determination on a Pre-Service Claim is not a guarantee of benefits. Plan benefit payments are subject to review upon submission of a claim to the Plan after medical services have been received, and are subject to all Plan provisions including exclusions and limitations. **See the Utilization Management Program section for information on the pre-service review requirements.** Submit the Pre-Service claim to:

   Hometown Health
   P.O. Box 981703
   El Paso, TX 79998
   EDI# 88023

   Requests for benefit determination where pre-service review is desired but not required should be directed to Hometown Health, the Contract Administrator, as identified in the "Post-Service Claim" information below or call (775) 982-5425 or (866) 988-5425.

2. **Post-Service Claims**
   A Post-Service Claim is a written request for benefit determination after a service has been rendered and expense has been incurred. Proof of loss for a Post-Service Claim must be submitted to the Contract Administrator within twelve (12) months after the date a service is rendered. It is the Claimant's responsibility for timely submission of all claims. See **Timely Filing of Claim**s above for additional information. Submit Post-Service claims to:

   Hometown Health
   P.O. Box 981703
   El Paso, TX 79998
   EDI# 88023

ASSIGNMENTS TO PROVIDERS

All Eligible Expenses reimbursable under the Plan will be paid to the covered Employee except that: (1) assignments of benefits to Hospitals, Physicians or other providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, within the time limits for filing proof of loss, and (3) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

In the event the Plan fails to pay benefits to a provider in respect of a claim incurred by a Covered Person, the Employee or Covered Person will be responsible for paying the provider any amounts due for the services received.

No covered Employee or Dependent may, at any time, either while covered under the Plan or following termination of coverage, assign his right to sue to recover benefits under the Plan, or enforce rights due under the Plan or any other causes of action which he may have against the Plan or its fiduciaries.

NOTE: Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or his beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable under the Plan.

CLAIMS DENIALS

If a claim is wholly or partially denied, the Claimant will be given adequate notice in writing of claims for benefits under this Plan that have been denied, written in a manner calculated to be understood by the Claimant, including:

- the specific reason(s) for the decision to reduce or deny benefits;
- specific reference to Plan provision(s) on which the denial is based as well as identification of an access to any guidelines, rules, and protocols that were relied upon in making the decision;
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to copies of, all documents, records or other information relevant to the Claimant's claim for benefits;
- a description of any additional information needed to change the decision and an explanation of why it is needed;

If the Claimant is not satisfied with the handling of the claim, the claimant may appeal to the Plan for Pre-Service and Post-Service claims by following the **Internal Appeal Procedures** below.

INTERNAL APPEAL PROCEDURES

Pre-Service Claims, Pre-Certification and Concurrent Review (Services not yet provided)
Pre-Service claims are those that require Pre-Certification prior to services being provided. An appeal can be made for any adverse determination made during pre-certification, concurrent review or retrospective review described under the Utilization Management Program. The appeal may be initiated by the Claimant, treating provider, legal guardian, or person authorized to make health care decisions by a power of attorney. If you believe your situation is urgent, please refer to the **Internal Expedited Appeal** below to see if you qualify.

Post-Service Claim (Services have been provided)
Post-Service claims are those claims that did not require Pre-Certification or are filed after services have been provided. The Claimant may appeal his claim, in writing, to a new decision-maker and he may submit new information (e.g., comments, documents and records) in support of his appeal. A Claimant may not take legal action on his denied claim until he has exhausted the Plan's mandatory appeal procedures. If the denial is upheld in Level I, Claimant may appeal to the next highest level of review. This may be repeated until the entire appeals process has been exhausted.

In response to his appeal, the Claimant is entitled to a full and fair review of the claim and a new decision. A "full and fair review" takes into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether the information was submitted

or considered in the initial benefit determination.

At such time a Claimant appeals a denied claim, he will be provided, upon request and free of charge, with access to copies of all documents, records and other information relevant to his claim for benefits.

LEVEL I - REVIEW OF THE CLAIM BY THE CONTRACT ADMINISTRATOR

The Claimant may submit an appeal letter, **within sixty (60) days** of the date he received the Pre-Certification notice, Explanation of Benefits (EOB) or letter with the initial claim determination. Failure to request a review in a timely manner will be deemed to be a waiver of any further right of review of appeal. The appeal letter must include the Claimant's name, social security number or member identification number along with a detailed written explanation why the claim is being appealed. The Claimant shall have this opportunity to present additional information and/or documentation supporting this appeal. The Contract Administrator will review the claim for appropriateness based on the Plan Document and, if needed for medical interpretation or clarification, request a Physician review. Appeal letter and additional information and/or documentation must be submitted to:

Hometown Health
Appeals Department
10315 Professional Circle
Reno, NV 89521

The Contract Administrator will render a decision **within thirty (30) days of receipt** of the appeal letter and will notify, in writing, the Claimant of the findings.

LEVEL II - APPEALS COMMITTEE REVIEW

If the Claimant is dissatisfied with the Level I appeal decision he may, **within thirty (30) days** of receiving the Level I decision, appeal his claim to the Washoe County Health Insurance Appeals Committee for review at a regularly scheduled Committee meeting. The Claimant shall have this opportunity to present additional information and/or documentation supporting his appeal. Any information or documents provided to the Appeals Committee will be considered Protected Health Information (PHI). Information or documents provided will not be returned to the Claimant and will be discarded in accordance with Privacy Rules. To file a Level II appeal you are encouraged to write a letter to request a level II appeal that includes pertinent information and submit to the Department of Human Resources/Benefits.

The written appeal should be submitted to:

Washoe County Human Resources
Attn: Health Benefits
1001 E. 9th Street
Reno, Nevada 89512-2845

The Claimant has the option to appear before the Committee in person or an attorney may represent the Claimant if so desired. The Claimant will be notified in writing of the Committee's decision within fourteen (14) days of the date the decision was made by the Committee. The Appeals Committee, which also serves as the County's Insurance Negotiating Committee, is comprised of ten (10) voting members representing nine (9) collective bargaining associations and one (1) management representative. In addition, the Committee includes the County's benefits program manager, the County's insurance broker/consultant and a representative from the Contract Administrator, all of whom are non-voting members. A quorum of at least six (6) voting members must be present to vote on a Level II appeal, and a majority vote is required for formal action.

In an appeal relative to a denied claim the Appeal Committee has the right to allow as an eligible expense, those medical services and/or supplies otherwise excludable, or otherwise not payable, under the Plan. The committee must find that the Claimant has satisfied each of the following criteria: The service and/or supplies must be less expensive than alternative treatment; Medically Necessary; with likelihood of a negative patient response if the service or supply is not provided.

Internal Expedited Appeal
An expedited medical review of a denied pre-service review (pre-certification) or con-current review request can be made if the physician certifies that the time required to process the internal appeal could cause significant negative change in your medical condition. Requests for an internal expedited appeal may be made by telephone or any other reasonable means that will ensure the timely receipt of information required to complete the appeal process with Utilization Management. If your physician requests a consultation with the reviewing physician, this will occur **within 1 business day**. Utilization Management will make a determination on an internal expedited appeal **within 72 hours** of receipt of the information needed to complete the appeal. The results of the determination of the internal expedited appeal will be provided immediately to the managing physician via a phone call and in writing to the patient, managing physician, facility and Contract Administrator. Upon receipt of a request, Utilization Management will provide the recipients of an adverse determination letter with the clinical rationale for the non-certification decision. If non-certification is upheld, Claimant may pursue an **External Appeal Review** as described below.

A Claimant or their designee may choose to bypass the **Internal Expedited Appeal** and request a review by an external review board if certain criteria are met. See **External Appeal Review** below to see if the criteria are met.

EXTERNAL APPEAL REVIEW

An External Appeal Review may be requested by the Claimant or the Claimant's treating physician after the Internal Appeal process has been exhausted. This means that the Claimant has the right to have the Plan's decision reviewed by an Independent Review Organization. External reviews are generally not available for benefit issues such as excluded benefits, limitations and other Plan provisions. To initiate an External Appeal Review contact Washoe County Human Resources or Hometown Health at (775) 982-5425 or (866) 988-5425 to request the necessary form to initiate the External Appeal Review.

There are two (2) types of External Review: (1) Standard External Review and (2) Expedited External Review

1. **Standard External Review**
   The Claimant has the right to have the Plan's decision reviewed by an Independent Review Organization if the Plan's decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested or received by submitting a request for External Review within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination.

2. **Expedited External Review**
   A Claimant may make a request for an expedited external review if the criteria below are met.

   b. Adverse Benefit Determination: The Claimant receives an adverse benefit determination that involves a medical condition of the Claimant for which the timeframe for completion of an Expedited Internal Appeal would seriously jeopardize the life or health of the Claimant, or would jeopardize the Claimant's ability to regain maximum function, and the Claimant has filed a request for an Expedited Internal appeal; or

   c. Final Internal Adverse Benefit Determination: The Claimant has a medical condition where the timeframe for completion of a Standard External Review would seriously jeopardize the life or health of the claimant or would jeopardize the Claimant's ability to regain maximum

function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health item or service for which the claimant received emergency services, but has not been discharged from a facility.

Upon determination by the Independent Review Organization that the claim is eligible for an Expedited Review, they must render a decision expeditiously as the Claimant's medical condition or circumstances require, but in no event more than **72 hours** after the Independent Review Organization received the request for an Expedited External Review. If the notice is not in writing, **within 48 hours after the date of providing that notice**, Independent Review Organization must provide written confirmation of the decision to the Claimant and the Plan.

Independent Review Organization's Reversal of Plan's Decision
Upon receipt of a notice of a final external review decision, reversing the adverse benefit determination or final internal adverse benefit determination, the Plan must immediately provide coverage or payment of the claim (including immediately authorizing or immediately paying benefits).

ARBITRATION

Arbitration may be requested by a Claimant and/or the Claimant's treating physician **after the Internal Appeal process has been exhausted and the dispute is not covered under the External Appeal Review above.**

If any dispute or controversy pertaining to the processing of a claim shall arise between the Plan and its agents and said dispute or controversy is not settled after completing all Internal Appeal Levels and is not a dispute or controversy that is covered under the External Appeal Review above, the dispute or controversy shall be settled by binding arbitration before one arbitrator selected from a panel of arbitrators of the American Arbitration Association in accordance with the Arbitration Rules of the American Arbitration Association and a judgment upon the award entered in any court having jurisdiction. A request for dispute or controversy must be in writing and submitted within 45 days of the determination from the Office of Consumer Health Assistance that the dispute or controversy does not meet the criteria to be handled by them. The Claimant is responsible for filing the claim with the American Arbitration Association and paying the costs to file. The Plan shall share equally the filing fee and will reimburse Claimant upon receiving copy of the filing receipt. The parties shall agree to accept the Arbitrator's award as final and binding upon them.

DEFINITIONS

When capitalized herein, the following items will have the meanings shown below.

Accidental Injury - An injury that results independently of an illness and all other causes, and is the result of an externally violent force or accident.

Ambulatory Surgical Center - Any public or private establishment which:

- complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;
- has an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
- provides continuous Physician services and registered professional nursing services whenever a patient is in the facility; and
- does not provide services or other accommodations for patients to stay overnight.

Behavioral Health Practitioner – A psychiatrist, psychologist, or a mental health or substance abuse counselor or social worker who has a master's degree and who is legally licensed and/or legally authorized to practice or provide service, care or treatment of behavioral health disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license.

Behavioral Health Treatment – All inpatient services, including room and board, given by a behavioral health treatment facility or area of a hospital that provides behavioral or mental health or substance abuse treatment for a mental disorder indentified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). If there are multiple diagnoses, only the treatment for the illness that is identified under the DSM code is considered a behavioral health treatment for the purposes of this Plan.

Behavioral Health Treatment Facility – A specialized facility that is established, equipped, operated and staffed primarily for providing a program for diagnosis, evaluation and effective treatment of behavioral health disorders and which fully meet one of the following two tests:

- It is licensed as a behavioral health treatment facility by the regulatory authority having responsibility for the licensing required under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all the following requirements: has at least one physician on staff or on call and provides skilled nursing care by licensed nurses under the direction of a fulltime registered nurse (RN) and prepares and maintains a written plan of treatment for each patient based on the medical, psychological and social needs of the patient.

A behavioral health treatment facility that qualifies as a hospital is covered by this Plan as a hospital and not a behavioral health treatment facility. A transitional facility, group home, halfway house, or temporary shelter is not a behavioral health treatment facility under this Plan unless it meets the requirements above in the definition of behavioral health treatment facility.

Benefit Document - A document that describes one (1) or more benefits of the Plan.

Birthing Center - A special room in a Hospital that exists to provide delivery and pre-natal and post-natal care with minimum medical intervention or a free-standing Outpatient facility which:

- is in compliance with licensing and other legal requirements in the jurisdiction where it is located;
- is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients;
- has organized facilities for birth services on its premises;

- provides birth services which are performed by or under the direction of a Physician specializing in obstetrics and gynecology;
- has 24-hour-a-day registered nursing services;
- maintains daily clinical records.

Calendar Year - The period of time commencing at 12:01 A.M. on January 1 of each year and ending at 12:01 A.M. on the next succeeding January 1. Each succeeding like period will be considered a new Calendar Year.

Cardiac Rehabilitation - A monitored exercise program directed at restoring both physiological and psychological well-being to individuals with heart disease.

Claimant - Any Covered Person on whose behalf a claim is submitted for benefits under the Plan.

Contract Administrator - A company that performs all functions reasonably related to the administration of one or more benefits of the Plan (e.g., processing of claims for payment) in accordance with the terms and conditions of the Benefit Document and an administration agreement between the Contract Administrator and the Plan Sponsor.

The Contract Administrator is not a fiduciary of the Plan and does not exercise any discretionary authority with regard to the Plan. The Contract Administrator is not an insurer of Plan benefits, is not responsible for Plan financing, and does not guarantee the availability of benefits under the Plan.
Convalescent Hospital - See "Skilled Nursing Facility"

Covered Person - A covered Employee, a covered Dependent, and a Qualified Beneficiary (COBRA). See **Eligibility and Effective Dates** and **COBRA Continuation Coverage** sections for further information.

NOTE: In enrolling an individual as a Covered Person or in determining or making benefit payments to or on behalf of a Covered Person, the eligibility of the individual for state Medicaid benefits will not be taken into account.

Covered Provider - Any 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; or
- in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association;
- and including, but not limited to a/an:
  - Acupuncturist (CA) or doctor of Chinese medicine
  - Audiologist
  - Certified or Registered Nurse Midwife
  - Certified Registered Nurse Anesthetist (CRNA)
  - Chiropractor (DC)
  - Dentist (DDS or DMD)
  - Hospitalist
  - Licensed Clinical Psychologist (PhD or EdD)
  - Licensed Clinical Social Worker (LCSW)
  - Licensed Practical Nurse (LPN)
  - Licensed Registered Dietician (RD)
  - Licensed Vocational Nurse (LVN)
  - Marriage Family and Child Counselor (MFCC)
  - Nurse Practitioner
  - Occupational Therapist (OTR)
  - Optometrist (OD)
  - Physical Therapist (PT or RPT)
  - Physician - see definition of "Physician"
  - Podiatrist or Chiropodist (DPM, DSC or PodD)
  - Psychiatrist (MD)
  - Registered Dietitian (RD)
  - Registered Nurse (RN)
  - Respiratory Therapist
  - Speech Pathologist
  - Substance Abuse Counselor

A "Covered Provider" will also include the following when appropriately-licensed and providing services which are covered by the Plan:

- facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, Birthing Centers, etc.;
- licensed Outpatient mental health facilities;
- behavioral health treatment facility;
- facilities for treatment of abuse of alcohol or drugs which are certified by the Bureau of Alcohol and Drug Abuse in the Rehabilitation Division of the Department of Human Resources of Nevada;

- health care facilities which are licensed by the Health Division of the Department of Human Resources of Nevada, accredited by the Joint Commission of Accreditation of Hospitals and which provide programs for the treatment of alcoholism or drug abuse as part of their accredited activities;
- freestanding public health facilities;
- hemodialysis and Outpatient clinics under the direction of a Physician (MD);
- enuresis control centers;
- prosthetists and prosthetist-orthotists;
- portable X-ray companies;
- independent laboratories and lab technicians;
- diagnostic imaging facilities;
- blood banks;
- speech and hearing centers;
- ambulance companies.

NOTE: A Covered Provider does not include: (1) a Covered Person treating himself/herself or any relative or person who resides in the Covered Person's household - see "Relative or Resident Care" in the list of **General Exclusions**, or (2) any Physician, nurse or other provider who is an employee of a Hospital or other Covered Provider facility and who is paid by the facility for services.

Criminal Act - A crime or offense which carries with it a punishment as determined by common law or statute within the presiding jurisdiction of law enforcement.

Day Care Center - An Outpatient psychiatric facility which is part of or affiliated with a Hospital. It must be licensed according to state and local laws to provide Outpatient care and treatment of mental and nervous disorders or substance abuse under the supervision of psychiatrists.

Dependent - See **Eligibility and Effective Dates** section

Eligible Expense (s) - Expense that is: (1) covered by a specific benefit provision of the Benefit Document and (2) incurred while the person is covered by the Plan.

Emergency - See "Medical Emergency"

Employee - See **Eligibility and Effective Dates** section

Employer(s) - The Employer or Employers participating in the Plan as stated in the **General Plan Information** section.

Fiduciary - A Fiduciary of the Plan is any entity having binding power to make decisions regarding Plan policies, interpretations, practices or procedures.

Home Health Care Agency - An agency or organization which:

- 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 nurse (RN) to govern the services provided;
- provides for full-time supervision of its services by a Physician or by a registered nurse;
- maintains a complete medical record on each patient;
- has a full-time administrator.

In rural areas where there are no agencies which meet the above requirements or areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.

Hospice or **Hospice Agency** - An entity providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one registered nurse, and must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital - **Hospital** - A public or private facility or institution, other than one owned by the U.S. Government, licensed and operating according to law, that:

- is legally operated in the jurisdiction where it is located;
- is engaged mainly in providing inpatient medical care and treatment for injury and illness in return for compensation;
- has organized facilities for diagnosis and major surgery on premises;
- is supervised by a staff of at least two (2) physicians;
- has 24-hour-a-day nursing services by registered nurses; and
- is not a facility specializing in dentistry; or an institution which is mainly a rest home; a home for the aged; a place for drug addicts; a place for alcoholics; a convalescent home; a nursing home; an extended care or skilled nursing facility or similar institution; or a Long Term Acute Care Facility (LTAC).

A hospital may include facilities for behavioral health treatment that are licensed and operated according to law. Any portion of a hospital used as an ambulatory surgical facility, birth (or birthing) center, hospice, skilled nursing facility, sub-acute care facility, or other place for rest, custodial care, or the aged shall not be regarded as a hospital for any purpose related to this Plan.

Inpatient - A person physically occupying a room and being charged for room and board in a facility (Hospital, Skilled Nursing Facility, etc.) which is covered by the Plan and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises. Any Hospital stay of eighteen (18) consecutive hours or more in any single or multiple departments or parts of a Hospital for the purpose of receiving any type of medical service will be considered an “Inpatient” confinement, even if the Hospital does not charge for daily room and board.

Intensive Care Unit (ICU), Coronary Care Unit (CCU), Burn Unit, or Intermediate Care Unit - A Hospital area or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician, which provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis and which is separated from the rest of the Hospital's facilities.

Lifetime - All periods an individual is covered under the Plan, including any prior statements of the Plan. It does not mean a Covered Person's entire lifetime.

Medical Emergency - A situation which arises suddenly and which either poses a serious threat or causes serious impairment of bodily functions and which requires immediate medical attention or hospitalization. This includes conditions arising as the result of accidental bodily injury and any of the following conditions or symptoms: acute severe abdominal pains, poisoning, vomiting, acute chest pains (angina, suspected heart attack, coronary, pneumothorax), shortness of breath, asthma, allergic reaction to drugs, angioneurotic edema, convulsions, coma, syncope, fainting, shock, hemorrhage, acute urinary retention, epistaxis (severe nose bleed), or high fever of at least 104 degrees.

Medically Necessary - Any health care treatment, service or supply determined by the Plan Administrator to meet each of the following requirements:

- it is ordered by a Physician for the diagnosis or treatment of a Sickness or Accidental Injury;
- the prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition;
- it is furnished by a provider with appropriate training and experience, acting within the scope of his or her license, and
- it is provided at the most appropriate level of care needed to treat the particular condition.

With respect to Inpatient services and supplies, "Medically Necessary" further means that the health condition requires a degree and frequency of services and treatment which can be provided ONLY on an Inpatient basis.

The Plan Administrator will determine whether the above requirements have been met based on: (1) published reports in authoritative medical and scientific literature, (2) regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration (FDA), and the Centers for Medicare and Medicaid Services (CMS), (3) listing in the following compendia: *The American Hospital Formulary Service Drug Information* and *The United States Pharmacopoeia Dispensing Information*; and (4) other authoritative medical resources to the extent the Plan Administrator determines them to be necessary.

Medicare - Health Insurance for the Aged and Disabled as established by Title I of Public Law 89-98 including parts A, B and D and Title XVIII of the Social Security Act, and as amended from time to time.

Outpatient - Services rendered on other than an Inpatient basis at a Hospital or at a covered non-Hospital facility.

Partial Hospitalization - A planned partial confinement treatment program of psychiatric services for the treatment of mental illness and substance abuse which is given in a Hospital or in a treatment facility on less than a full-time inpatient basis and which meets the following requirements:

- It must be licensed according to state and local laws to provide Outpatient care and treatment of mental and nervous disorders or substance abuse under the supervision of psychiatrists.
- it involves a generally accepted form of evaluation and treatment of a condition diagnosed as a mental illness or substance abuse which does not require full-time confinement in a Hospital or treatment facility;
- it is supervised by a psychiatric Physician who both reviews the program and evaluates its effectiveness at least once a week;
- for partial day care, the facility’s treatment program must be available for at least six (6) hours during the day and at least five (5) days a week;
- for night care, the facility’s treatment program must be available for at least eight (8) hours a night and at least five (5) nights a week.

Participating Employer - An Employer who is participating in the coverages of the Plan. See **General Plan Information** section for the identity of the Participating Employer(s).

Physician - A Doctor of Medicine (MD) or Doctor of Osteopathy (DO), who is licensed to practice medicine or osteopathy where the care is provided. A Physician will also include a Christian Science practitioner accredited by the Mother Church - The First Church of Christ, Scientist, in Boston, Massachusetts.

NOTE: The term "Physician" will not include the Covered Person himself/herself, relatives (see **General Exclusions**), interns, residents, fellows or others enrolled in a graduate medical education program.

Plan - The plan of employee welfare benefits provided by the Plan Sponsor. The name of the Plan is shown in the **General Plan Information** section.

Plan Administrator - The entity with the authority to interpret the Plan and that make determinations regarding coverage, eligibility and benefits. See **General Plan Information** section for further information.

Plan Document - A formal written document that describes the Plan and the rights and responsibilities of the Plan Sponsor with regard to the Plan, including any amendments.
Plan Sponsor - The entity sponsoring this Plan and who has the authority to modify or amend the Plan. See **General Plan Information** section for further information.

Pregnancy - Pre-natal and post-natal care during pregnancy, childbirth, miscarriage or complications arising therefrom. See "Pregnancy" in the list of **Eligible Medical Expenses** for further information.

Reasonable - The Plan will only pay fee(s) that, in the Plan Administrator's discretion, are for services and supplies which are necessary for the care and treatment of an illness or injury not caused by the treating provider. Determination that charges are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the charges(s).

The determination will consider, but not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and Organizations; and (b) The Food and Drug Administration. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable. The Plan Administrator retains discretionary authority to determine whether charge(s) are reasonable based upon information presented to the Plan Administrator. A finding of provider negligence and/or malpractice is not required for charge(s) to be considered not reasonable.

Rehabilitation Therapy - Physical, occupational, or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery and that is performed by a licensed therapist acting within the scope of his or her license.

Active rehabilitation refers to therapy in which a patient, who has the ability to learn and remember, actively participates in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

Maintenance rehabilitation refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of active rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonable be prescribed to maintain, support, and/or preserve the patient's functional level. Maintenance rehabilitation is not covered.

Passive rehabilitation refers to therapy in which a patient does not actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive rehabilitation may be covered by the Plan, but only during a course of hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an Outpatient

basis with the patient when and until such time as the patient is able to achieve active rehabilitation. Continued hospitalization for the sole purpose of providing passive rehabilitation is not considered to be Medically Necessary.

Semi-Private Room Charge - The standard charge by a facility for semi-private room and board accommodations, or the average of such charges where the facility has more than one established level of such charges, or 90% of the lowest charge by the facility for single bed room and board accommodations where the facility does not provide any semi-private accommodations.

Sickness - Sickness will mean bodily illness or disease (other than mental health conditions), congenital abnormalities, birth defects and premature birth. Also, a condition must be diagnosed by a Physician in order to be considered a Sickness by this Plan.

Skilled Nursing Facility - An institution which:

- is duly licensed as a convalescent hospital, extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with the governing laws and regulations;
- is primarily engaged in providing accommodations and skilled nursing care 24-hours-a-day for convalescing persons;
- is under the full-time supervision of a Physician or a registered nurse;
- admits patients only upon the recommendation of a Physician, maintains complete medical records, and has available at all times the services of a Physician;
- has established methods and procedures for the dispensing and administering of drugs;
- has an effective utilization review plan;
- is approved and licensed by Medicare;
- has a written transfer agreement in effect with one or more Hospitals; and
- is not, other than incidentally, 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.

Surgery - Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one (1) surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits.

Urgent Care Facility - A facility which is engaged primarily in providing minor emergency and episodic medical care and which has:

- a board-certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance at all times;
- X-ray and laboratory equipment and a life support system.

An Urgent Care Facility may include a clinic located at, operated in conjunction with, or which is part of a regular Hospital.

Usual and Customary - With regard to charges made by any PPO and Non-PPO Provider, the Usual and Customary will be:

PPO or Participating Provider - Usual and Customary for a PPO Provider will be the contracted rate set forth in the agreement between the Preferred Provider Network or the Plan.

Non-PPO Provider - Usual and Customary for a Non-PPO Provider will be the fee that is allowed for a PPO Provider for the same or similar service. The amount in excess of the allowable will be the patient's responsibility.

The Plan will apply the Usual and Customary definition listed below in the following situations:

Covered Persons Residing Outside of PPO Service Area - If you permanently reside more than 50 miles from a PPO Provider, your local provider's fees will be covered at the **Usual and Customary** allowance.

Emergency Care - When a Covered Person requires care for a **Medical Emergency** as defined under **Definitions** and is transported by an ambulance or private transportation to a Non-PPO facility. See **CHOICE OF PPO OR NON-PPO PROVIDERS** section for further information and criteria regarding this.

Unavailable Services - When a Covered Person requires a specialty provider that is not represented in the PPO Network. See **CHOICE OF PPO OR NON-PPO PROVIDERS** section for further information.

Ancillary Services - Services of a Non-PPO ancillary provider (i.e. emergency room Physician, urgent care Physician, radiologist, pathologist, on-call Physician) if such services are received while a Covered Person is being treated in a PPO emergency room, PPO Urgent Care Facility, PPO Ambulatory Surgery Center or confined in a PPO hospital facility.

When determining whether an expense is Usual and Customary, the Plan Administrator will take into consideration the fee(s) which the provider most frequently charges the majority of patients for the service or supply and the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply. The terms "same geographic locale" and/or "area" shall be defined as a metropolitan area, county or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same locale in which the charge is incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Covered Person by a provider or services or supplies, such as a physician, therapist, nurse, hospital or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service or supply, and whether a specific procedure, service, or supply is Usual and Customary.

Usual and Customary charges may alternatively be determined and established by the Plan using normative data such as Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for services and supplies and devices.

The Claims Administrator has the discretionary authority to determine the Usual and Customary Charge based upon standards set forth by the Plan Administrator.

GENERAL PLAN INFORMATION

Name of Plan(s):	Washoe County Self-funded PPO Self-funded HDHP Self-funded Dental
Plan Sponsor: Address: Business Phone Number:	Washoe County 1001 East Ninth Street Reno, NV 89512 (775) 328-2081
Participating Employer(s):	Washoe County
Source of Plan Contributions:	Washoe County, Employee and Retiree Contributions
Plan Year:	January 1 through December 31
Named Fiduciary: Address: (See also definition of "Fiduciary")	Washoe County 1001 East Ninth Street Reno, NV 89512
Employer I.D. #:	88-6000138
Agent for Service of Legal Process: Address: (Legal process may be served upon the Plan Administrator or a Fiduciary)	Washoe County 1001 East Ninth Street Reno, NV 89512
Type of Plan(s):	The PPO and HDHP are employee welfare benefit plans providing group benefits
Plan Benefits Described Herein:	Self-Funded Medical, Dental and Prescription Benefits
Type of Administration:	**Contract Administration** - See “Administrative Provisions” for additional information
Privacy Officer:	Phone (775) 328-2081
Medical Contract Administrator: Mailing and Street Address: Phone:	Hometown Health 10315 Professional Circle Reno, NV 89521 (775) 982-5425 or (866) 988-5425
Dental Contract Administrator: Mailing and Street Address: Phone:	CDS Group Health 1510 Meadow Wood Lane P.O. Box 50190 Sparks, NV 89435-0190 (775) 352-6900 or (800) 455-4236

FUNDING - SOURCES AND USES

Employee and Employer Obligations
Plan benefits are paid from the Plan Sponsor's employee internal service fund per NRS 287.015. The Plan Administrator shall, from time to time, evaluate and determine the amount to be contributed, if any, by each Employee or Plan participant.

COBRA costs are fully the Employee's or Qualified Beneficiary's responsibility and are generally 102% of the full cost of coverage for active (non-COBRA) enrollees, except in special circumstances where a greater cost is allowed by law. See the **COBRA Continuation Coverage** section for more information.

For active Employees, the Employee's share of the cost(s) will be deducted on a regular basis from his wages or salary. In other instances, the Employee or Plan participant will be responsible for remitting payment to the Employer in a timely manner as prescribed by the Employer.

Plan Funded Benefits
The contributions will be applied to provide the benefits under the Plan.

Taxes
Any premium or other taxes which may be imposed by any state or other taxing authority and which are applicable to the coverages of the Plan will be paid by the Plan Sponsor.

NOTE: To provide benefits, purchase insurance protection, pay administrative expenses and any necessary taxes, the contributions which are paid by Employees will be used first and any remaining Plan obligations will be paid by Employer contributions. Should total Plan liabilities in a Plan Year be less than total Employee contributions, any excess will be applied to reduce total Employee contribution requirements in the subsequent Plan Year or, at Plan Sponsor's discretion, may be used in any other manner which is consistent with applicable law.

ADMINISTRATIVE PROVISIONS

Administration (type of)
Certain benefits of the Plan are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator. The Contract Administrator is not an insurance company.

Alternative Care
In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to administer the Plan thereafter in strict accordance with the provisions of the Benefit Document.

Amendment or Termination of the Plan
Since future conditions affecting the Plan Sponsor or Employer (s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any participant or beneficiary:

- determine eligibility for benefits or to construe the terms of the Plan;

- alter or postpone the method of payment of any benefit;
- amend any provision of these administrative provisions;
- make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of applicable law; and
- terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those benefits to which he/she has become entitled under the Plan.

NOTE: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's Board of Trustees, or by written amendment which is signed by at least one Fiduciary of the Plan. Employees will be provided with notice of the change within the time allowed by federal law.

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), any amendment limiting benefits under a Plan shall be universally applicable to all individuals in the same eligible class, shall be based on bona fide employment classifications consistent with the Employer's usual business practices, and shall not be directed at individual participants or beneficiaries based on any health factor of such individual(s). However, a Plan amendment applicable to all individuals in one or more groups of similarly situated individuals and made effective no earlier than the first day of the first Plan Year after the amendment is adopted is not considered to be directed at individual participants and beneficiaries.

Anticipation, Alienation, Sale or Transfer
Except for assignments to providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Clerical Error
Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Creditable Coverage Certificates
Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a “certificate of creditable coverage” or “certificate of group health plan coverage,” from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates (including termination due to exhaustion of all lifetime benefits under the Plan), the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

Discrepancies
In the event that there may be a discrepancy between the booklet(s) provided to Employees (the "Summary Plan Description") and the Benefit Document, the Benefit Document will prevail.

Facility of Payment
Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he/she can be located for payment, the Plan may,

during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Plan.

Fiduciary Responsibility, Authority and Discretion
Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Plan Document, even if the terms are found to be ambiguous, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

Force Majeure
Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

Gender and Number
Except when otherwise indicated by the context, any masculine terminology will include the feminine (and vice-versa) and any term in the singular will include the plural (and vice-versa).
Illegality of Particular Provision

The illegality of any particular provision of the Benefit Document will not affect the other provisions, but the Benefit Document will be construed in all respects as if such invalid provision were omitted.

Indemnification
To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions
No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Benefit Document and Plan Document.

No legal action may be brought to recover on the Plan: (1) more than three years from the time written proof of loss is required to be given, or (2) until the Plan's mandatory claim appeal(s) are exhausted. See the **Claims Procedures** section for more information.

Loss of Benefits
To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or beneficiary might otherwise reasonably expect the Plan to provide based on the description of benefits:

- an employee's cessation of active service for the employer;
- a Plan participant's failure to pay his share of the cost of coverage, if any, in a timely manner;
- a dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces);
- a Plan participant is injured and expenses for treatment may be paid by or recovered from a third party;
- a claim for benefits is not filed within the time limits of the Plan.

Material Modification
In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days. "Material modifications" are those which would be construed by the average Plan participant as being "important" reductions in coverage. Such reductions are outlined by the Department of Labor in Section 2520.104b-3(d)(3) of the regulations.

Misstatement / Misrepresentation
If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual in an enrollment form or claims filing, his eligibility, benefits or both, will be adjusted to reflect his true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

Misuse of Identification Card
If an Employee or covered Dependent knowingly permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

Non-Discrimination Due to Health Status
An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

- a medical condition (whether physical or mental and including conditions arising out of acts of domestic violence)
- claims experience
- receipt of health care
- medical history
- evidence of insurability
- disability
- genetic information

Physical Examination
The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

Plan Administrator Discretion and Authority
The Plan Administrator has the exclusive authority, it its sole and absolute discretion, to take any and all actions necessary or appropriate to interpret the terms of the Plan in order to make all determinations thereunder. The Plan Administrator shall make determinations regarding coverage and eligibility. The Plan Administrator or the delegated Contract Administrator shall make determinations regarding Plan Benefits.

Privacy Rules and Security Standards and Intent to Comply
To the extent required by law, the Plan Sponsor certifies that the Plan will: (1) comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the “Privacy Rules”) of the Health Insurance Portability and Accountability Act (HIPAA) and (2) comply with HIPAA Security Standards with respect to electronic Protected Health Information.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

Purpose of the Plan
The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Participating Employer (s) and their eligible Dependents.

Reimbursements
Plan's Right to Reimburse Another Party - Whenever any benefit payments which should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Clerical Error - When, as a result of clerical error, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or

other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Rights against the Plan Sponsor or Employer
Except as required by law, neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Titles or Headings
Where titles or headings precede explanatory text throughout the Benefit Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Benefit Document and will not affect the validity, construction or effect of the Benefit Document provisions.

Termination for Fraud
An individual's Plan coverage or eligibility for coverage may be terminated if:

- the individual submits any claim that contains false or fraudulent elements under state or federal law;
- a civil or criminal court finds that the individual has submitted claims that contain false or fraudulent elements under state or federal law;
- an individual has submitted a claim which, in good faith judgment and investigation, he/she knew or should have known, contained false or fraudulent elements under state or federal law.

Termination for fraud will be made in writing and with 31-day notice to the individual.

Type of Plan
This Plan is not a plan of insurance. This Plan is a self-funded governmental group health plan which, for the most part, is exempt from the requirements of the Employee Retirement Income Security Act (ERISA). However, governmental plans are not automatically excluded from the following amendments to ERISA: The Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns and Mothers Health Protection Act (NMHPA), and the Women's Health and Cancer Rights Act (WHCRA). To be exempt from requirements of these laws, the Plan must make an affirmative written election to be excluded. Such election must be filed with the Centers for Medicare and Medicaid Services (CMS) prior to the beginning of each Plan Year, with notice provided to each Plan participant. Unless such written election is filed and participant notices are made, this Plan intends to fully comply with the above-stated federal laws.

Workers' Compensation
The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, which is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent will prevail over this summary.

If a retired Employee is covered under the Plan and one of his Dependents has a Qualifying Event (e.g., divorce, loss of Dependent child eligibility, etc.), such Dependent may be eligible for COBRA Continuation Coverage. Also, certain other COBRA rights apply to such retirees and their covered Dependents with regard to an Employer's bankruptcy. Anywhere "retirees" are referenced herein, it means only those retired Employees who were covered under the Plan.

Definitions
When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary - An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee or a covered Dependent of a covered Employee.

- Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverages the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the child.
- An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

Exception: An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which he was a non-resident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

Qualifying Event - Any of the following events that would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

- voluntary or involuntary termination of Employee's employment for any reason other than Employee’s gross misconduct as determined by the Employer;
- reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his portion of the cost of Plan coverage during the FMLA leave;
- for an Employee's spouse or child, Employee’s entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that his Medicare coverage is in effect;

- for an Employee's spouse or child, the divorce or legal separation of the Employee and spouse;
- for an Employee's spouse or child, the death of the covered Employee;
- for an Employee's child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit);
- for retirees and their Dependent spouses and children, loss of Plan coverage due to the Employer's filing of a bankruptcy proceeding under Title 11 of the U.S. Bankruptcy Code. In order for a Qualifying Event to occur, the Employee must have retired on or before the date of substantial elimination of the Plan's benefits and must be covered under the Plan on the day before the bankruptcy proceedings begin. "Substantial elimination" of the Plan's benefits must occur within 12 months before or after the bankruptcy proceedings begin.

Non-COBRA Beneficiary - An individual who is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

Notification Responsibilities
If the Employer is the Plan Administrator and if the Qualifying Event is Employee's termination/reduction in hours, death, or Medicare entitlement, then the Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights, or the unavailability of COBRA rights, within 44 days of the event. If the Employer is not the Plan Administrator, then the Employer's notification to the Plan Administrator must occur within 30 days of the Qualifying Event and the Plan Administrator must provide Qualified Beneficiaries with their COBRA rights notice within 14 days thereafter. Notice to Qualified Beneficiaries must be provided in person if the employee is the only qualified beneficiary or by first-class mail.

If COBRA continuation coverage terminates early (e.g., the Employer ceases to provide any group health coverage, a Qualified Beneficiary fails to pay a required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election), the Plan Administrator must provide the Qualified Beneficiary(ies) with notification of such early termination. Notice must include the reason for early termination, the date of termination and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred that permits him to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is a Dependent child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the Employee from his spouse. A Qualified Beneficiary is also responsible for other notifications. See the **COBRA Notification Procedures** as included in the Plan's Summary Plan Description (and the Employer's "COBRA General Notice" or "Initial Notice") for further details and time limits imposed on such notifications. Upon receipt of a notice, the Plan Administrator must notify the Qualified Beneficiary(ies) of their continuation rights within 14 days.

Election and Election Period
COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary. See NOTE.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Plan Administrator.

Open enrollment rights that allow non-COBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

NOTE: See the “Effect of the Trade Act” provision for information regarding a second 60-day election period allowance.

Effective Date of Coverage
COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

Level of Benefits
COBRA continuation coverage will be equivalent to coverage provided to similarly situated non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated non-COBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to his deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

Cost of Continuation Coverage
The cost of COBRA continuation coverage will not exceed 102% of the Plan’s full cost of coverage during the same period for similarly situated non-COBRA Beneficiaries to whom a Qualifying Event has not

occurred. The “full cost” includes any part of the cost that is paid by the Employer for non-COBRA Beneficiaries. Qualified Beneficiaries can be charged up to 150% of the full cost for the 11-month disability extension period if the disabled person is among those extending coverage.

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Administrator permits a billing grace period later than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Administrator.

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase if:

- the cost previously charged was less than the maximum permitted by law;
- the increase is due to a rate increase at Plan renewal;
- the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law that is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or
- the Qualified Beneficiary changes his/her coverage option(s) that results in a different coverage cost.

Timely payments that are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least 30 days) to make full payment. A payment will be considered an "insignificant shortfall" if it is not greater than $50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTE: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the state may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the state through a program for the medically-indigent or due to a certain disability. The Employer’s personnel offices should be contacted for additional information.

See the “Effect of the Trade Act” provision for additional cost of coverage information.

Maximum Coverage Periods

The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

- if the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the Qualifying Event. With a disability extension (see "Disability Extension" information below), the 18 months is extended to 29 months;
- if the Qualifying Event occurs to a Dependent due to Employee's enrollment in the Medicare program before the Employee himself experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare;

- if the Qualifying Event is the employer's filing of bankruptcy petition under Title 11 of the United States Code, the maximum applicable COBRA continuation period is: 1) for covered employees who retired on or before the date of a substantial elimination of coverage, coverage continues until their date of death; 2) for individuals who are widows or widowers of such retirees on the day before the petition is filed, coverage continues until their date of death; 2) in the case of the spouse and dependent children of a retiree, coverage continues until 36 months after the retiree's date of death;
- for any other Qualifying Event, the maximum coverage period ends 36 months after the Qualifying Event.

If a Qualifying Event occurs that provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment or a bankruptcy of the Plan Sponsor following any Qualifying Event will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first Qualifying Event, except in the case of a bankruptcy Qualifying Event with regard to a retiree where the maximum coverage period is to the date of the retired Employee's death.

COBRA entitlement runs concurrently with continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) - USERRA does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

Disability Extension
An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the Qualifying Event or at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date that falls within the allowable periods described. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension himself.

Termination of Continuation Coverage
Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the Qualifying Event and ending on the earliest of the following dates:

- the last day of the applicable maximum coverage period - see "Maximum Coverage Periods" above;
- the date on which the Employer ceases to provide any group health plan to any Employee;
- the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any Pre-existing condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary;

- the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his Medicare coverage is in effect;
- in the case of a Qualified Beneficiary entitled to a disability extension, the later of:
  - 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
  - the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;
- the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated non-COBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

Effect of the Trade Act
In response to Public Law 107-210, referred to as the Trade Act of 2002 (“TAA”), the Plan is deemed to be “Qualified Health Insurance” pursuant to TAA, the Plan provides COBRA continuation of coverage in the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, as amended.

Eligible Individuals - The Plan Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation (“PBGC”), pursuant to TAA as of or after November 4, 2002. The Plan Administrator shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement, federal income tax filings, etc. The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

Temporary Extension of COBRA Election Period

Definitions:

- Non-electing TAA-Eligible Individual - A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA continuation coverage during the TAA-Related Election Period.

- TAA-Eligible Individual - An eligible TAA recipient and an eligible alternative TAA recipient.

- TAA-Related Election Period - with respect to a TAA-related loss of coverage, the 60-day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual.
- TAA-Related Loss of Coverage - means, with respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

In the case of an otherwise COBRA Qualified Beneficiary who is a non-electing TAA-Eligible Individual, such individual may elect COBRA continuation of coverage during the TAA-Related Election Period, but only if such election is made not later than six (6) months after the date of the TAA-Related Loss of Coverage.

Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period, and shall not include any period prior to the such individual's TAA-Related Election Period.

HIPAA Creditable Coverage Credit

With respect to any TAA-Eligible Individual who elects COBRA continuation of coverage as a non-electing TAA Individual, the period beginning on the date the TAA-Related Loss of Coverage, and ending on the first day of the TAA-Related Election Period shall be disregarded for purposes of determining the 63-day break-in-coverage period pursuant to HIPAA rules regarding determination of prior creditable coverage for application to the Plan's Pre-existing condition exclusion provision, if any.

Applicable Cost of Coverage Payments

Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA-Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in IRS regulations 54.4980B-8, A-5(d), the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.

HIPAA PRIVACY

Definitions

- Breach means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information
The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Covered Persons. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Covered Person's PHI, and inform him/her about:

the Plan's disclosures and uses of PHI;

the Covered Person's privacy rights with respect to his/her PHI;

the Plan's duties with respect to his/her PHI;

the Covered Person's right to file a complaint with the Plan and with the Secretary of HHS; and

the person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed
In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is:

to carry out Payment of benefits;

for Health Care Operations;

for Treatment purposes; or

if the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes
In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);

ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

establish safeguards for information, including security systems for data processing and storage;

maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;

receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;

not use or disclose genetic information for underwriting purposes;

not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);

make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);

make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);

make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;

train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;

if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

the following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

in the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor
The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Contract Administrator , to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Covered Person's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule;

Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Person's information; and

Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Covered Person has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;

Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

A public health authority or other appropriate government authority authorized by law to receive reports of Child abuse or neglect;

Report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;

Locate and notify persons of recalls of products they may be using; and

A person who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition, if authorized by law;

The Plan may disclose PHI to a government authority, except for reports of Child abuse or neglect, when required or authorized by law, or with the Covered Person's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Covered Person that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI;

Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws;

Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Covered Person's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Covered Person of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards;

Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Covered Person's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises;

Decedents: The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years;

Research: The Plan may use or disclose PHI for research, subject to certain limited conditions;

To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public;

Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law; and

Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

Disclosures to Covered Persons: The Plan is required to disclose to a Covered Person most of the PHI in a Designated Record Set when the Covered Person requests access to this information. The Plan will disclose a Covered Person's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Covered Person's personal representative if it has a reasonable belief that the Covered Person has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Covered Person's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Covered Person; and

Disclosures to the Secretary of the U.S. Dept. of Health and Human Services: The Plan is required to disclose the Covered Person's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Instances When Required Authorization Is Needed From Covered Persons Before Disclosing PHI

most uses and disclosures of psychotherapy notes;

uses and disclosures for marketing;

sale of PHI; and

other uses and disclosures not described in can only be made with authorization from the Covered Person. The Covered Person may revoke this authorization at any time.

Covered Person's Rights

The Covered Person has the following rights regarding PHI about him/her:

Request Restrictions: The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions;

Right to Receive Confidential Communication: The Covered Person has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests;
Right to Receive Notice of Privacy Practices: The Covered Person is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator;

Accounting of Disclosures: The Covered Person has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Person is entitled to such an accounting for the 6 years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Covered Person of the basis of the disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Privacy Compliance Coordinator;

Access: The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI, or to have a copy of your PHI transmitted directly to another designated person, contact the Privacy Compliance Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Covered Person and the recipient must be clearly identified. The Plan must respond to the Covered Person's request within thirty (30) days (in some cases, the Plan can request a thirty (30) day extension). In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial;

Amendment: The Covered Person has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Covered Person's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request; and

Fundraising contacts: The Covered Person has the right to opt out of fundraising contacts.

Questions or Complaints
If the Covered Person wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Covered Person may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Covered Person with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Covered Person for filing a complaint with the Plan or the U.S. Department of Health and Human Services

Contact Information

Compliance/Legal Department
Director Washoe County Human Resources
(775) 328-2081

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions
Electronic Protected Health Information (ePHI), as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
Security Incidents, as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations
To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

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;

ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;

ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware; and

report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI
The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

Notify the Covered Person whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. Breach Notification must be provided to individual by:

Written notice by first-class mail to Covered Person (or next of kin) at last known address or, if specified by Covered Person, e-mail;

If Plan has insufficient or out-of-date contact information for the Covered Person, the Covered Person must be notified by a "substitute form;

If an urgent notice is required, Plan may contact the Covered Person by telephone.

The Breach Notification will have the following content:

Brief description of what happened, including date of breach and date discovered;

Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);

Steps Covered Person should take to protect from potential harm;

What the Plan is doing to investigate the branch, mitigate losses and protect against further breaches;

Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered;

Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than five hundred (500) individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each Calendar Year; and

When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected Covered Persons may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

APPENDIX A – PREVENTATIVE SERVICES

When the following covered preventive care services are provided by a Network provider, a Covered Person will not have to a meet a deductible, pay a Co-pay or pay a percentage share of the cost. See Schedule Of Benefit Percentages (page 11) for non-Network provider coverage.

NOTE: The following lists are subject to change periodically. Check the website references at the end of this section or contact the medical claims contract administrator for the most up-to-date information.

COVERED PREVENTIVE SERVICES FOR ADULTS (AGE 18 & OLDER)	
Abdominal Aortic Aneurysm	One-time screening for men ages 65 to 75 who have ever smoked
Alcohol Misuse	Screening and counseling
Aspirin Prevention Medication	Adults aged 50 to 59 years with ≥10% 10-year cardiovascular risk
Blood Pressure	Screening for all adults
Cholesterol	Screening for adults of certain ages or at higher risk
Colorectal Cancer	Screening for adults over age 45
Depression	Screening for adults
Diabetes (Type 2)	Screening for adults with high blood pressure
Diet	Counseling for adults at higher risk for high cholesterol or heart disease
Hepatitis C	Screening for adults at increased risk, and one time for everyone born 1945-1965
HIV	Screening for everyone ages 15 to 65, and others ages at increased risk
Immunizations & Vaccines Doses, recommended ages and recommended populations vary	Diphtheria Hepatitis A Hepatitis B Herpes Zoster Human Papillomavirus Influenza Measles Mumps Meningococcal Pertussis Pneumococcal Rubella Tetanus Varicella
Lung Cancer	Screening for adults 55-80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years.
Obesity	Screening and counseling for all adults
Prostate Specific Antigen	PSA lab test for men of certain age and risk level as determined by the American Cancer Society recommendations
Sexually-Transmitted Infection (STI)	Prevention counseling for adults at higher risk
Syphilis	Screening for all adults at higher risk
Tobacco Use	Screening only

ADDITIONAL COVERED PREVENTIVE SERVICES FOR WOMEN (AGE 18 & OLDER)	
BRCA Gene	Risk assessment and genetic counseling/testing
Breast Cancer Mammography	Screenings every 1 to 2 years for women over 40 – including dense breast procedures
Breast Cancer Chemoprevention	Counseling for women at higher risk
Cervical Cancer	Screening for sexually-active women
Chlamydia Infection	Screening for younger women and other women at higher risk
Contraception	FDA Approved contraceptive methods, sterilization procedures, and patient education and counseling; prescription may be filled for a period not to exceed 12 months (See Prescription Benefits page 36)
Domestic and Interpersonal Violence	Screening and counseling
Folic Acid	Supplements for women who may become pregnant
Gonorrhea	Screening for all women at higher risk
HPV DNA Test	Every 3 years for women with normal cytology results who are 30 or older
Osteoporosis	Screening for women over age 60 depending on risk factors
Sexually Transmitted Infections	Counseling for sexually active women
Well-woman visits	To get recommend services for women under 65
PREVENTIVE SERVICES FOR COVERED PREGNANCIES	
Anemia	Screening on a routine basis for pregnant women
Bacteriuria Screening	Urinary tract or other infection screening for pregnant women
Breast Feeding	Interventions to support and promote breast feeding
Gestational diabetes screening	For women 24-28 weeks pregnant and those at high risk
Hepatitis B	Screening for pregnant women at their first prenatal visit
Rh Blood Typing	Screening for all pregnant women
Tobacco Use	Screening, interventions and expanded counseling for pregnant tobacco users
Syphilis	Screening for all pregnant women or other women at increased risk
COVERED PREVENTIVE SERVICES FOR CHILDREN (BIRTH TO AGE 18)	
Alcohol & Drug Use Assessment	Adolescents
Autism Screening	18 and 24 months
Behavioral Assessments	All children throughout development
Blood Pressure Screening	All children throughout development
Cervical Dysplasia Screening	Sexually active females

COVERED PREVENTIVE SERVICES FOR CHILDREN, *continued* **(BIRTH TO AGE 18)**	
Congenital Hypothyroidism Screening	All newborns
Depression Screening	For adolescents
Developmental Screening	Children under age 3 and surveillance throughout childhood
Dyslipidemia Screening	Children at higher risk of lipid disorders
Fluoride Chemoprevention Supplements	Children without fluoride in their water source
Gonorrhea Preventive Eye Medication	All newborns
Hearing Screening	All newborns
Height, Weight & Body Mass Index	All children throughout development
Hematocrit or Hemoglobin Screening	All children
Hemoglobinopathies/Sickle Cell Screening	All newborns
HIV Screening	Adolescents at higher risk
Hypothyroidism screening	All newborns
Immunizations & Vaccines	Diphtheria Haemophilus Influenza (Type b) Hepatitis A Hepatitis B Human Papillomavirus Inactivated Poliovirus Influenza Measles Meningococcal Mumps Pertussis Pneumococcal Rotavirus Rubella Tetanus Varicella
Iron Supplements	Children ages 6 to 12 months at risk for anemia
Lead Screening	Children at risk of exposure
Medical History	All children throughout development
Obesity Screening & Counseling	All children throughout development
Oral Health Risk Assessment	Young children
Phenylketonuria (PKU) Genetic Screening	All newborns
Sexually Transmitted Infection (STI) Prevention Counseling	Adolescents at higher risk
Tuberculin Testing	Children at higher risk of tuberculosis
Vision Screening	All children

IMPORTANT DETAILS:

- A doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that the plan can require the Covered Person to pay some costs of the office visit if the preventive service is not the primary purpose of the visit, or if the doctor bills the claimant for the preventive service separately from the office visit.
- A Covered Person should ask his health care provider to help him understand which covered preventive services are right for him – based on his age, gender and health status.

WEBSITE REFERENCES:

Regulation: http://www.hhs.gov/healthcare/about-the-law/read-the-law/index.html#

Overview: https://www.healthcare.gov/coverage/preventive-care-benefits/

THE FOLLOWING ANCILLARY BENEFITS ARE PROVIDED TO ALL ELIGIBLE WASHOE COUNTY EMPLOYEES REGARDLESS OF CHOICE OF MEDICAL PLAN

The following program information is provided as a courtesy only. If there are any conflicts between the information in this document and the terms of the vendor's agreement, the agreements will prevail. Participants should refer to the applicable vendor's website or contact customer service for specific questions regarding coverage.

VISION PLAN
BENEFIT SUMMARY

THROUGH

VISION SERVICE PLAN
(VSP)

VISION PLAN BENEFITS SUMMARY

Vision benefits are provided to all employees, retirees and their respective dependents through the County's contract with Vision Service Plan regardless of their selection of Medical Plans.

Vision Service Plan (VSP) is a nationwide preferred provider organization with over 14,000 providers. You may use one of the VSP providers for a co-payment for exam, standard lenses and frames, or you may choose to use a non-VSP provider, pay for services and send the bill to VSP for reimbursement in accordance with the VSP Reimbursement Schedule. Visit vsp.com or call 1-800-877-7195.

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Doctor			
WellVision Exam	• Focuses on your eyes and overall wellness	$10 for exam and glasses	Every 12 months
Prescription Glasses			
Frame	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • $80 allowance at Costco	Combined with exam	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Combined with exam	Every 12 months
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$55 $95 -$105 $150 - $175	Every 12 months
Contacts (Instead of lenses)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
Diabetic Eyecare Plus Program	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP doctor within 12 months of your last WellVision Exam.		
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Your coverage with Other Providers			
Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.			
Exam - up to $45	Single Vision Lenses - up to $30	Lined Trifocal Lenses - up to $65	Contacts – up to $105
Frame – up to $70	Lined Bifocal Lenses – up to $50	Progressive Lenses – up to $50	
VSP Guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Base on applicable laws, benefits may vary by location.			

BENEFITS WHEN USING VSP PROVIDERS

When you use a VSP provider, you are covered for the noted benefits for a $10 co-payment. However, VSP does not pay for optional features. Such features are listed in "*Benefit Limitations*" on the following page. You may still request these optional features, but you will be responsible for the additional charge.

When you choose one of these VSP providers, you simply call to make your appointment noting that you are with Washoe County and have coverage through Vision Service Plan. With that notation, the VSP provider will contact VSP for verification of your coverage and have all necessary paper work in the office upon your arrival for your appointment.

BENEFITS IF YOUR DOCTOR IS NOT A VSP PROVIDER

You have the option of using one of the VSP providers or any other optometrist, ophthalmologist and/or dispensing optician and still receive benefits under the Plan.

If you choose to go to a non-VSP provider, the Plan becomes an *indemnity plan* reimbursing you for your expenses according to the schedule of allowances listed below. Send copies of your itemized bills to **VSP, Attn: Out of Network Claims, PO Box 997105, Sacramento, CA 95899-7105**. VSP is also available over the Internet at www.vsp.com.

There is no assurance that the schedule will be sufficient to pay for the examination or the materials. The lens allowances are for two lenses. If only one lens is needed the allowance will be one-half the pair allowance. Reimbursement benefits are not assignable.

You can find eligibility information and provider lists at www.vsp.com. For specific questions or concerns regarding this benefit, or to request a provider list through the mail, please contact VSP's customer service at (800) 877-7195.

VISION BENEFIT LIMITATIONS

You must pay the additional cost for non-covered options recommended by your provider or selected by you. The VSP provider will inform you of that cost which will reflect a discount of approximately 20%. Such options include:

Patient Options **Description**

High Index Plastic .....High Index plastic lenses are made thinner and lighter
Polycarbonate .....High Index, impact resistant lens
Low Power Aspheric .....Thinner lenses to eliminate the magnified effect

Occupational Lenses	Lenses used to meet the visual demands of a specific occupation
Polarized/Laminated	Sunglass lens
Blended Myo-Disc	Reduces lens edge thickness
Progressive	Multifocal lenses where lines are replaced with gradual blending of power
Near Variable Focus	Progressive lens providing near and intermediate reading vision
Progressive Flat Top	A segment in a lens with a clear mid-range vision
Blended Bifocal	A bifocal lens where the segment lines are invisible
Dyes, Tints, Color Coatings	These dyes are uniform in color and have degrees of shading
Gradient Color Dyes	Coloring is generally darker at top and lighter toward bottom of lens
Color Tints – Glass Lens only	Tints dyed into lens material
Solid Color Coatings	Color coating applied to the front surface of the lens
Gradient Color Coatings	Gradient color coating is applied to the front surface of a lens
Photochromic	Photochromic lenses darken in sunlight and lighten in the indoors
Anti-Reflective Coating	Reduces reflections
Mirror Coating	Front surface of a lens reflect like a mirror
Scratch Resistant Coating	Increases resistance to surface scratches
Ski-Type Coating	Combination of gradient mirror coating and tint
Oversize (61 mm Eye Size +)	Size is measured from horizontally
Specified Center Thickness of 1.2mm or below	Center of lens is grinded to less than 1.2 mm reduces the edge thickness
Edge Treatments	Buffs the edge of a lens to improve the appearance of a thick lens
Edge Coating, Painting Groove	Colors the edge of a lens to decrease the edge's visibility
Facetted Lenses	Edging and polishing the lens to give a jewel-like appearance
Slab-Off	The grinding of two different curvatures to compensate for unequal powers at the reading distance
UV Protection	Blocks potentially harmful ultraviolet light rays
PLS Series	Reduces glare

EXCLUSIONS

There will be **no benefits** for professional services or materials connected with:

- Orthoptics or vision training or any associated supplemental testing, plane lenses, or two pair of glasses in lieu of bifocals
- Lenses and frames furnished under this Plan which are lost or broken, will not be replaced except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Any eye examination or any corrective eyewear required by an employer as a condition of employment
- **Claims filed more than 180 days after the service date**

CLAIMS APPEAL PROCESS

If your claim has been denied, VSP will notify you in writing of the specific reason for the denial. To appeal this decision, you may request a review of the claim by the VSP administrator **within ninety (90) days** of receipt of the written denial.

You will be given the opportunity to review pertinent documents, submit any statements or arguments in support of your claim, and appear in person at the VSP office if you so desire.
The VSP administrator will **notify you within 60 days** of receipt of the request for review of their decision. They will advise you in writing of the specific reasons for the decision, including specific references to the plan provisions on which the decision is based.

GROUP LIFE/
ACCIDENTAL DEATH
AND DISMEMBERMENT
BENEFIT SUMMARY

LIFE INSURANCE BENEFIT SUMMARY

You are eligible for the life insurance benefits described below if you are enrolled in the Health Benefit Program offered by Washoe County. The actual eligibility requirements are described in Section I of this booklet. Additional requirements or provisions associated with the Life Insurance Plan appear in the "*Group Insurance Certificate.*" *Exception: COBRA enrollees do not retain life insurance benefits nor do retirees who reinstate their coverage pursuant to NRS #287.0475*.

AMOUNT OF INSURANCE

	LIFE INSURANCE	ACCIDENTAL DEATH, DISMEMBERMENT* AND LOSS OF SIGHT INSURANCE
COVERED EMPLOYEES/RETIREES		
Under Age 65	**$20,000**	**$20,000**
Age 65 through 69	**$13,000**	**$13,000**
Age 70 and Over	**$7,000**	**$7,000**
COVERED DEPENDENTS AND SURVIVING SPOUSES (RETIREES)		
Spouse	**$1,000**	**NONE**
Child	**$1,000**	**NONE**

** AD&D coverage includes a "Seat Belt Benefit" for the lesser of $20,000 or amount of AD&D and an "Air Bag Benefit" for the lesser of $5,000 or amount of AD&D.*

BENEFICIARY

You must designate/update the beneficiary for your life insurance when you log onto ESS to enroll or certify your health insurance benefits. You may update your beneficiary at any time via ESS. If you name more than one beneficiary and do not state the interest of each, they will share equally. If any beneficiary is not living when you die, his/her share will be payable equally to the named beneficiaries who survive you, unless you have requested otherwise. The amount of insurance will be payable as directed by policy if: (1) you have not named a beneficiary; or (2) no named beneficiary survives you. (Policy directs as follows: 1) spouse; 2) child/ren; 3) parents; 4) siblings; and 5) estate.)

LIFE INSURANCE FOR DEPENDENTS

The amount of "**dependent**" life insurance as shown above is **payable to you** in the event of your dependent's death. If you are not living at that time the amount will be paid per policy direction (see above).

NOTE: The insurance company contracted by the County to provide this benefit may change annually, therefore, the vendor name and group number is not included in this Plan Booklet. Should you wish a copy of the Life Insurance Certificate, please contact Human Resources.