CLARK COUNTY
SELF-FUNDED GROUP MEDICAL AND DENTAL BENEFITS PLAN

Plan Document
Effective January 1, 2023

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TABLE OF CONTENTS

INTRODUCTION

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

No oral interpretations can change this Plan. The Plan Administrator fully intends to maintain this Plan indefinitely, however, it reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason. Changes in the Plan may occur in any or all parts of the Plan including but not limited to benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, and eligibility.

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

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

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

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

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

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

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

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

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

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

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

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

ELIGIBILITY PROVISIONS

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

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

1. A Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if the employee routinely works in a position which is eligible for employer sponsored pension contribution, and the employee is on the regular payroll of the Employer for that work; and
2. Continuously employed for a period of fifteen (15) days as an Active Employee; not to exceed 45 days; or
3. A Retired Employee of the Employer who was covered on the Plan at the time they separated from active employment with the Employer; or
4. A surviving Spouse of a Retired Employee, provided such spouse was covered under the Plan at the time of the Retired Employee's death; or
5. In a class eligible for coverage under the terms of the Plan in effect prior to the Effective Date, who, within 31 days of the date of termination of employment, becomes an Employee of another public entity which provides coverage under the group health plan; or
6. Currently covered as a dependent spouse of an Employee or Retiree, and who was a former covered Employee or Retiree covered by the Plan and has remained continuously covered under the Plan at the time of the employee or retiree's termination of coverage, may revert to employee or retiree status within 31 days of such date of termination of coverage providing the member submits a completed enrollment form within that timeframe to Clark County Risk Management: or

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

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

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

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

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

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

Special Provisions for Elected Officials
The following provisions shall apply concerning benefits for Elected Officials.

1. Elected Officials. Individuals who are elected to county office shall be considered Employees for purposes of this Plan during the term of their elected position.
2. Waiting Period. Elected Officials are not required to serve a waiting period.
3. Effective Date. Elected Officials and their eligible Dependents will be covered under this Plan effective on the date the official takes the oath of office, so long as the Elected Official complies with the Plan's Enrollment Requirements within 31 days of the date the oath of office is taken.

Special Provisions for Firefighters Transferring to an M-Plan
The following provisions shall apply concerning benefits for Employees who are Firefighters including Battalion Chiefs transferring to an M-Plan Position:

1. Waiting Period. A Firefighter described above is not required to serve a waiting period.
2. Actively at Work. A Firefighter described above and his or her Dependents must satisfy the Plan's requirements concerning actively at work and enrollment.
3. Partial Year Coverage. A Firefighter described above and his or her Dependents will be credited with expenses incurred during the partial calendar year prior to becoming covered under this Plan for purposes of the Plan's deductible requirements as if they had been covered under this Plan when such expenses were incurred.

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

Dependent Eligibility
A Dependent is any one of the following persons:

1. A covered Employee's Spouse. The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the marriage was performed (celebrated). The Plan Administrator will require documentation proving a legal marital relationship. A Spouse who also qualifies as an eligible Employee will not be considered a Dependent for purposes of the Plan as long as such Spouse continues in the employment of the Employer.
2. A covered Employee's children from birth to the limiting age of 26 years. The term "children" shall include natural children, adopted children, children placed in the home for adoption, step-children, natural child of the covered grandfathered Domestic Partner, or children for whom a court has ordered coverage through a National Qualified Medical Child Support Order.

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

Requirement for spousal enrollment in other group insurance. If a spouse is covered as a dependent of an employee or retiree covered by the Clark County Self-Funded Health Benefits Plan, and the spouse is employed by a company that offers an employee health benefit plan, or a retiree health benefit plan as a retiree of another company, and he/she is eligible for any such (non-HMO) coverage at a monthly cost equal to or less than the current Clark County employee and spouse employee premium deduction rounded to the next lowest $5.00 increment for employee only, the spouse is required to enroll in such other employer sponsored program. If the spouse declines any other employer-sponsored coverage, the Clark County Self-Funded Benefits Plan will provide coverage to the spouse at 20% of the Plan allowable, either the contracted rate or the reasonable and customary allowable when the contracted rate is not available, instead of the normal benefit payable for such service covered by the Clark County Self-Funded Plan.
If the dependent spouse of an employee misses his/her employer's open enrollment period for the calendar year for which the employee is enrolling the newly eligible dependent spouse in this coverage, the above benefit limitation will be waived for the first year of the dependent spouse's coverage, but not to exceed 12 months from the effective date of the dependent spouse's coverage with this Plan.

Guardianship/Legal Custody Children
This coverage is only available to those guardianship/legal custody children who the Employee covered as a dependent on December 31, 2010. Guardianship/legal custody children who were not covered on December 31, 2010, are not eligible to be enrolled at a future date.

Subject to the foregoing limitation, if a covered Employee or spouse is the court appointed Legal Guardian or has court ordered Legal Custody of a minor child or minor children, these children may be enrolled in this Plan as covered dependents until those minor reaches majority (age eighteen in Nevada).

The plan shall require that the dependent be dropped from the coverage upon reaching majority as ineligible. In the case of extended guardianship (if applicable through state statutes), the Plan shall require copies of the new petition for extended guardianship and Letters of Guardianship issued as a result of this petition. The Plan Administrator shall also request annually a copy of the member's tax return transcript from the Internal Revenue Service verifying the continued dependency of the minor child covered by this Plan through court appointed guardianship/custody.

If both the father and mother are Employees, their children or guardianship/legal custody children will be covered as Dependents of one employee, but not of both.
OR
Child(ren) who are a covered dependent(s) of the Plan due to their relationship with a covered employee who later become a benefit eligible employee must obtain primary coverage from the Plan and drop their dependent status.

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

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

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

Ineligible for Dependent Coverage
These persons are excluded as Dependents:

- Individuals living in the covered Employee's home, but who are not eligible as defined;
- The legally separated or divorced/annulled former Spouse of the Employee;
- An Employee's Domestic Partner regardless of gender. Domestic Partners enrolled in the plan prior to January 1, 2018, will remain eligible;
- Parents of any Employee;
- Any person who is on active duty in any military service of any country;

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

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

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

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

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

ENROLLMENT

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

Submission of this application is required before coverage will begin, even if the Employer provides coverage on a non-contributory basis.

The completed form must be received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, or enrollment can only take place during the annual Open Enrollment period.

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

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

Enrollment Requirements for Newborn Children

Newborn children will automatically be covered for the first 31 days following birth. **Coverage will cease beginning with the 32nd day unless the newborn child has been affirmatively enrolled as a Dependent in the plan by completing and submitting an approved enrollment change form by the end of the 60th day following the date of birth.** Additionally, the employee will be required to submit a certified copy of the birth certificate and social security card/number, either with the approved enrollment form or as soon as a copy can be obtained.

If the child is required to be enrolled and is not enrolled by the end of the 60th day following the date of birth, enrollment can only take place as provided in the Open Enrollment provisions and will be subject to the Plan's open enrollment limitations.

Enrollment Requirements for Newly Eligible Dependents

When an employee acquires eligible dependents through marriage, birth, adoption, or placement for adoption, they may add these dependents to their coverage by affirmatively requesting enrollment by the end of the 60th day following acquisition by completing and submitting an approved enrollment form. Additionally, the employee will be required to submit a copy of the applicable documentation (i.e., certified marriage certificate, certified adoption orders, certified birth certificate, etc. A copy of the individuals social security card, or proof you have filed for it, is also required).

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

The Enrollment Period for newly eligible dependents is a period of 60 days and begins on the date of the marriage, birth, adoption, or placement for adoption. If the dependent is not enrolled by the end of the 60th day following the event, enrollment can only take place as provided in the Open Enrollment Provisions and will be subject to the Plan's Open Enrollment limitations.

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

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

Enrollment Requirements for Dependents who suffer Involuntary Loss of Coverage

In the event an eligible dependent loses other group health insurance coverage involuntarily the employee may enroll such dependent within 31 days of such involuntary loss of coverage. To enroll the dependent, the employee must complete and submit an approved dependent enrollment/change form

within 31 days of such loss. Additionally, the employee will be required to submit a copy of verification of such loss from the former employer/plan administrator, and any other applicable documentation (i.e., certified marriage certificate, certified birth certificate, etc.). If the dependent, who suffers involuntary loss of coverage, is not enrolled within 31 days, enrollment may only take place as provided in the Open Enrollment Provisions.

Effective Dates for Special Enrollments

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

1. In the case of marriage, the first of the month following the date the employee requests coverage for the spouse (signature date);
2. In the case of a Dependent's birth, as of the date of birth;
3. In the case of a Dependent's adoption or placement for adoption, the date the adoption is finalized, and the Child is physically residing in the member's home; or the date the child is placed for adoption, and is Physically residing in the member's home; or
4. In the case of involuntary loss of coverage, the first of the month beginning after the date of the completed request for enrollment and supporting documentation is received, or the date of the loss of coverage, whichever is later.

Medicaid or State Child Health Insurance Plan (SCHIP)

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

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

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

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

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

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

Other Miscellaneous Enrollment Requirements

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

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

Required Documentation for covered Employees and their covered Dependents

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

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

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

The mid-year Enrollment Period for newly eligible Dependents is a period of 60 days and begins on the date of the marriage, birth, adoption, or placement for adoption. If the Dependent is not enrolled by the end of the 60th day following the event, enrollment can only take place as provided in the annual open enrollment Provisions and will be subject to the Plan's annual open enrollment limitations. Covered Employees shall have 90 days from the date of the Plan's receipt of the enrollment request, to provide a copy of the certified birth certificate, certified marriage certificate, or other necessary dependent documentation, as required by the Administrator, to verify dependent eligibility.

Timely Enrollment and Notification

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

1. For New Employees the form must be received within 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.
2. For Newly eligible dependents the form must be received by the end of the 60th day following the date of the qualifying event.
3. For Employees and Retirees notification of an address change must be received within 31 days of the change of address.
4. For Retirees the form must be received within 31 days of retirement.

Disenrollment of Ineligible Dependents and Notification of Medicare Entitlement

You must notify your Employer within 31 days of a change in family status or when a covered dependent is no longer eligible for coverage or becomes eligible for other group health insurance coverage, or if there is a change in Medicare entitlement. This notification must be made by completing and submitting an approved change form to the Plan Administrator and/or providing appropriate documentation. The member's failure to timely notify the Employer as required by this section may result in disenrollment of the member. The member will be responsible for all expenditures incurred by both the Plan and their Employer as a consequence of the member's failure to provide the timely notification required by the Plan. These changes include, but are not limited to:

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

Dual Choice of Health Care Benefits

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

An Employee who is enrolled in the HMO may transfer to the Plan's coverage at specified times as follows: (a) during the annual Open Enrollment periods, (b) the first of the month following your move out of the HMO service area, and (c) upon the HMO ceasing operation.

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

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

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

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

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

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

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

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverage. Plan Participants will receive detailed information from their Employer.

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

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

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

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

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

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

1. Completion of Health Benefit Enrollment form. If retiree requests reinstatement of previously covered dependents, a copy of the certified marriage certificate for the spouse and copy of the certified birth certificate for each child being reinstated will be required.
2. Coverage will be effective March first of an even numbered year following completion and receipt of the Plan approved enrollment form, and any applicable dependent records. PERS will be notified regarding applicable premium deduction from the retiree's monthly retirement check. Non-PERS participating Employers shall collect retiree premiums on behalf of the Plan and deliver the premium payments to the Plan on behalf of the Non-PERS retirees.

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

Section 125 Tax Regulations on This Plan

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

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

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

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

**The Enrollment Period for newly eligible dependents is a period of 60 days and begins on the date of the marriage, birth, adoption or placement for adoption. Refer to Enrollment section for details.*

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

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

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

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

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

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

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

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

TERMINATION OF BENEFITS

When Employee Coverage Terminates

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

1. The date the Plan is terminated.
2. The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of employment of the covered Employee. (See the Continuation of Coverage section)
3. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Good Faith Reliance upon Information Provided

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

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

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

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

Rehiring a Terminated Employee

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

When Dependent Coverage Terminates

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

1. The date the Plan is terminated.
2. The date that the Employee's coverage under the Plan terminates for any reason including death.

(See the Continuation of Coverage section.)

3. The date Dependent coverage is terminated under the Plan.
4. On the last day of the calendar month that he or she ceases to be a Dependent as defined by the Plan. (See the Continuation of Coverage section.)
5. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
6. The end of the 90-day period following the Administrator's initial request for certified birth certificates, certified marriage certificates or other necessary dependent documentation.

Extension of Benefits

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

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

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

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

Family and Medical Leave Act

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

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

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

Military Leave of Absence

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

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

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

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

CONTINUATION OF COVERAGE

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

The COBRA regulations gives certain persons the right to continue their health care benefits beyond the date that they might otherwise terminate. The entire cost (plus the administration fee allowed by law) must be paid by the continuing person. Coverage will end if the covered individual fails to make timely payment of premiums.

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

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

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

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

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

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

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

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

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

PROTECT YOUR GROUP HEALTH INSURANCE CONTINUATION COVERAGE RIGHTS!
EMPLOYEE/QUALIFIED BENEFICIARY 60 DAY NOTIFICATION REQUIREMENT!

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

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

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

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

If a qualified beneficiary elects continuation coverage, they will be required to pay the entire cost for the health insurance, plus a 2% administration fee. Clark County is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the plan to similarly situated non-COBRA participants and/or covered dependents. Should coverage change or be modified for non-COBRA participants, then the change and/or modification will be made to your coverage as well. *Initial premium is due no later than 45 days after electing COBRA coverage. Subsequent premium payments are due on the 1st of each month and will be considered late if not received or post-marked by the 30th day after the due date. Payment is considered not received if a check is returned for insufficient funds.*

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

Social Security Disability Extension - The 18 months of continuation coverage can be extended for an additional 11 months of coverage, to a maximum of 29 months, for all qualified beneficiaries if the Social Security Administration determines a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act on the date of the qualifying event or at any time during the first 60 days of continuation coverage. It is the qualified beneficiaries' responsibility to obtain this disability determination from the Social Security Administration and provide a copy of the determination to Clark County, Nevada according to the below listed notification procedures within 60 days after the date of determination and

before the original 18 months expire. In general, if coverage is extended due to a Social Security Disability, premium rates will be raised to 150% of the applicable rate.

Secondary Event Extension - Another extension of the 18 or above mentioned 29-month continuation period can occur, if during the 18 or 29 months of continuation coverage, a second qualifying event takes place such as a divorce, legal separation, death, Medicare entitlement, or a dependent child ceasing to be a dependent. If a second event occurs coverage will be extended to 36 months from the date of the original qualifying event date for eligible dependent qualified beneficiaries. It is the qualified beneficiaries' responsibility to notify Clark County, Nevada according to the below listed notification procedures within 60 days of the second event and within the original 18- or 29-month continuation timeline. In the case of a newborn or adopted child that is added to a covered employee's continuation coverage, then the first 60 days of continuation coverage for the newborn or adopted child is measured from the date of the birth or the date of the adoption. In no event, however, will continuation coverage last beyond three years (36 months) from the date of the event that originally made the qualified beneficiary eligible for continuation coverage. A reduction in hours followed by a termination of employment is not a second event.

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

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

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

A qualified beneficiary will have to pay all of the applicable premium plus a 2% administration charge for continuation coverage. These premiums will be adjusted during the continuation period if the applicable premium amount changes. In addition, if continuation coverage is extended from 18 months to 29 months due to a Social Security disability, Clark County can charge up to 150% of the applicable premium during the extended coverage period. Qualified beneficiaries will be allowed to pay monthly. In addition, there will be a maximum grace period of 30 days for the regularly scheduled monthly premiums.

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

1. Clark County and/or Affiliates ceases to provide any group health plan to any of its employees;
2. Any required premium for continuation coverage is not paid in a timely manner;
3. A qualified beneficiary first becomes, after the date of COBRA election, covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary other than such an exclusion or limitation which does not apply to or is satisfied by such beneficiary by reason of the Health Insurance Portability and Accountability Act;
4. A qualified beneficiary first becomes, after the date of COBRA election, entitled to Medicare;
5. A qualified beneficiary extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer

disabled;

6. A qualified beneficiary notifies The Plan Administrator they wish to cancel continuation coverage.
7. For cause, on the same basis that the plan terminates the coverage of similarly situated non-COBRA participants.

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

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

Should an actual qualifying event occur, and it is determined that you are eligible for continuation; you will be notified of all your actual rights at that time. Should you have any questions regarding the information contained in this notice, you should contact Clark County Risk Management or your employer's benefit office, or you may contact the Centers for Medicare and Medicaid (CMS) via email at phig@cms.hhs.gov or call toll free at 1-877-267- 2323, option #4, extension 61565.

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

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

IF YOU HAVE QUESTIONS

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

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

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

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

COORDINATION OF BENEFITS PROVISION

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

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

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

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

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

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

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

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

Order of Benefit Determination

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

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

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

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

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

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

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

Birthday Rule – The primary plan is the plan of the parent whose birthday is earlier in the year, if the parents are married or if a court order awards joint custody without specifying which parent has responsibility for providing health care coverage. If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

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

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

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

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

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

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

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

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

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

Requirement for Spousal Enrollment in Other Group Insurance

If a spouse is covered as a dependent of an employee or retiree under the Clark County Self- Funded Health Benefit Plan and has access to a non-HMO health benefit plan through his or her own employer or former employer at a monthly cost equal to or less than the current Clark County employee and spouse employee premium deduction rounded to the next lowest $5.00 increment for employee only, the spouse is required to enroll in such other employer sponsored program.

If the spouse declines any other employer-sponsored coverage, this Plan will provide coverage to the spouse at 20% of the Plan's regular allowable, either the contracted rate or the reasonable and customary allowable when the contracted rate is not available.

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

Coordination with Medicare

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

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

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

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

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

How Much This Plan Pays When It is Secondary to Medicare

- ***When the Plan Participant is Covered by Medicare Parts A and B***: When the Plan Participant is covered by Medicare Parts A and B and this Plan is secondary to Medicare, the Plan pays benefits according to the following: In the case of Medicare Assigned claims, this plan will pay the 20% of the Medicare approved amount, and the Medicare Part A or Part B deductibles, provided there is sufficient Self-Funded benefit available with respect to that claim. In the case of non-covered Medicare unassigned claims, the payment of benefits will be based on the Clark County Self-Funded allowable and plan provisions. In no event will benefits exceed the benefits provided to active employees.
- ***When a Plan Participant is Covered by Medicare + Choice (Part C):*** If a Plan Participant is covered by a Medicare + Choice plan (Part C of Medicare) all medical services or supplies are provided in compliance with the rules of that program (including, without limitation, obtaining all services In-Network when the Medicare Part C requires it). This Plan will not reimburse the retiree for any out-of-pocket expenses. Retirees should not enroll in both a Medicare + Choice plan and the Self-Funded plan.
- ***When the Plan Participant is Not Covered by Medicare***: You are responsible to enroll for all Medicare coverage for which you are eligible. This Plan will pay as primary if you are on Medicare but not eligible for Medicare Part A. However, this Plan will always be secondary to Medicare Part B, whether you have enrolled; this Plan will estimate Medicare's benefit and this Plan will only pay up to 20% of the Plan's allowable.

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

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

IMPORTANT HIGHLIGHTS

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

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

(1) **MANDATORY PRE-AUTHORIZATION**

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

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

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

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

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

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

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

GENERAL PROVISIONS

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

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

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

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

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

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

Medical Care Decision – The benefits under the Plan provide solely for the payment of certain health care expenses. All decisions regarding health care are solely the responsibility of each Plan Participant in consultation with the health care providers selected. The Plan contains rules for determining the percentage of allowable health care expenses that will be reimbursed, and whether treatments or health care expenses are eligible for reimbursement. Any decision with respect to the level of health care reimbursements, or the coverage of a particular health care expense, may be disputed by the Plan Participant in accordance with the Plan's claim procedures.

Each Plan Participant may use any source of care for health treatment and health coverage as selected, and neither the Plan nor the employer shall have any obligation for the cost or legal liability for the outcome of such care, or as a result of a decision by a Plan Participant not to seek or obtain such care, other than the liability of the Plan for the payments of benefits as outlined herein.

Assignment, Reimbursement & Third-Party Recovery

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Plan shall have no obligation to compromise its recovery for any reason. The Plan's right of assignment and refund are limited solely to the extent to which the Plan has made, or will make, payments for medical or dental charges, as well as any costs and fees associated with the enforcement of its rights under the Plan.

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

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

7. **Defined terms:**

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

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

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

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

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

8. **Caveats:**

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

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

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

MEDICAL EXPENSE BENEFIT PROVISION

Verification of Eligibility

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

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

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

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

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

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

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

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

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

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

SCHEDULE OF MEDICAL BENEFITS

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

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

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

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

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

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

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

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

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

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

CARE MANAGEMENT PROGRAM

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

The Case Management program consists of the following:

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

b. Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;
c. Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
d. Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

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

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

The purpose of the program is to determine what is medically appropriate. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider, however, the fact that a physician may prescribe, order, recommend, or approve a service does not, of itself, make it medically necessary or make the charge a covered expense, even though it is not specifically listed as an exclusion under this Plan.

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

Here's how the program works

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

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

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

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

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

The utilization review administrator will determine the number of days of Medical Care Facility confinement authorized for payment.

Failure to obtain inpatient prior authorization will reduce reimbursement received from the Plan.

If the Plan Participant does not receive prior authorization as explained in this section, the Physician, hospital, and any related services will be reduced to only services that have been prior authorized.

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

Concurrent review, discharge planning

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

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

Preadmission Testing Service

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

1. performed on an outpatient basis within five days before a Hospital confinement;
2. related to the condition which causes the confinement; and
3. performed in place of tests while Hospital confined.

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

Case Management

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

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

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or nursing homecare;
- determining alternative care options; and/or
- assisting in obtaining any necessary equipment and services.

Case Management occurs in the following situations:

- The catastrophic Injury or Illness must have occurred while the patient was covered, and the Injury or Illness must have been covered under the Plan.
- An alternate benefit will be beneficial to both the patient and the Plan.

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

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

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

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

COVERED MEDICAL EXPENSES

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

Acupuncture – Services for the insertion of needles into the human body by piercing the skin of the body to control and regulate the flow and balance of energy in the body and to cure any ailment or disease of the mind or body; or any wound, bodily injury or deformity performed by a doctor of acupuncture or doctor of oriental medicine, licensed by the state, practicing under the scope of their state license.

Ambulance – Local Medically Necessary professional ground transportation ambulance service (within 100 miles). A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided. In accordance with NRS 689B.047, reimbursement for this service must be made directly to the provider if that provider does not receive reimbursement from any other source.

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

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

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

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

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

The following terms apply to the coverage for Autism:

- *"Applied behavior analysis"* means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.
- *"Autism spectrum disorders"* means a neurobiological medical condition including, without limitation, Autistic Disorder, Asperger's Disorder and Pervasive Development Disorder Not Otherwise Specified.
- *"Behavioral therapy"* means any interactive therapy derived from evidence-based research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, licensed behavior analyst, licensed assistant behavior analyst or certified autism behavior interventionist.
- *"Certified autism behavior interventionist"* means a person who is certified as an autism behavior interventionist by the Board of Psychological Examiners and who provides behavior therapy under the supervision of:
  - (1) A licensed psychologist;
  - (2) A licensed behavior analyst; or
  - (3) A licensed assistant behavior analyst.
- *"Evidence-based research"* means research that applies rigorous, systematic, and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.

- *"Habilitative or rehabilitative care"* means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.
- *"Licensed assistant behavior analyst"* means a person who holds current certification or meets the standards to be certified as a board-certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Board of Psychological Examiners and who provides behavior therapy under the supervision of a licensed behavior analyst or psychologist.
- *"Licensed behavior analyst"* means a person who holds current certification or meets the standards to be certified as a board-certified behavior analyst or a board-certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and who is licensed as a behavior analyst by the Board of Psychological Examiners.
- *"Prescription care"* means medications prescribed by a licensed physician and any health- related services deemed medically necessary to determine the need or effectiveness of the medications.
- *"Psychiatric care"* means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
- *"Psychological care"* means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
- *"Screening for autism spectrum disorders"* means all medically appropriate assessments, evaluations, or tests to diagnose whether a person has an autism spectrum disorder.
- *"Therapeutic care"* means services provided by licensed or certified speech pathologists, occupational therapists, and physical therapists.
- "*Treatment plan*" means a plan to treat an autism spectrum disorder that is prescribed by a licensed physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a licensed behavior analyst.

Bariatric Surgery – Surgical intervention to alter the path of digestion or the volume of food intake in order to surgically reduce the member's caloric intake, to include but not limited to, restrictive procedures such as gastric banding or gastric stapling; mal-absorptive procedures such as biliopancreatic diversion; combination restrictive/mal-absorptive procedures such as gastric bypass (Roux-en-Y).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Caregiver requirements.

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

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

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

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
- Emergency repair due to Injury to sound natural teeth. This repair must be made within 12 months from the date of an accident.
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor, and roof of the mouth.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands, or ducts.
- Removal of impacted teeth. (Only covered under medical when dental benefits exhausted.)
- Dental services when need for such service is directly related to another medical condition for which treatment is covered under the Plan. This coverage becomes effective only after the member has exhausted benefits available under the Dental Services portion of the Plan, and is limited to those services excluding dental implants. Medical documentation must be provided indicating medical condition warranting the necessity of such dental services and approved by the utilization review organization. Cosmetic dental services are not a covered expense.

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

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

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

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

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

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

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

Eye Correction Surgery – Radial Keratotomy or other eye surgery to correct near-sightedness when visual acuity could not have been corrected to 20/50 with eyeglasses or contact lenses prior to surgery. Procedure must be performed by an ophthalmologist.

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

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

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

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

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

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

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

Limitations

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

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

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

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

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

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

Inpatient Medical Rehabilitation Care – The inpatient rehabilitation services in a licensed acute care hospital rehabilitation unit, or skilled nursing facility for short term, active, progressive rehabilitation services that cannot be provided in an outpatient or home setting. Maximum of 60 days in a calendar year.

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

Newborns' and Mothers' Health Protection Act

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

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

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

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

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

Organ Transplants – Expenses incurred by a Plan Participant who is the recipient of a human organ or tissue transplant which is not experimental or investigational in nature. There is no coverage under the Plan for charges or services incurred in obtaining donor organs if such charges or services are covered under any group or individual coverage of the donor. The transplant must be performed at a Plan designated or contracted organ transplant facility to receive the maximum benefits.

Orthotics – Custom molded devices for the feet.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Custodial in nature. The only charges covered for Outpatient nursing care are those outlined under Home Health Care. Outpatient private duty nursing care on a shift-basis is not covered.

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

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

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

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

Screenings Due to Possible Exposure – The Southern Nevada Health District has determined that unsafe medical practices have been occurring at several Las Vegas-area medical clinics; and those unsafe medical practices identified by the Southern Nevada Health District may have exposed Plan Participants to hepatitis B, hepatitis C, and HIV. Plan Participants who had potential exposure to hepatitis B, hepatitis C, and HIV, due to unsafe medical practices in Las Vegas area medical clinics, and who have received written notification from the Southern Nevada Health District recommending laboratory screening for the participant, or meet other eligibility requirements, shall be eligible for laboratory screenings for these three tests. Eligibility requirements will be determined by the Plan Administrator. Testing will be subject to all Plan provisions.

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

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

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

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

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

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

Speech Therapy – Speech therapy by a qualified speech therapist, other than a close relative, to restore or rehabilitate any speech loss or impairment caused by injury or illness, (except a mental, psychoneurotic or

personality disorder) or by surgery for that injury or illness and includes speech therapy undertaken for correction of physical bodily function, i.e., swallowing. Speech therapy undertaken for correction of stuttering is not an eligible charge. In the case of congenital defect, expenses will be considered only if incurred after corrective surgery for the defect. Additional visits subject to review for medical necessity.

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

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

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

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

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

Wellness Benefit – The Plan provides a wellness benefit up to $200.00 per calendar year for the following routine services for each covered employee/retiree and covered spouse and covered dependent child through age 26. This benefit may not be accumulated from year to year if the benefit is not used each year. To receive reimbursement, Plan Participants must complete a Wellness Benefit Designation Form with substantiation in order to receive this benefit. For the submission of medications for smoking cessation or weight loss, the medication must be recognized and approved by the FDA for the treatment of smoking cessation or weight loss; receipts must be from a pharmacy and include the name of the drug, patient's name, date dispensed, and amount of purchase. The wellness benefit does NOT cover Deductibles, co-

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

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

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

MEDICAL EXCLUSIONS AND LIMITATIONS

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

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

Ancillary Services means services rendered in connection with care provided to treat a medical condition whether scheduled or unscheduled, including, but not limited to: surgery, anesthesia, diagnostic testing, and imaging or therapy services. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency. With respect to the Protection from Balance Billing section, Ancillary Services means items and services provided by out-of-network Physicians at network facilities that are related to Emergency medicine, anesthesiology, pathology, radiology, neonatology, laboratory services, or diagnostic services; provided by assistant surgeons, hospitalists, and intensivists; or provided by an out-of-network Physician when a network Physician is not available.

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

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

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

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

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

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

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

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

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

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

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

Excess Charges – The part of an expense for care and treatment of an injury or illness that is in excess of the reasonable and customary charge. This exclusion does not apply to payments that may be required under the No Surprises Act.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Prophylactic Services – Surgical services or treatment performed for the purpose of avoiding the risk of an illness, disease, physical or mental disorder or condition based on genetic information or genetic testing Prophylactic mastectomy performed on individuals who have tested positive for the BRCA 1 or BRCA 2 mutations will be covered.

Recognized Amount means, in the Plan's determination of the allowed amount payable for covered services subject to Protection from Balance Bills, the amount on which Co-pays, Plan Participation, and applicable Deductibles are based for the below covered health services when provided by non-network providers:

Non-network Emergency health services.
Non-Emergency covered health services received at certain network facilities by non-network Physicians, when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act. For the purpose of this provision, the term "certain network facility" is limited to a Hospital (as defined in section 1861(e) of the Social Security Act), a Hospital Outpatient department, a critical access Hospital (as defined in section 1861(mm)(1) of the Social Security Act), an ambulatory surgical center (as described in section 1833(i)(1)(A) of the Social Security Act), and any other facility specified by the Secretary of Health and Human Services.

The amount is based on either:

- an All-Payer Model Agreement if adopted,
- state law, or
- the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the provider or facility.

The Recognized Amount for air ambulance services provided by a non-network provider will be calculated based on the lesser of the qualifying payment amount as determined under applicable law or the amount billed by the air ambulance service provider.

Note: Covered health services that use the Recognized Amount to determine Your cost-sharing may be higher or lower than if cost-sharing for these covered health services was determined based upon a Covered Expense. **Relative Providing Services** – Charges for treatment or services of physicians, nurses, chiropractors, physiotherapists, or other practitioners, who live in your home and/or if the provider of service is the employee, employee's spouse/grandfathered domestic partner, child, brother, sister, or parent, whether the relationship is by blood or exists in law.

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

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

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

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

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

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

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

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

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

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

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

PRESCRIPTION DRUG EXPENSE BENEFIT

Clark County Self-Funded Group Medical and Dental Benefits Plan provides a Prescription Drug Plan. The Plan has contracted with a Pharmacy Benefit Manager to provide a comprehensive preferred formulary pharmacy benefit program. Coverage is provided only for those preferred formulary medications approved by the U.S. Food and Drug Administration (FDA) as requiring a prescription and FDA approved for the condition, dose, duration, and frequency as prescribed by a Physician. The Plan Participant is responsible for the applicable co-payment when the card is presented in the drugstore.

Retail Co-payment
The retail co-payment is applied to each covered formulary prescription drug charge, which is shown in the Schedule of Benefits. The co-payment amount is not a covered charge under the Medical Plan but does accumulate towards the Prescription Drug Out-of-Pocket Maximum. Formulary prescription coverage is available at any in-network retail pharmacy. The location of the in-network pharmacies is available through the Pharmacy Benefit Manager. Any one prescription is limited to a maximum of a 30-day supply with the exception of the Retail 90-day program

Mail Order Drug Benefit Option
The mail order drug benefit option is available for up to a 90-day supply of non-emergency, extended use maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, etc.). Certain medications, such as controlled substances for pain management, are not available through the mail order program. The list of covered mail order medications is available through the Pharmacy Benefit Manager and is the easiest way to obtain covered maintenance medications.

Mail Order Co-payment
The co-payment is applied to each covered formulary mail order prescription charge and is shown in the Schedule of Benefits. It is not a covered charge under the Medical Plan but does accumulate towards the Prescription Drug Out-of-Pocket Maximum. Any one covered prescription is limited to a maximum of a 90-day supply.

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

Qualifying expenses include:

- All formulary drugs prescribed by a Physician that require a prescription either by federal or state law and are in treatment of an illness or injury.
- All formulary compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- Insulin when prescribed by a Physician.
- Injectable medications when prescribed by a physician, and as authorized through the Drug Utilization Review Program.
- Covered Prescription Drugs will be dispensed in accordance with the Pharmacy Benefit Manager preferred drug formulary or approved preferred generic substitution when permissible.
- Preferred Generic Prescription Drugs will be dispensed if: (a) the generic has been approved by the Food and Drug Administration (FDA), (b) the particular generic substitution has been manufactured by an FDA approved manufacturer, and (c) the generic substitution has been shown, through bioequivalent studies, to be equivalent to the name brand products in terms of bioavailability and therapeutic effectiveness.

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

Coverage for Injectable Medications

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

Limits To The Prescription Drug Benefit

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

- Refills only up to the number of times specified by a Physician.
- Refills up to one year from the date of order by a Physician.
- The reasonable and customary allowance as determined by the Pharmacy Benefit Manager.
- If a prescription is written for a Brand medication which has a generic equivalent, and the prescribing physician does not specify "dispense as written" (DAW) the prescription will be filled with the generic equivalent. If the member requests the Brand medication, the member will be responsible for the Brand co-payment plus the difference in cost between the Brand and generic medication.
- If a covered dependent has pharmacy benefits through their primary health benefit plan, they must utilize the benefits of the primary pharmacy benefit first. This pharmacy benefit does not coordinate with the primary pharmacy benefit plan.

No prescription benefits will be paid for charges incurred for:

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

Employer Group Waiver Plan (EGWP)

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

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

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

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

Contact the Pharmacy Benefit Manager for more information regarding EGWP.

CLAIMS PROCEDURES FOR SUBMITTING A CLAIM

How To File A Claim

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

Preferred Network and In-Network (PPO) Claims

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

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

To avoid a delay in claims processing, the PPO Provider should be provided with the Plan Participant's ID card listing the current billing instructions for the claim's administrator. If the claim is the result of an accident, please give date, place, and cause of accident, and a completed Accident Detail Form available from the Claims Administrator at: : https://clicktime.symantec.com/15tpNxm8xMo7tPC44ekuE?h=TUxcsh04-YYt7bTqLdi6ARjgQL1qkw3fSyIPJWNnQKE=&u=www.lnlattorneys.com/subro1/

Out-of-Network Claims

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

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

- Plan Participant's name, Plan ID Number and the Plan Number as shown on the ID card. If the claim is for a dependent, identify that individual in the same fashion as you did on your enrollment form.
- Have all charges presented on an original itemized bill listing dates of service, type of service and the charge for each service as rendered, including the provider's name, address, telephone number, and tax identification number.
- Have the attending physician identify the diagnosis for which treatment was rendered on the bill.
- If the claim is the result of an accident, please give date, place, and cause of accident, and a completed Accident Detail Form available from the Claims Administrator at: https://clicktime.symantec.com/15tpNxm8xMo7tPC44ekuE?h=TUxcsh04-YYt7bTqLdi6ARjgQL1qkw3fSyIPJWNnQKE=&u=www.lnlattorneys.com/subro1.

Claim Timely Filing

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

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

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

1. The specific reason or reasons for the denial;
2. Specific reference to those Plan provisions on which denial is based;
3. A description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and
4. Appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

Claim Overpayments

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

Non-U.S. Providers of Emergency Services

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

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

PROTECTION FROM BALANCE BILLING

This section is to be interpreted in accordance with the No Surprises Act, as amended. Covered health care services that are subject to the No Surprises Act requirements will be reimbursed according to this section. Retiree-only plans are not subject to the Protection from Balance Billing requirements.

Emergency health care services provided by an Out-of-Network provider will be reimbursed as set forth under Allowed Amounts below.

Covered health care services provided at certain network facilities by Out-of-Network Physicians, when not Emergency health care services, will be reimbursed as set forth under Allowed Amounts below. For these covered health care services, the term "certain network facility" is limited to a Hospital, a Hospital Outpatient department, a critical access Hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

Air Ambulance Transportation provided by an Out-of-Network provider will be reimbursed as set forth under Allowed Amounts below.

ALLOWED AMOUNTS

For covered health care services that are Ancillary Services received at certain network facilities on a non-Emergency basis from Out-of-Network Physicians, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

For covered health care services that are non-Ancillary Services received at certain network facilities on a non-Emergency basis from Out-of-Network Physicians who have not satisfied the notice and consent criteria, or for unforeseen or urgent medical needs that arise at the time a non-Ancillary Service is provided for which notice and consent has been satisfied as described below, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

For covered health care services that are Emergency health care services provided by an Out-of-Network provider, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

For covered health care services that are air Ambulance Transportation services provided by an Out-of-Network provider, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the rates that would have applied if the service had been provided by a network provider and on the Recognized Amount as defined in this SPD.

Allowed amounts are determined in accordance with the claims administrator's reimbursement policy guidelines or as required by law, as described in this SPD.

OUT-OF-NETWORK BENEFITS

When covered health care services are received from an Out-of-Network provider as described below, allowed amounts are determined as follows:

- For non-Emergency covered health care services received at certain network facilities from Out-of-Network Physicians when such services are either Ancillary Services or non-Ancillary Services that have not satisfied the notice and consent criteria of section 2799B-2(d) of the Public Service Act with respect to a visit as defined by the Secretary of Health and Human Services, the allowed amount is based on one of the following, in the order listed as applicable:
    - The reimbursement rate as determined by a state All Payer Model Agreement. -39- 7670-00-414937, 7670-05-414937
    - The reimbursement rate as determined by state law.

- The initial payment made by the claim's administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
- The amount determined by Independent Dispute Resolution (IDR).
- For the purpose of this provision, the term "certain network facility" is limited to a Hospital, a Hospital Outpatient department, a critical access Hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

IMPORTANT NOTICE: For Ancillary Services, non-Ancillary Services provided without notice and consent, and non-Ancillary Services for unforeseen or urgent medical needs that arise at the time a service is provided for which notice and consent has been satisfied, You are not responsible, and an Out of-Network Physician may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

- For Emergency health care services provided by an Out-of-Network provider, the allowed amount is based on one of the following, in the order listed as applicable:

  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claim's administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD.

- For air Ambulance Transportation provided by an Out-of-Network provider, the allowed amount is based on one of the following, in the order listed as applicable:

  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claim's administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

IMPORTANT NOTICE: You are not responsible, and an Out-of-Network provider may not bill You, for amounts in excess of Your Co-pay, Plan Participation, or Deductible, based on the rates that would have applied if the service had been provided by a network provider and on the Recognized Amount as defined in this SPD.

After the Plan has issued payment for covered health care services, the Plan may be required to pay the provider an additional amount or discount to resolve and settle the provider's balance bill.

How To Appeal A Claim Denial

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

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

During the period that the claim is being reconsidered, if there is reason to believe that medical records contain information that should be disclosed by a physician or other health professional, the Plan Participant or the Plan Participant's authorized representative will be referred to the physician for the information before the Plan will provide the requested documents directly to the Plan Participant or the Plan Participant's authorized representative. However, if the provider fails to provide the requested information to the Plan Participant or the Plan Participant's authorized representative in a reasonable period of time and without charge, the request will be honored by the Plan. Neither the Plan Participant nor the Plan Participant's authorized representative will be provided access to or copies of files of other Plan Participants. For an appeal resulting in an adverse benefit determination, the identity of any medical or vocational expert consulted in connection with the appeal will be provided upon request, without regard to whether the advice was relied upon in making the determination.

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

Appeals of Adverse Benefit Determinations Will be Considered as Follows:

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

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

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

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

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

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

Frequently Asked Claims Procedure Questions:

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

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

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

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

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

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

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

Definitions and Rights Relevant to the Appeal Process

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

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

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

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

DENTAL BENEFITS

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

If dental benefits have not been waived, this benefit applies when covered dental charges are incurred by a person while covered under this Plan.

A. DEDUCTIBLE

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

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

B. BENEFIT PAYMENT

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

C. MAXIMUM BENEFITAMOUNT

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

D. DENTALCHARGES

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

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

SCHEDULE OF SELF-FUNDED DENTAL BENEFITS

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

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

COVERED DENTAL SERVICES

Class A Services: Preventative and Diagnostic Dental Procedures

Visits & Examinations

- Office visits during regular office hours, for periodic oral examination (limited to twice per calendar year). Office visits during regular office hours for treatment and observation of injuries to teeth and supporting structure (other than for routine operative procedures)
- Prophylaxis for children under age 14 (limited to twice per calendar year)
- Prophylaxis for individuals aged 14 and over, treatments to include scaling and polishing (limited to twice per calendar year)
- Topical applications of sodium fluoride, including prophylaxis (limited to one treatment per year and to children under age 18)
- Emergency palliative treatment per visit
- Sealants for dependent children under age 14 (lifetime maximum payable $150)

X-Rays

- Bitewing films (not more than twice per year)
- 2 films
- 4 films

Class B Services: Basic Dental Procedures

Visits & Examinations

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Professional visit during regular office hours – Problem focused
- Special consultation by a specialist for case presentation when diagnostic procedures have been performed by a general dentist

X-Rays & Pathology

- Single film
- Additional films (up to 12), each
- Entire denture series consisting of at least 14 films, including bitewings, if necessary(limited to once every 12months)
- Intra-oral, occlusal view, maxillary or mandibular, each
- Upper or lower jaw, extra-oral, one file
- Upper or lower jaw, extra-oral, one films
- Panoramic survey, maxillary, and mandibular, single film (considered an entire denture series)
- Biopsy and examination of oral tissue
- Study models
- Microscopic examinations

Oral Surgery

- Includes local anesthesia and routine postoperative care

Extractions

- Uncomplicated (single)
- Each additional tooth
- Surgical removal of erupted tooth
- Postoperative visit (sutures and complications) after multiple extractions and impaction

Impacted Teeth

- Removal of tooth (soft tissue)
- Removal of tooth (partially bony)
- Removal of tooth (completely bony)

Alveolar or Gingival Reconstructions

- Alveolectomy (edentulous) per quadrant
- Alveolectomy(in addition to removal of teeth) per quadrant
- Alveolectomy with ridge extension, per arch
- Removal of palataltorus
- Removal of mandibular tori, per quadrant
- Excision of hyperplastic tissue, per arch
- Excision of pericoronal gingiva

Cysts & Neoplasms

- Incision and drainage of abscess
- Removal of cystor tumor up to ½"
- Removal of cystor tumor over ½"

Other Surgical Procedures

- Sialolithomy(removal of salivary calculus)
- Closure of salivary fistula
- Dilation of salivary duct
- Transportation of tooth or tooth bud
- Removal of foreign body from bone (independent procedure)
- Maxillary sinusotomy for removal of tooth fragment or foreign body
- Closure of oral fistula of maxillary sinus
- Sequestrectomy for osteomyelitis or bone abscess, superficial
- Condylectomy of temporomandibular joint
- Meniscectomy of temporomandibular joint
- Radical resection of mandible with bone graft
- Crown exposure for orthodontia
- Removal of foreign body from soft tissue
- Frenectomy
- Suture of soft tissue injury
- Injection of sclerosing agent into temporomandibular joint
- Treatment of trigeminal neuralgia by injection into second and third divisions

Anesthesia

- General, only when provided in conjunction with a surgical procedure
- Nitrous Oxide for dependent children under the age of six

Periodontics

- Periodontic prophy (limited to one treatment every three months)
- Emergency treatment (periodontal abscess, acute periodontitis.)
- Subgingival curettage, root planing, scaling per quadrant (not prophylaxis)
- Correction of occlusion related to periodontal problems per quadrant
- Gingivectomy (including post-surgical visits) per quadrant
- Gingivectomy, osseous or muco-gingival surgery(including post-surgical visits) per quadrant
- Gingivectomy, treatment per tooth (fewer than 6 teeth)
- Localized delivery of therapeutic agentvia controlled vehicle into diseased crevicular tissue

Endodontics

Unless otherwise indicated, the limit shown is for one tooth

- Pulp capping
- Therapeutic pulpotomy (in addition to restoration)
- Vitalpulpotomy
- Remineralization (Calcium Hydroxide, temporary restoration) as a separate procedure only

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

- Single rooted canal therapy (Traditional method)
- Single rooted canal therapy (Sargent method)
- Bi-rooted canal therapy (Traditional method)
- Bi-rooted canal therapy (Sargent method)
- Tri-rooted canal therapy (Traditional method)
- Tri-rooted canal therapy (Sargent method)
- Endodontic retreatment
- Apicoectomy(including filling of root canal)
- Apicoectomy (separate procedure)

Restorative Dentistry

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

Amalgam Restorations - Primary Teeth

- Cavities involving one surface
- Cavities involving two surfaces
- Cavities involving three or more surfaces

Amalgam Restorations - Permanent Teeth

- Cavities involving one surface
- Cavities involving two surfaces
- Cavities involving three or more surfaces

Synthetic Restorations

- Silicate cement filling
- Plastic filling
- Composite filling involving one surface
- Composite filling involving two surfaces
- Composite filling involving three or more surfaces

Pins

- Pin (Retention) when part of the restoration used instead of gold or crown restoration
- Core buildup including any pins; prefabricated cast post and core in addition to crown

Crowns

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

Full & Partial Denture Repairs

- Broken dentures, no teeth involved
- Partial denture repairs(metal)
- Replacing missing or broken teeth, each tooth

Adding Teeth to Partial Denture to Replace Extracted Natural Teeth

- First tooth
- First tooth with clasp
- Each additional tooth and clasp

Recementation

- Inlay
- Crown
- Bridge

Repairs Crowns & Bridges

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

Restorative

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

Inlays

- One surface
- Two surfaces
- Three or more surfaces
- Onlay, in addition to inlay allowance

Crowns

- Acrylic
- Acrylic with gold
- Acrylic with non-precious metal
- Porcelain
- Porcelain with gold
- Porcelain with non-precious metal
- Non-precious metal (full cast)
- Gold (full cast)
- Gold (3/4 cast).
- Gold dowel pin.

Space Maintainers

- Includes all adjustments within 6 months after installation
- Fixed space maintainer (band type)
- Removal acrylic with round wire rest only

- Stainless steel clasps and/or activating wires, in addition to basic allowances, per wire or clasp
- Removal inhibiting appliance to correct thumb sucking
- Fixed or cemented inhibiting appliance to correct thumb sucking
- Occlusal guard

Class C Services: Major Dental Procedures

Prosthodontics

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

- Cast Gold (sanitary)
- Cast non-precious metal
- Slotted facing (Steele's)
- Slotted pontic (True Pontictype)
- Porcelain fused to gold
- Porcelain fused to non-precious metal
- Plastic processed to gold
- Plastic processed to non-precious metal

Removal Bridge (Unilateral)

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

Dentures and Partial

- Fees for dentures and partial dentures include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible
- Complete upper denture
- Complete lower denture
- Partial acrylic upper or lower with gold or chrome cobalt alloy clasps, base, up to 4 teeth and 2 clasps
- Each additional tooth or clasp
- Partial lower or upper with chrome cobalt alloy lingual or palatal bar and acrylic saddles, base, up to 4 teeth and 2 clasps
- Simple stress breakers,extra
- Stayplate, base
- Each additional tooth or clasp
- Special tissue conditioning, per denture
- Denture duplication (jump case), per denture
- Adjustment to denture more than 6months after installation

Dental Implants

- Surgical placement of endosteal implant
- Surgical placement of eposteal implant
- Surgical placement of transosteal implant

Class D Services: Orthodontic Treatment and Appliances

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

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

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

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

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

4. Orthodontia benefits are subject to Coordination of Benefits provisions

The benefits for orthodontic charges will be paid as follows:

$750 - For Banding, or removable, fixed or cemented appliance for tooth guidance
$125 per month for monthly adjustments

Participant will be responsible for any orthodontic care that exceeds this payment schedule. In no event will benefits be payable for services incurred prior to the member's effective date or after termination of coverage.

PREDETERMINATION OF BENEFITS

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

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

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

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

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

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

ALTERNATE TREATMENT

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

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Diversified Dental PPO network allowable amount, or the Reasonable and Customary Charge for an out-of-network claim, for an amalgam filling. If the Plan bases its reimbursement on the Reasonable and Customary Charge, the patient will pay the difference in cost.

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

DENTAL EXCLUSIONS AND LIMITATIONS

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

1. Crowns. Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.
2. Excluded under Medical. Services that are excluded under Medical Plan Exclusions.
3. Hygiene. Oral hygiene, plaque control programs or dietary instructions.
4. No listing. Services which are not included in the list of covered dental services.
5. Medical Services. Services that, to any extent, are payable under any medical expense benefits of the Plan.
6. Orthognathic surgery. The surgical correction of a skeletal anomaly or malformation of the jaw involving the mandible or maxillary joint.
7. Personalization. Personalization of dentures.
8. Replacement. Replacement of lost or stolen appliances and dentures.
9. Not Reasonably Necessary. A service not reasonably necessary or not customarily performed for the Dental and Orthodontia care of a covered individual.
10. Service Not Furnished. A service not furnished by a Dentist, except x-rays ordered by a Dentist and services by a licensed Dental Hygienist under the Dentist's supervision.
11. U.S. Government Services. (a) furnished by or on behalf of the U.S. Government, or any other government, unless as to such government payment is legally required, or (b) to the extent to which any benefit in connection with such a service or charge is provided under any law or governmental program under which the individual is, or could be, covered.
12. Prior Service. A service to a covered individual which is (a) an appliance, or modification of an appliance, for which an impression was made before the person became a covered individual, or (b) a crown, bridge or gold restoration for which a tooth was prepared before the person became a covered individual, (c) root canal therapy, for which the pulp chamber was opened before the person became a covered individual, or
(d) an orthodontic procedure in connection with which an active appliance has been installed prior to the first day on which the person became a covered individual.
13. Prior 5 Years. A partial or full removable denture or fixed bridgework, or for the addition of teeth thereto, or for a crown or gold restoration, if involving a replacement or modification of a denture, bridgework, crown or gold restoration which was installed during the immediately preceding five years
14. Prior Extractions. A partial or full removable denture or fixed bridgework if involving replacement of one or more natural teeth extracted prior to the person's becoming a covered individual under this Coverage unless the denture of fixed bridgework also includes replacement of a natural tooth which (a) is extracted while the person is such a covered individual and (b) was not an abutment to a partial denture or fixed bridge installed within the immediately preceding five years.
15. Dental implants to replace teeth extracted prior to the person becoming a covered individual under this Coverage.
16. Occupational. Care and treatment of an Injury or Illness that is occupational -- that is, arises from work for wage or profit including self-employment.
17. Restorations. Restorations for the purpose of splinting, or to increase vertical dimension or restore occlusion.

18. Cosmetic. Services for cosmetic purposes unless made necessary by an Injury occurring while covered, or dental care of a congenital or developmental malformation. Facings on molar crowns or pontics are always considered cosmetic.
19. Appointments. Charges for failure to keep a scheduled appointment with a Dentist and/or completion of claim forms.
20. Reasonable and Customary. The portion of any charge for any service in excess of the reasonable and customary dental charge which is performed by a non-participating provider in the Diversified Dental PPO network. The reasonable and customary charge is the usual charge made by the provider for a like service in the absence of the coverage, but not more than the prevailing charges, as determined by the County, for dental care of a comparable nature, made by providers of similar training and experience, within the area in which the service is actually provided. "Area" means the municipality (or in the case of a large city, the subdivision thereof) in which the service

is actually provided, or such greater area as is necessary to obtain a representative cross section of charges for a like service.

Extension of Benefits

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

DEFINED TERMS

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

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

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

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

Applied Behavior Analysis – Applied Behavior Analysis (ABA) shall mean the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.

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

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

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

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

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

Birthing Center – Any freestanding health facility, place, professional office or institution, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located.
The birthing center must provide facilities for obstetrical delivery and short-term recovery after delivery (no more than 24 hours); provide care under the full-time supervision of a physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

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

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

management and repricing; or

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

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

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

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

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

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

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

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

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

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

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

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

Durable Medical Equipment – Equipment which (a) Can withstand repeated use, (b) Is primarily and customarily used to serve a medical purpose, (c) Generally is not useful to a person in the absence of an illness or injury and (d) Is appropriate for use in the home.

Effective Date – means January 1, 2022. The provisions of the Plan as in effect on the date of service shall remain applicable with respect to Plan Participants on the date of service, and with respect to the Plan coverage available at the time the expenses were incurred.

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

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

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

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

Employer – Includes the following public agencies: Clark County, Nevada; Clark County Water Reclamation District; University Medical Center of Southern Nevada; Henderson District Public Library, Southern Nevada Health District, the Las Vegas Convention & Visitors Authority; the Las Vegas Valley Water District; the Regional Transportation Commission of Southern Nevada County, Mt. Charleston Fire Protection District, the Las Vegas Metropolitan Police Department and the Chief of the Moapa Valley Fire Protection District.

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

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

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

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

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

- if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use, procedure or technology.
The facility will not be deemed a nursing home, a hotel, a school or a similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

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

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

Generic Drug – A prescription drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a generic drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

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

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

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

Habilitative or Rehabilitative Care – Habilitative or Rehabilitative Care shall mean any counseling, guidance, and professional services and treatment programs, including, without limitation, Applied Behavior Analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.

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

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

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

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

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

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

Hospice Agency – An agency where its main function is to provide hospice care services and supplies and it is licensed by the state in which it is located if licensing is required.

Hospice Care Plan – A plan of terminal patient care that is established and conducted by a hospice agency and supervised by a physician.

Hospice Care Services and Supplies – Those provided through a hospice agency and under a hospice care plan and include inpatient care in a hospice unit or other licensed facility, home care, and family counseling during the bereavement period.

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

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

- A facility operating legally as a psychiatric hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of substance abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a physician in regular attendance; continuously provides 24-hour-a-day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of substance abuse.

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

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

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

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

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

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

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

Intensive Care Unit (ICU) – A separate, clearly designated service area, which is maintained within a hospital solely for the care and treatment of patients who are critically ill and or injured. This also includes what is referred to as a **coronary care unit** (CCU) or an **acute care unit** (ACU). It has facilities for special nursing care not available in regular rooms and wards of the hospital; special lifesaving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

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

Legal Guardian – A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

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

Lifetime Maximum Benefit – Refers to the maximum amount of certain benefits paid while covered under this Plan.

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

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

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

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

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

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

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

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

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

Mental Disorder – Any disease or condition that is classified as a mental disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

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

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

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

Outpatient Care – Treatment including services, supplies and medicines provided and used at a hospital under the direction of a physician to a person not admitted as a registered bed patient; or services rendered in a physician's office, laboratory or x-ray facility, an ambulatory surgical center, or the patient's home.

Pharmacy – A licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

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

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

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

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

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

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

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

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

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

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

Prescription Drug – Any of the following: a drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed physician. Such drug must be medically necessary in the treatment of an illness or injury.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- Its services are provided for compensation and under the full-time supervision of a Physician.
- It provides 24 hour per day nursing services by licensed nurses, under the direction of a full- time registered nurse.
- It maintains a complete medical record on each patient.
- It has an effective utilization review plan.
- It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
- It is approved and licensed by Medicare.

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

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

Special Enrollment Event means an opportunity for a Special Enrollee to enroll for coverage:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

LEGISLATIVE COMPLIANCE – HIPAA OPT-OUT

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

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

EFFECTIVE DATE: JANUARY 1, 2023

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THAT INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact Clark County's HIPAA Compliance Office.

Who Will Follow This Notice:

This Notice describes the privacy policies of the Clark County Self-Funded Group Medical, Wellness, Vision, Prescription Drug, and Dental Benefits Plan (the "Plan"), which is sponsored by Clark County ("County"). Please note that each insurer of an insured program provided under the Plan will provide a separate notice of its privacy practices.

Our Pledge Regarding Medical Information:

We understand that medical information about you and your health is personal, and we are committed to protecting it. We create a record of the care and benefits that you receive under the Plan. This notice applies to all of those records of your care and benefits.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Provide you this Notice of our legal duties and privacy practices regarding your medical information; and follow the terms of the notice that are currently in effect. We may change the terms of our Notice at any time without advance notice to you. The new Notice will be effective for all medical information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may obtain a copy of the Notice by contact Clark County's HIPAA Compliance Office at (702) 383-3854. The current version of this Notice may also be found on Clark County's website at: http://www.clarkcountynv.gov/audit/services/Pages/HIPAAProgramManagementOffice.aspx

How We May Use And Disclose Medical Information About You:

The following categories describe ways that we use and disclose medical information. Examples of each category are included. Not every use or disclosure in each category is listed; however, all of the ways we are permitted to use and disclose information fall into one of these categories:

For Treatment: We may use medical information about you to coordinate or manage medical treatment or services as Plan benefits. For example, we may disclose medical information about you to physicians or health care providers who are or will be involved in taking care of you. Your medical information may also be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to provide treatment.

For Payment: We may use your medical information to pay for your health care benefits under the Plan. These activities may include making benefit determinations and paying claims. For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

For Healthcare Operations: We may use or disclose, as needed, your medical information in order to support the business activities of the Plan. These activities include, but are not limited to, quality assessment and improvement, reviewing the competence or qualifications of health care professionals, disease management, case management, conducting or arranging for medical review, business planning and development, legal services and auditing functions (including fraud and abuse compliance programs) and general administrative activities. For example, the Plan may use information about your claims to project future benefit costs or audit the accuracy of its claims processing functions. We may also use or disclose your medical information, as necessary, to contact you to remind you of an appointment.

We may share your medical information with third party "business associates" that perform various

activities (*e.g.*, claims administration and eligibility status inquiries) for the Plan.
Whenever an arrangement between the Plan and a business associate involves the use or disclosure of your medical information, we will have a written contract that contains terms to protect the privacy of your medical information.

Disclosures to Plan Sponsor: The Plan also will disclose your medical information to Clark County, the Plan's sponsor, for administrative purposes permitted by law and related to treatment, payment or health care operations. The County has amended its plan documents to protect your medical information as required by federal law.

Others Involved in Your Healthcare: After we provide you an opportunity to object, and unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your medical information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure because of incapacity or emergency circumstances, we may disclose such information as necessary that directly relates to that person's involvement in your care or payment for your care if we determine that it is in your best interest based on our professional judgment. We may use or disclose medical information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your location, general condition or death. Finally, we may use or disclose your medical information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Object

We may use or disclose your medical information in the following situations without your authorization. These situations include:

Required By Law: We may use or disclose your medical information to the extent that the law requires the use or disclosure, including requested disclosures to the Secretary of the Department of Health and Human Services to determine our compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Public Health: We may disclose medical information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report the abuse or neglect of children, elders and dependent adults;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight: We may disclose medical information to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws. For example, we may disclose medical information to a licensing board to investigate a complaint against a provider.

Legal Proceedings: We may disclose medical information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful legal process, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness or missing person;

- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe maybe the result of criminal conduct;
- About criminal conduct on County premises; or
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Nevada Attorney General and Grand Jury Investigations: We may release medical if asked to do so by an investigator for the Nevada Attorney General, or a grand jury, investigating an alleged violation of Nevada laws prohibiting patient neglect, elder abuse or submission of false claims to the Medicaid program. We may also release medical information to an investigator for the Nevada Attorney General investigating an alleged violation of Nevada workers' compensation laws.

Workers' Compensation: We may disclose your medical information as authorized to comply with workers' compensation laws and other similar legally established programs. These programs provide benefits for work-related injuries or illness.

For Specific Government Functions: We may disclose your medical information for the following specific government functions: (1) health information of military personnel, as required by military authorities; (2) health information of inmates, to a correctional institution or law enforcement official; and (3) for national security purposes.

YOUR RIGHTS

The following is a statement of your rights with respect to your medical information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your medical information.

You may inspect and obtain a copy of medical information about you that is contained in a designated record set for as long as we maintain the medical information. A "designated record set" contains medical and billing records and any other records that the Plan uses to make decisions regarding your health care services or benefits. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

Under federal law, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and medical information that is subject to a law that prohibits access to medical information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to appeal this decision.

If you wish to make a request for access, you should make your request to the applicable business associates named at the end of this Notice. You may also make a written request to our Privacy Officer with respect to designated records sets, if any, held by the County or any business associate not named at the end of this Notice.

You have the right to request a restriction of your medical information.

You may ask us not to use or disclose any part of your medical information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your medical information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse).

The Plan is not required to agree to a restriction that you may request. If the Plan believes it is in your best interest to permit use and disclosure of your medical information, your medical information will not be restricted. If the Plan does agree to the requested restriction, we may not use or disclose your medical information in violation of that restriction unless it is needed to provide emergency treatment. With this in

mind, please discuss any restriction you wish to request with your caregiver.

If you wish to make a request to restrict uses and disclosures of your medical information, you should make your request to the applicable business associates named at the end of this Notice. You may also make a written request to Clark County's HIPAA Compliance Office with respect to uses and disclosures by the County or any business associate not named at the end of this Notice.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Your request must specify how or where you wish to be contacted.

If you wish to make a request for communications by alternative means, you should make your request to the applicable business associates named at the end of this Notice. You may also make a written request to Clark County's HIPAA Compliance Office with respect to uses and disclosures by the County or any business associate not named at the end of this Notice.

You may have the right to have us amend your medical information.

If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You may request an amendment of medical information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

If you wish to make a request to amend your medical information, you should make your request to the applicable business associates named at the end of this Notice. You may also make a written request to Clark County's HIPAA Compliance Office with respect to designated records sets, if any, held by the County or any business associate not named at the end of this Notice.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the Plan;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

You have the right to receive an accounting of certain disclosures we have made, if any, of your medical information.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations, as described in this Notice. The right to receive this information is subject to certain exceptions, restrictions and limitations.

If you wish to make a request for an accounting, you should make your request to the applicable business associates named at the end of this Notice. You may also make a written request to Clark County's HIPAA Compliance Office with respect to disclosures, if any, by the County or any business associate not named at the end of this Notice.

Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

You have the right to receive a paper copy of this Notice.

You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice upon request.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. The Notice will contain on the first page, in the top right-hand corner, the effective date.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services (HHS) if you believe your privacy rights have been violated by us. To file a complaint with HHS, send a letter to:

Office of Civil Rights
Medical Privacy, Complaint Division,
U.S. Department of Health and Human Services
200 Independence Avenue, SW, HHH Building, Room 509H
Washington, D.C. 20201
866-627-7748 or for the hearing-impaired call 886-788-4989

To file a complaint with the Plan, submit your complaint in writing and address it to:

Clark County HIPAA Compliance Program Management Office
P.O. Box 551120
Las Vegas, NV 89155.

You may also call (702) 383-3854 for further information about the complaint process.

We will not retaliate against you for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of your medical information for marketing purposes or that constitute a sale of medical information can only be made with your written authorization. Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose medical information about you by signing an authorization, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

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

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

CONTACT INFORMATION

If you wish to exercise one or more of the rights listed in this Notice, contact the representative listed for the appropriate program(s) in which you participate:

Privacy Officer for the Benefits Administrator

Clark County HIPAA Compliance Program Management Office
P. O. Box 551120
Las Vegas, NV 89155
(702) 383-3854

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

Vision Plan

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

RESPONSIBILITIES FOR PLAN ADMINISTRATION

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

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

DUTIES OF THE PLAN ADMINISTRATOR.

1. To administer the Plan in accordance with its terms.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
3. To decide disputes which may arise relative to a Plan Participant's rights.
4. To prescribe procedures for filing a claim for benefits and to review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a Claims Administrator to pay claims.
7. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

In addition, the Plan Administrator shall have the following duties.

(1) Contracting. Contracting and administering all agreements necessary or incidental to the operation of the Group Plan. The agreements which the Plan Administrator is authorized to enter into on behalf of the Group Plan include, but are not limited to, agreements for claims administration, preferred providers, excess and aggregate insurance, and utilization review.

(2) Trust Fund. Administration of the expendable trust fund established for the deposit of contributions and the payment of expenses necessary for the operation of the Group Plan. The Plan Administrator's responsibilities regarding the trust fund shall include the collection of payments and contributions to the fund and making payments and transfer from the fund as required to affect the provisions of the Group Plan.

(3) Executive Board. The Plan Administrator shall establish an Executive Board not to exceed seven members which shall consist of representatives from management appointed from the governmental agencies participating in the Plan.

The Chief Administrative Officer for the Plan Administrator shall appoint the members of the Board and designate a Chairman and Vice-Chairman who will act in the absence or disability of the Chairman.

The duties of the Executive Board shall include monitoring the financial performance of the Plan including the administration of periodic independent actuarial studies, the evaluation and recommendation of contractors to the Plan Administrator, and the negotiation of Plan changes with the Nevada Service Employees Union subject to the approval of the governing bodies.

The Board shall meet at a mutually agreed upon time at least once every other month and may hold such other meetings as circumstances may require or render desirable for the performance of its function and discharge of its duties and responsibilities.

(4) Group Health Committee. The Plan Administrator shall establish a seven-member committee which shall consist of representatives from both labor and management appointed from the governmental agencies participating in the Plan. Effective January 1, 1990, the committee shall

be increased to nine members. Effective January 1, 1995, the committee shall be increased to ten members. The committee shall meet to resolve disputes and appeals from determinations made by the Claim Administrator and make Plan change recommendations to the Executive Board.

The Clark County Manager or his designee shall appoint the members of the committee and designate a Chairman and a Vice-Chairman who will act in the absence or disability of the Chairman.

The committee shall meet at a regularly appointed time at least once every other month and may hold such other meetings as circumstances may require or render desirable for the performance of its function and the discharge of its duties and responsibilities. A majority of the members shall constitute a quorum for all purposes. Action taken by the committee shall require a majority affirmative vote of the committee members present and voting. The committee will be responsible for Level 2 review of an adverse benefit determination as provided by the Plan Document. The committee may review and consider coverage determinations made by the Claims Administrator, but the committee may not authorize payment for services which are not covered by the Plan, or which are specifically excluded from Plan coverage.

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

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

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

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

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

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered. If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

TERMINATION OF THE PLAN

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

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

the extent of funds available, continue to pay all benefits then due and payable to the Covered Individual.

FINAL AUTHORITY OF THE PLAN DOCUMENT

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

APPENDIX A – SPECIALPROVISIONS

SPECIAL PROVISIONS CONCERNING EMPLOYEES OF THE MOUNT CHARLESTON FIRE PROTECTION DISTRICT

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

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

(2) **Effective Date** June 1, 2015

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

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

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

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

(3) **Effective Date**: January 1,2016.

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

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

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

(2) Effective Date July 21, 2020

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

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

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

SPECIAL PROVISIONS CONCERNING THE EIGHTH JUDICIAL COURT

The following provisions shall apply concerning benefits for The Eighth Judicial Court employees and their covered dependent(s).

(1) **Waiting Period**. The Eighth Judicial District Court employees and their dependents covered after the effective date are subject to the Plan's waiting period for the initiation of coverage as set forth on page 6.

(2) Effective Date July 1, 2022

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION
The Plan is a self-funded health plan, and the claims administration is provided through a third-party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME Self-Funded Group Medical and Dental Benefits Plan

PLAN EFFECTIVE DATE: January 1, 2023

PLAN YEAR ENDS: December 31st

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

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

ADDITIONAL PARTICIPATING EMPLOYERS	
Clark County Water Reclamation District 702.668.8066	University Medical Center of Southern Nevada 702.383.2230
Las Vegas Convention & Visitors Authority 702.892.7527	Las Vegas Valley Water District 702.258.3115
Regional Transportation Commission of Southern Nevada 702.676.1500	Clark County Regional Flood Control District 702.685.0000
Southern Nevada Health District 702.759.1101	Henderson District Public Libraries 702.207.4278
Mt. Charleston Fire Protection District 702.486.5123	Las Vegas Metropolitan Police Department Appointed Employees 702.828.2904
Chief of the Moapa Valley Fire Protection District 702.398-3568	Eighth Judicial District Court 702.671.4667

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

CLAIMSADMINISTRATOR
UMR Inc. 115 W.
Wausau Ave.
Wausau, ,WI 54401
(800) 826-978