CITY OF SPARKS

GROUP HEALTH PLAN DOCUMENT

January 1, 2017

Plan Administrator
Hometown Health
830 Harvard Way
Reno, Nevada 89502
775-982-4150

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INRODUCTION

This Group Health Plan Document is both the Summary Plan Description and the Evidence of Coverage for the City of Sparks Group Health Plan, hereinafter referred to as Plan Sponsor. It includes benefits, exclusions, limitations, and applicable administrative policies, rights, responsibilities, and procedures for your health insurance policy.

This Group Health Plan Document is the governing document that determines the benefits or interpretation of those benefits.

This Group Health Plan complies with the requirements of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, together referred to as the Affordable Care Act (ACA) and all other applicable state and federal insurance laws, regulations and guidance effective on the date of publication of this this Plan Document.

When laws, regulations and supporting guidance change, the Plan Sponsor will provide coverage under this Policy in accordance with these laws, regulations and guidance as they are issued.

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GENERAL PLAN INFORMATION

Name of Plan	**City of Sparks Group Health Plan**
Plan Sponsor	**City of Sparks**
Address	**City of Sparks Human Resources** 431 Prater Way Sparks, NV 89431 Business Phone Number: (775) 353-2345
Participating Employer	**City of Sparks**
Plan Year	**January 1 through December 31**
Plan Status	**Self Insured Non-Grandfathered Group Health Plan**
Plan Benefits Described Herein	**Medical and Dental Benefits** **Prescription Drug Program** **Vision Care Program** **Employee Assistance Program** **Life Insurance** **AD&D Insurance** **Emergency Travel Assistance Expenses** **Healthy Lifestyle Benefit**
Named Fiduciary:	**City of Sparks**
Address	431 Prater Way Sparks, NV 89431 Business Phone Number: **(775) 353-2345**
Agent for Service of Legal Process	**City of Sparks**
Address	**431 Prater Way** Sparks, NV 89431 Business Phone Number: **(775) 353-2345**
Plan Administrator	**Hometown Health**
Street Address:	830 Harvard Way Reno, NV 89502 **(775) 982-4150 or (866) 991-4150**

Funding Sources and Contribution Determination
The Plan Sponsor will evaluate the costs of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed, if any, by Employees and Retirees and subject to the conditions set forth in the collective bargaining agreements and resolutions of the City of Sparks. If an Employee or Retiree elects to enroll Dependents under the Plan, the Employee or Retiree may be responsible for payment of all or a portion of the Dependent contributions suitable to cover such enrollment.

Pre-Tax Contributions
Active Employee contributions for coverage are made on a pre-tax basis unless otherwise indicated by the Employee. The Internal Revenue Service (IRS) does not permit an Employee to make election changes or terminate participation outside of the Plan's Open Enrollment period unless there is a qualifying life event or has Special Enrollment Right as defined in this Plan Document.

SPECIAL NOTICES

The Newborns' and Mothers' Health Protection Act
This Plan Sponsor generally may not, under Federal law, restrict benefits for any hospital length of stay for childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean delivery. 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). This Plan may not, under Federal law, require that a provider obtain authorization from the Plan Sponsor for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Women's Health and Cancer Rights Act
Under Federal law, this Plan must include coverage for the following post-mastectomy services and supplies as determined by Physician and the patient:

A. Reconstruction of the breast on which a mastectomy has been performed;
B. Surgery and reconstruction of the other breast to produce symmetrical appearance;
C. Breast prostheses; and,
D. Physical complications of all stages of mastectomy, including lymphedemas.

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

Ongoing Regulations
This Plan Sponsor complies with the requirements of the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010, together referred to as the Affordable Care Act (ACA) and all other applicable state and federal insurance laws, regulations and guidance effective on the date of publication of this Plan Document. Coverage under this Plan will remain in accordance with any changes to laws, regulations and guidance as they are issued.

Non-Grandfathered Plan
Notwithstanding anything to the contrary in this Plan Document, Non-Grandfathered Plans will cover the following services without any Covered Member cost-sharing requirements if such services are provided by a Participating Provider:

A. 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.
B. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;
C. With respect to infants, children, and adolescents, evidence-informed Preventive Care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services; and
D. With respect to women, such additional Preventive Care and screenings not described under this section as provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services: well-woman visits, screening for gestational diabetes, human papillomavirus (HPV) testing, counseling for sexually transmitted infections, counseling and screening for human immune-deficiency virus, contraceptive methods and counseling, breast feeding support, & and counseling, screening and counseling for interpersonal and domestic violence.

Website references:

Regulations:	www.healthcare.gov
Overview:	www.healthcare.gov/law/features/rights/preventive-care/index.html
USPSTF Regulations:	www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm
Vaccines:	www.cdc.gov/vaccines/schedules/index.html
Women's Health	www.hrsa.gov/womensguidelines/

Family and Medical Leave Act (FMLA)
If a Covered Member is on employer-approved FMLA in accordance with the requirements of Public Law 103, coverage will continue under the same terms and conditions which would have applied had the employee continued in Active Employment.

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

Pregnancy Discrimination Act of 1978
Most employers must provide coverage for pregnancy expenses in the same manner coverage is provided for any other Illness. This requirement applies to pregnancy expenses of a Covered Member or a Covered Dependent.

Genetic Information and Non-Discrimination Act of 2008 (GINA)
Under GINA, the term "Genetic Information" includes:

A. Information about an individual or their family member's genetic tests (defined as analyses of the individual's DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations or chromosomal changes);
B. The manifestation of a disease or disorder in the family members of the individual. Family members are broadly defined under GINA to include individuals who are dependents, as well as any other first, second, third or fourth degree relative.
C. Genetic Information includes that information of any fetus or embryo carried by a pregnant woman; and,
D. Information obtained through genetic services (that is genetic tests, genetic counseling or genetic education) or participation in clinical research that includes genetic services.
E. Genetic Information does not include the sex or age of an individual.

GINA allows the Plan to obtain and use the results of genetic tests for purposes of making payment determinations. GINA prohibits the Plan from:

A. Adjusting premiums or contribution amounts for the group based on genetic information;
B. Requesting or requiring a Covered Member or Covered Dependent to undergo a genetic test. Subject to certain conditions, the Plan may request that an individual voluntarily undergo a genetic test as part of a research study if the results are not used for underwriting purposes;
C. Requesting, requiring or purchasing genetic information for underwriting purposes (which includes eligibility rules or determinations, computation of premium or contribution amounts, and other activities related to the creation, renewal or replacement of coverage); and,
D. Requesting, requiring or purchasing genetic information with respect to any individual prior to such individual's enrollment under the Plan. If the Plan obtains Genetic Information incidental to the collection of other information prior to enrollment, it will not be in violation of GINA if it is not used for underwriting purposes.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
HIPAA was enacted, among other things, to improve portability and continuity of health care coverage.

HIPAA also requires that Covered Members and beneficiaries receive a summary of any change that is a "Material Reduction in covered services or benefits under a group health plan" within 60 days after the adoption of the modification or change, unless the Plan Sponsor provides summaries of modifications or changes at regular intervals of 90 days or less.

THIRD PARTY ADMINISTRATOR (TPA)

Medical & Dental Claims
Medical and Dental claims for the Plan are handled by a Plan Administrator, also known as a Third-Party Administrator (TPA). The name, address and phone number of that company is:

Hometown Health
830 Harvard Way
Reno, NV 89502
(775) 982-4150
(866) 991-4150
www.hometownhealth.com

The TPA should be contacted if you have questions or concerns regarding medical and dental claims or need additional information regarding Preferred Providers, Preferred Hospitals and Facilities, Preferred Labs, Preferred Urgent Cares and/or about Plan coverage for a treatment, procedure, preventive service, etc. No charge will be made for the information.

Pharmacy Claims
Pharmacy service, claims and mail order for the Plan are handled by a Third-Party Administrator (TPA).
See **Appendix A – Prescription Drugs.**

WellDyne Rx
844-635-7351
www.welldynerx.com

Vision Claims
Vision services and claims for the Plan are handled by a Third-Party Administrator (TPA).
See Appendix B – Vision Services.

Vision Service Plan (VSP)
800-877-7195
www.vsp.com

PREFERRED PROVIDER ORGANIZATION (PPO)

Choice of Providers
Covered Members on this Plan, have a Preferred Provider Organization (PPO) group health plan, which means you have a choice of obtaining health care services and supplies from a PPO or any other provider of your choice (Non-PPO).

PPO's are In-Network providers that bill Covered Members at negotiated rates. When a Covered Member uses a PPO, out-of-pocket costs may also be reduced because PPO providers will not bill for expenses more than what is considered "Usual, Customary and Reasonable" (UCR). If you choose a Non-PPO, also known as Out-of-Network, rates will be significantly higher and Non-PPO's will typically bill more than the UCR.

PPO's and In-Network, are determined by a Covered Member's physical residence. Providers should be utilized as follows:

Northern Nevada
- Hometown Health Network
- When in southern Nevada, use the OneHealth Network. When outside of Nevada use the PHCS Provider Network

Southern Nevada
- OneHealth Network
- When in northern Nevada, use the Hometown Health Network. When outside of Nevada use the PHCS Provider Network

Outside of Nevada
- PHCS Provider Network
- When in northern Nevada, use the Hometown Health Network. When in southern Nevada use the OneHealth Provider Network

PPO Directory
A Covered Member should refer to the online PPO directory. A PPO directory can be obtained by visiting the website:

- **Hometown Health** www.hometownhealth.com - select "self-funded" from the dropdown
- **OneHealth Network** www.one-healthcare.com
- **PHCS Network** www.multiplan.com

You may also contact:

Hometown Health
866-991-4150 or (775) 982-4150

No Network Available
When a PPO cannot be used, Non-PPO providers will be paid at the PPO benefit level only when:

A. A Covered Member permanently resides outside of all the above PPO Service Areas;
B. A Covered Member has a Medical Emergency and must use a Non-PPO. PPO benefit levels will be paid until the patient's condition has stabilized to the point they can be transferred to PPO care. A Medical Emergency is a sudden situation which causes serious impairment of bodily functions and requires immediate medical attention or hospitalization. This includes accidental bodily injury; acute severe abdominal pain, poisoning, vomiting, acute chest pains (angina, suspected heart attack, coronary, pneumothorax), shortness of breath, asthma, allergic reactions, angio-neurotic edema, convulsions, coma, syncope, fainting, shock, hemorrhage, acute urinary retention, severe nose bleed or high fever of at least 104 degrees.
C. While receiving treatment in PPO facility, a Covered Member receives ancillary services from a Non-PPO in which there is no choice over provider selection (such as an emergency room Physician, anesthesiologist or for diagnostic services.
D. A Covered Member must use a Non-PPO specialist because the specialty is not represented by a PPO or is not reasonably accessible to the patient due to geographic constraints. Services rendered outside the PPO Network because of an unavailable PPO, must be approved by the Plan Administrator.

UTILIZATION MANAGEMENT PROGRAM

This program is designed to determine if a proposed setting and course of treatment is Medically Necessary and appropriate. Benefits under the Plan will depend upon the Member's eligibility for coverage and the Plan's limitations and exclusions.

The Plan's Utilization Management Program is administered by:

Hometown Health
Phone: (775) 982-4150 or (866)-991-4150

Hometown Health's medical professionals will provide pre-certification to a Covered Member after their review on the quality, necessity, appropriateness and cost-effectiveness of inpatient stays and proposed medical or surgical services.

Inpatient hospitalizations, transplant services and clinical trials require pre-certification.

How to Request Pre-Certification
It is the Covered Member's responsibility to ensure that pre-certification occurs when it is required by the Plan. Any penalty for failure to pre-certify is the Covered Member's responsibility, not the health care provider. The Covered Member, Physician or facility must call **Utilization Management** at least fourteen (14) days before the expected date of service. A Covered Member should contact Utilization Management to make certain that the facility or Physician has initiated the necessary processes. For an emergency admission, Utilization Management must be contacted within 48 hours after admission or on the first business day after admission.

Inpatient Admission
Any elective, non-emergency inpatient admission to a PPO facility (Hospital, mental health facility, substance abuse treatment facility, skilled nursing facility or rehabilitation facility) must be pre-certified at least fourteen (14) days prior to admission.

Pre-certification is not required for a Pregnancy admission which does not exceed 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section delivery. When Pregnancy confinement for the mother or newborn is expected to exceed these limits, pre-certification for such extended confinement is required.

Transplant Services
All transplant related expenses, including the admission for transplant services must be pre-certified by Utilization Management. See **Eligible Medical Expenses**.

Clinical Trials
Utilization Management must be contacted prior to obtaining such services. See **Eligible Medical Expenses** and **General Exclusions**.

Failure to Pre-Certify
If the required Pre-Certification requirements are not completed, benefits payable for the service that was not pre-certified will be reduced by 50% of the allowable charges. Expenses related to the penalty will not be counted towards your plan year deductible or out-of-pocket maximum.

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

Pre-certification is not a guarantee of coverage. Benefits under the Plan will depend upon the Member's eligibility for coverage and the Plan's limitations and exclusions. Nothing in the Utilization Management Program will increase benefits to cover any confinement or service that is not covered under the Plan.

BACK ON TRACK PROGRAM

The Back on Track Program is a voluntary program coordinated through Specialty Health.

This program is for back and neck disease management, designed to assist individuals with managing their acute and chronic back and neck pain with the help of providers who specialize in the management of acute and chronic back pain.

By enrolling in and complying with this program, the City has agreed to waive your co-pays and deductibles for your spine, neck and back care.

Once accepted in the Back on Track Program, Specialty Health will manage your care for all non-surgical neck and back services including, but not limited to:

A. Physical therapy
B. Chiropractic services
C. Specialist services
D. MRI's/CT scans
E. EMG's
F. Inpatient and outpatient hospitalization

All treatment must receive prior approval from Specialty Health.

To receive the full benefits of the Back on Track Program and have your deductible and co-insurance waived for spine care, you must utilize a provider on the Back on Track network.

To Enroll
An individual wishing to enroll in the Back on Track program will contact Specialty Health at **(775) 398-3620**. Once accepted in the Program, Specialty Health will manage your care.

While in the Program all services authorized by Specialty Health, except surgery related services, will not be subject to a calendar year deductible or co-insurance.

A Covered Member can opt-out of the program at any time. Once the Covered Member is released from the program or opts-out out of the Program, the deductible and co-insurance will apply to services related to the back and neck going forward.

A Covered Member may "opt back in" within 60 days of your "opting out" and you may "opt-out"/discontinue in the program only once.

Spinal surgery will be subject to the calendar year deductible and co-insurance limits.

For additional information on this program, contact:

Specialty Health
(775) 398-3620

MEDICAL BENEFIT SUMMARY

Maximum Lifetime Benefit	Unlimited
Maximum Annual Benefit	Unlimited

The Maximum Plan Benefit applies to all periods a Member is covered under the Plan. Lesser limits may apply and are included in this summary. Any use of the term "Lifetime" refers to all periods an individual is covered under the Plan. It does not mean a Covered Member's entire lifetime.

Calendar Year Deductibles	**PPO & NON-PPO PROVIDERS**
Individual Deductible	$200
Family Deductible	$400

Individual Deductible - The Individual Deductible is an amount a Covered Member must contribute toward payment of eligible medical expenses. In most instances, the Deductible applies before the Plan will begin to pay benefits. The "Annual Deductible" applies each Calendar Year.

Family Deductible – The family deductible is an amount a Covered Member and Eligible Dependents must contribute toward payment of eligible medical expenses. If $400 in eligible medical expenses is incurred collectively by covered family members during a Calendar Year, the entire family will have met the Family Deductible. If both the covered Employee and the covered Spouse work for the City of Sparks, eligible expenses will be combined when calculating the family deductible.

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

Calendar Year Out-Of-Pocket Maximums	**PPO Providers**	**Non-PPO Providers**
Individual Out-of-Pocket Maximum	$1,000	$5,000 plus UCR
Family Out-of-Pocket Maximum	$2,000	$10,000 plus UCR

Individual Out-of-Pocket Maximum – A Covered Member will not be required to pay more than $1,000 plus deductible for PPO expenses or $5,000 plus deductible, plus UCR for Non-PPO expenses in any Calendar Year for Eligible Medical Expenses.

Once the deductible and out-of-pocket maximums have been met, Eligible Medical Expenses will be paid at 100% for the balance of the Calendar Year. Network and Non-Network Out-of-Pockets do not cross-apply. Expenses applied toward Network Out-of-Pockets will not also apply to Non-Network Out-of-Pockets or vice versa.

Family Out-of-Pocket Maximum - A Covered Family which includes a Covered Member and Covered Eligible Dependents will not be required to pay more than $2,000 plus deductible for PPO expenses or $10,000 plus deductible, plus UCR for Non-PPO provider expenses in any Calendar Year for their share of Eligible Expenses.

If both the Covered Member and Covered Spouse both work for the City of Sparks, eligible expenses will be combined when calculating the family Out-of-Pocket Maximum.

Once the Covered Family has paid their Deductible and Out-of-Pocket Maximum, Eligible Expenses will be paid at 100% for the balance of the Calendar Year. Network and Non-Network Out-of-Pockets do not cross-apply. Expenses applied toward Network Out-of-Pockets will not also apply to Non-Network Out-of-Pockets or vice versa.

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

A. Annual Deductible
B. Dental, Prescription or Vision Co-Pays
C. Failure to comply with the requirements of the Utilization Management Program
D. Expenses not covered by the Plan, for any reason.

MEDICAL BENEFIT SUMMARY…continued

IMPORTANT INFORMATION - The percentages shown under PPO and Non-PPO reflect the amounts the Plan pays of eligible medical expenses after any required Deductible has been subtracted. The remaining percentage is the Covered Members **Co-Insurance**.

For PPO, this means that the percentages apply to the negotiated rates and not necessarily to the provider's actual charges or the usual charges of similar providers. For Non-PPO providers, the percentages apply to "Usual, Customary and Reasonable" (UCR) charges. When using a Non-PPO, your out-of-pocket expenses will be more than using a PPO.

The following is a description of **Eligible Medical Expenses**. All services must be medically necessary and follow clinical guidelines. **Eligible Medical Expenses** are subject to **Medical Limitations and Exclusions.**

Eligible Medical Expenses Summary	Deductible	PPO	Non-PPO
Acupuncture	Yes	80%	60%
Ambulance Services	Yes	80%	60%
Ambulatory Surgical Center – Facility Only			
HHN Providers, Renown, Northern Nevada	No	100%	N/A
All Other Providers	Yes	80%	60%
Autism Spectrum Disorder	Yes	80%	60%
Behavioral Health Care			
Outpatient Physician Visits	Yes	80%	60%
Inpatient Physician Visits	Yes	80%	60%
Inpatient Facility	Yes	80%	60%
The first 5 Outpatient visits per Calendar Year may be covered under the EAP program. See **Appendix D**.			
Breast Pumps	No	100%	N/A
Contraceptives See **Eligible Medical Expenses**	No	100%	N/A
Diagnostic Lab & X-ray	Yes	80%	60%
Durable Medical Equipment	Yes	80%	60%
Emergency Room			
For Sickness	Yes	80%	60%
For Accidental Injury within 48 hours	No	100%	100%
For Accidental Injury after 48 hours	Yes	80%	60%
Healthy Lifestyle Benefit	No	100% up to $150	N/A
Limited to $150 per calendar year for covered members age 6 and over. Activities that promote or encourage an active and healthy lifestyle. Subject to the approval of the Group Health Care Committee. See **Appendix G**.			
Hearing Aid	Yes	80%	60%
Hearing Aid benefit limited to a maximum of two hearing aid appliances in any three-year period. Testing and fitting for the hearing aid is covered. Batteries are not covered.			
Home Health Care	Yes	80%	60%
Limited to 365 visits per Calendar Year. Each home health provider visits of 4 hours or less will count as 1 (one) visit.			

MEDICAL BENEFIT SUMMARY…continued

Eligible Medical Expenses Summary	Deductible?	PPO	Non-PPO
Hospice Care			
Patient Care	No	100%	100%
Bereavement Counseling, per visit	No	100% to $25	100% to $25
Bereavement counseling is limited to 8 visits per family member within 6 months following the death of the Covered Member.			
Hospital			
Out-Patient Services (non ER)	Yes	80%	60%
In-patient	Yes	80%	60%
Orthotics (custom shoe inserts)	Yes	80%	60%
Limited to a maximum of 2 orthotic appliances in any 5-year period.			
Physician Office Visit	Yes	80%	60%
Pregnancy	Yes	80%	60%
Skilled Nursing Facility	Yes	80%	60%
Eligible Expenses for room and board in a Skilled Nursing Facility are limited to the facility's Semi-Private Room Charge.			
Substance Abuse Care	Yes	80%	60%
Urgent Care	Yes	80%	60%
Virtual Visits at Renown – Nevada Residents Only	Yes	100%	N/A
All Other Eligible Medical & Professional Expenses	Yes	80%	60%
Eligible Preventative Care Summary	**Deductible?**	**PPO**	**Non-PPO**
Colonoscopy	No/Yes	100%	60%
Immunizations & Vaccines See a complete list in **Appendix A**.	No/Yes	100%	60%
Osteoporosis Screening	No/Yes	100%	60%
Prostate Screening & Exam	No/Yes	100%	60%
Routine Physical Exam	No/Yes	100%	60%
Lab & X-ray for preventative purposes	No/Yes	100%	60%
Mammogram Ultrasound	No/Yes	100%	60%
Mammogram	No/Yes	100%	60%
Pregnancy Preventative Services For a complete list, see Preventative Services for Pregnancy in **Eligible Medical Expenses**	No/Yes	100%	60%
Well Child Care to age 18 For a complete list, see Preventative Services for Children in **Eligible Medical Expenses**	No/Yes	100%	60%
Well Woman Exam For a complete list, see Preventative Services for Women in **Eligible Medical Expenses**	No/Yes	100%	60%

THIS IS A SUMMARY ONLY

Please refer to the Eligible Medical Expenses and Medical Limitations and Exclusions sections for more information.

ELIGIBLE MEDICAL EXPENSES

This section is a listing of those professional services, supplies and conditions which are covered by the Plan. This section must be read in conjunction with the **Medical Benefit Summary** to understand how Plan benefits are determined.

Except as otherwise noted below or in the **Medical Benefit Summary**, eligible medical expenses are the Usual, Customary and Reasonable (UCR) charges for the items listed below and which are incurred by a Covered Member- subject to the **Definitions**, **Limitations and Exclusions** and all other provisions of the Plan. In general, services and supplies must be approved by a Physician or other appropriate provider and must be Medically Necessary for the care and treatment of a covered Sickness, Accidental Injury, Pregnancy or other covered health care condition.

Medical expenses will be deemed to be incurred on:

A. The date delivery is made; or,
B. The actual date a service is rendered.

1. Abortion
A Medically Necessary abortion and, to comply with Federal law, complications arising out of an abortion. Elective abortions are not covered.

2. Acupuncture/Acupressure
Needle puncture or application of pressure at specific points, whether used to cure disease, to relieve pain or as a form of anesthesia for surgery.

3. Alcoholism
See "Substance Abuse"

4. Allergy Testing & Treatment
Allergy testing and treatment, including allergy injections.

5. Ambulance
Professional ground or air ambulance when used to transport Eligible Member from the place injured or stricken by sickness; or, from the nearest Hospital where treatment can be given. Includes transfer from a Non-PPO Hospital to a PPO Hospital when authorized.

6. Ambulatory Surgical Center
Services and supplies provided by an Ambulatory Surgical Center for a covered out-patient surgery.

7. Amniocentesis
See "Pregnancy".

8. Anesthesia
Anesthetics and services of a Physician or certified registered nurse anesthetist for the administration of anesthesia.

9. Autism Spectrum Disorder
Screening for and diagnosis of autism spectrum disorders and applied behavior analysis treatment of autism spectrum disorders under the age of 19 or, if enrolled in high school, until the Member reaches the age of 22. This does not require the Plan to provide reimbursement to an early intervention agency or school for services delivered through early intervention or school services. Treatment of autism spectrum disorders must be identified in a treatment plan and may include medically necessary habilitative or rehabilitative care, prescription care, psychiatric care, psychological care, behavior therapy or therapeutic care that is:

A. Prescribed for a Member diagnosed with an autism spectrum disorder by a licensed Physician or licensed psychologist; and,
B. Provided for a Member diagnosed with an autism spectrum disorder by a licensed Physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed Physician, psychologist or behavior analyst.

Autism Spectrum Disorder continued - as used in this section:

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 Developmental 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:

A. A licensed psychologist;
B. A licensed behavior analyst; or,
C. 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 Member.

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

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, 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 medically necessary assessments, evaluations or tests to screen and diagnose whether a Member 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.

10. Behavioral Health Care
Behavioral health care includes in-patient, out-patient and residential treatment facilities for a mental disorder identified in the current edition of the International Classification of Diseases manual or is identified in the current edition of Diagnostic and Statistical Manual of Mental Disorders. Behavioral health disorders include, but are not limited to: attention deficit disorders (ADD, ADHD), bereavement counseling, bipolar disorder, depression, marriage and family counseling, obsessive-compulsive disorder, panic disorder, schizophrenia and phobias.

NOTE**:** A "residential treatment facility" is a licensed facility with on-site housing/dormitory accommodations or on-site day treatment programs.

11. Birthing Center
Services and supplies provided by a Birthing Center for a covered Pregnancy.

12. Blood
Blood and blood derivatives (if not replaced by or for the patient), including blood processing and administration services.

13. Chemical Dependency
See "Substance Abuse".

14. Chemotherapy
The use of chemical agents in the treatment or control of disease.

15. Chiropractic Care
Musculoskeletal manipulation by a chiropractor to correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain.

16. Clinical Trials - Cancer and Chronic Fatigue Syndrome
Clinical trials that are allowed by Nevada law when certain criteria are met. See "Experimental/Investigational Treatment" in the **Medical Limitations and Exclusions** section.

17. Clinical Trials
Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Covered Member is participating in a Phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition, provided the clinical trial is approved by:

A. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
B. The National Institute of Health;
C. The U.S. Food and Drug Administration;
D. The U.S. Department of Defense;
E. The U.S. Department of Veterans Affairs; or,
F. An institutional review board in Nevada that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and, the research institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Costs incurred are covered if:

A. There is no medical treatment available that is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study;
B. There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment;

Clinical Trials, continued

C. The clinical trial or study is conducted in Nevada or as approved by the Plan Administrator;
D. You have signed, before your participation in the clinical trial or study, a statement of consent indicating that you have been informed of, without limitation: 1) The procedure to be undertaken; 2) Alternative methods of treatment; and, 3) The risks associated with participation in the clinical trial or study.

Coverage will not be provided for:

A. The cost of an investigational new drug or device that is not approved for any indication by the US Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial;
B. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial;
C. The cost of a service clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
D. A cost associated with managing an Approved Clinical Trial;
E. The cost of a health care service that is specifically excluded by the Plan;
F. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research institution conducting the Approved Clinical Trial;
G. Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry.

18. Cochlear Implants
Implanted electronic hearing device, designed to produce useful hearing sensations to a Member with severe to profound nerve deafness who derives little benefit from hearing aids and the Plans criteria for cochlear implants has been met.

19. Contraceptives
Contraceptive supplies and related Physician services provided for the fitting, administration or placement of contraceptive devices, injectables, implants, etc. If Covered Member's Physician determines that these type of contraceptive methods is inappropriate for the individual based on medical or Member history, the Plan will provide coverage for another prescription contraceptive method that is approved by the Food and Drug Administration (FDA) and is prescribed by a Physician.

Contraceptives which can be obtained without a Physician's written prescription (e.g., condoms, foams, jellies, etc.) or contraceptives which do not require the services of a Physician are not covered. Contraceptives does not cover sterilization procedures. Please see "Sterilization Procedures".

Any contraceptive which can be obtained through the prescription drug program must be obtained through that program. See **Appendix A**.

20. Diagnostic Lab & X-ray
Laboratory, X-ray and other non-surgical services performed to diagnose medical disorders, including scanning and imaging work, electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the US.

21. Diabetic Services
Management and treatment of diabetes, including infusion pumps and related supplies, medication, equipment and appliances for the treatment of diabetes. Training and education provided after diagnosed with diabetes for the care and management of diabetes, including, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes.

Supplies for the administration of insulin - including test strips, syringes and needles - are covered through the prescription drug plan. See **Appendix A**.

22. Dialysis Services
Dialysis services, including the training of a Member to assist the patient with home dialysis, when provided by a hospital, freestanding dialysis center or another appropriate Covered Provider.

23. Durable Medical Equipment (DME)

Rental of DME 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 Sickness or Accidental Injury. Excess charges for deluxe equipment or devices will not be covered. DME includes such items as crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, and oxygen and dialysis equipment which:

A. Can withstand repeated use;
B. Primarily and customarily used to serve a medical purpose;
C. Generally are not useful to a Member in the absence of Sickness or Accidental Injury; and,
D. Is appropriate for use in the home.

24. Emergency Room Use

Eligible Medical Expenses incurred while in a Hospital's emergency room for treatment of a sickness or accidental injury.

25. Gender Reassignment

Gender reassignment surgery consisting of any combination of the following when the following criteria is met:

Requirement for mastectomy for female-to-male patients:

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

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

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

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

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

NOTE: See Gender Reassignment under **MEDICAL LIMITATIONS AND EXCLUSIONS** for services and procedures that are not covered.

26. Genetic Counseling & Testing

Genetic testing may only be done after consultation with an appropriately certified genetic counselor and/or, as approved by a Physician designated to review the utilization, medical necessity, clinical appropriateness, and quality of such genetic testing. Coverage is not available for tests solely for research or for the benefit of individuals not covered under the Policy.

Eligible Medical Expenses include:

A. BRCA 1 and BRCA 2 testing.
B. Genetic disease testing of human DNA, chromosomes, proteins, or other gene products to determine the presence of disease-related genotypes, phenotypes, karyotypes, or mutations for clinical purposes. Such purposes include those tests meeting criteria for the medically accepted standard of care for the prediction of disease risk, identification of carriers, monitoring, diagnosis, or prognosis within the confines of the statements in this definition.
C. Explanation by a genetic counselor of medical and scientific information about an inherited condition, birth defect, or other genome-related effects to an individual or family. Genetic counselors are trained to review family histories and medical records, discuss genetic conditions and how they are inherited, explain inheritance patterns, assess risk and review testing options, where available.
D. Genetic counseling in connection with pregnancy management with respect to the following individuals: 1) Parents of a child born with a genetic disorder; 2) Birth defect, inborn error of metabolism, or chromosome abnormality; 3) Parents of a child with mental retardation, autism, Down syndrome, trisomy conditions, or fragile X syndrome; 4) Pregnant women who, based on prenatal ultrasound tests or an abnormal multiple marker screening test, maternal serum alpha-fetoprotein test, test for sickle cell anemia, or tests for other genetic abnormalities, have been told their pregnancy may be at increased risk for complications or birth defects; 5) Parents affected with an autosomal dominant disorder who are contemplating pregnancy; 6) Women who are known to be, or who are likely to be, carriers of an X-linked recessive disorder.

Eligible Medical Expenses will include genetic testing of heritable disorders when the following conditions are met:

A. The results will directly impact clinical decision-making and/or clinical outcome for the individual;
B. The testing method is considered scientifically valid for identification of a genetically-linked heritable disease; and one of the following conditions is met: 1) Member demonstrates signs/symptoms of a genetically-linked heritable disease; 2) Member or fetus has a direct risk factor (e.g., based on family history or pedigree analysis) for the development of a genetically-linked heritable disease.

Additional genetic testing will be covered per federal or state mandates. In the absence of specific information regarding advances in the knowledge of mutation characteristics for a particular disorder, the current literature indicates that genetic tests for inherited disease need only be conducted once per lifetime for the Covered Member.

Routine panel screening for preconception genetic diseases, routine chorionic villous sampling, or amniocentesis panel screening testing, and pre-implantation embryonic testing will not be covered unless the testing is endorsed by the American College of Obstetrics and Gynecology, or mandated by federal or state law.

27. Healthy Lifestyle Benefit

Certain activities that promote or encourage an active and healthy lifestyle; or to aid in the cost of additional medical, dental, vision or Rx expenses after applicable annual deductibles have been met.

Subject to approval of the Group Health Care Committee. See **Appendix G.**

28. Hearing Exam and Hearing Aid

Hearing aid and hearing exam for furnishing hearing aids. Batteries are not covered.

29. Home Health Care

Services and supplies which are furnished to a Covered Member who is disabled and which are furnished in accordance with a written home health care plan. The home health care plan must be established in writing by the Covered Member's attending Physician and must be certified by the Physician every month during the period of home health care. Covered home health care services and supplies include the following. Except as noted, such services and/or supplies must be provided through a Home Health Care Agency as specified in the written home health care plan:

A. Part-time or intermittent services of a registered nurse (RN) or a licensed vocational nurse (LVN);
B. Services of physical, occupational and speech therapists;
C. Part-time or intermittent services of home health aides under the supervision of a registered nurse (RN) or a physical, occupational or speech therapist;
D. Social work performed by a licensed social worker;
E. Nutrition services performed by a licensed nutritionist;
F. Special meals;
G. Medical supplies, drugs and medicines prescribed by a Physician and related pharmaceutical and laboratory services which are billed by the Home Health Care Agency.

NOTE**:** Services of visiting nurses rendered in place of services of a Home Health Care Agency will be covered when the patient resides in a rural area which is not serviced by any Home Health Care Agency or where the services of such agencies are not sufficient to meet the needs of the community. Covered home health care expenses will not include housekeeping services or other services which are custodial in nature and could be rendered by non-professionals.

30. Hospice Care

Care of a Covered Member with a terminal prognosis who has been admitted to a formal program of Hospice care. Eligible Medical Expenses include Hospice program charges for:

A. Inpatient Hospice facility services and supplies;
B. Out-patient services (i.e., services provided in the patient's home) including: Part-time nursing care by or under the supervision of a registered nurse, home health aide services, nutrition services, special meals; and, counseling services provided by a licensed social worker or a licensed pastoral counselor;
C. Benefits for bereavement counseling for the patient's immediate family when provided by a licensed social worker or a licensed pastoral counselor, limited to 8 visits per covered family member following the patient's death.

31. Hospital Services

Hospital services and supplies provided on an out-patient basis and in-patient care, including daily room and board and ancillary services and supplies when approved by Utilization Management.

32. Infertility Testing & Treatment

Procedures consistent with established medical practices for diagnostic testing related to infertility and Medically Necessary surgery to correct the condition. Infertility means either: The presence of a demonstrated condition recognized by a licensed Physician as a cause of infertility; or, the inability to conceive a pregnancy or to carry a pregnancy to a live birth. See "Impregnation" in the list of **Medical Limitations and Exclusions** for services that are not covered.

33. Mastectomy Reconstructive Surgery

Breast reconstructive surgery and internal or external prosthetic devices for Covered Members who have undergone mastectomies or other treatments for breast cancer. Treatment will be provided in a manner determined in consultation with a Physician and the Member. Eligible Medical Expenses include:

A. All stages of reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical structure;
B. Prostheses;
C. Physical complications for all stages of mastectomy, including lymphedemas.

34. Medical Supplies
Supplies such as casts, splints, trusses, surgical dressings, catheters, electronic heart pacemakers, colostomy bags and related supplies, and blood pressure home test units when accompanied by a letter from the Physician confirming diagnosis and Medical Necessity.

35. Medicines
Medicines which are dispensed and administered to a Covered Member during an in-patient confinement.

36. Midwife
Services of a certified or registered nurse midwife when provided in conjunction with a covered Pregnancy.

37. Newborn Care
Circumcision of a covered male newborn child. For Hospital nursery care during the birth confinement, see "**Pregnancy**" and/or "**Preventative Care for Children to Age 18**".

38. Nutritional Counseling
Services of a Registered Dietician for dietary or nutritional services.

39. Occupational Therapy
Therapy, under the direction of a licensed Physician and provided 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.

40. Orthognathic Procedures
Jaw (mandibular) augmentation or reduction procedures.

41. Orthotics
Specially prescribed and molded or casted shoe inserts. Limited to two orthotic appliances in any five-year period.

42. Oxygen
See "Durable Medical Equipment".

43. Physical Therapy
Professional services of a licensed physical therapist, when specifically prescribed by a Physician or surgeon as to the type of therapy and duration, but only to the extent that the therapy is for improvement of bodily function.

44. Physician Services
Medical and surgical treatment by a Physician, including office, home or hospital visits, clinic care and consultations.

45. Pregnancy and Pregnancy Preventative Care
Pregnancy-related expenses and Pregnancy Preventative care include the following, but may include other services which are deemed Medically Necessary by the Covered Member's attending Physician:

A. Prenatal visits and routine prenatal and post-partum care including breast feeding interventions to support and promote breast feeding, access to trained providers and breastfeeding supplies;
B. Expenses associated with a vaginal delivery or cesarean section;
C. Amniocentesis, chronic villus sampling (CVS), and alpha-fetoprotein (AFP) analysis;
D. Rh Blood Typing Screening for all pregnant women and follow-up testing for women at higher risk;
E. Routine well-baby nursery expenses billed by the hospital and which are incurred during the child's birth confinement and while the mother and child are both confined post-delivery;
F. Screenings for gestational diabetes, Hepatitis B, HIV, HPV, Syphilis, anemia, bacteriuria, urinary tract infections or other infections;
G. Tobacco Use Screening, interventions and expanded counseling for pregnant tobacco users.

Pregnancy continued - In no instance, will the Plan restrict benefits for a Pregnancy Hospital stay for a mother and her newborn to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section.

NOTE**:** Pregnancy coverage does not include: Lamaze and other charges for education related to prenatal care and birthing procedures, adoption expenses; or, expenses of a surrogate mother not covered by this Plan.

46. Prescription Drugs
Outpatient drug coverage is provided through a separate program. See **Appendix A**.

47. Preventive Care for Children to Age 18
With respect to infants, children and adolescents, Preventive Care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the US Department of Health and Human Services; and, certain "preventive" measures (routine exams and diagnostic services) provided in the absence of sickness or injury. Eligible Medical Expenses include:

A. Alcohol and drug use assessment for all adolescents;
B. Autism screening for children at 18 and 24 months;
C. Behavioral assessments for all children throughout development;
D. Blood pressure screening for all children throughout development;
E. Cervical dysplasia screening for sexually-active females;
F. Depression screening for all adolescents;
G. Developmental screening for children under age 3 and surveillance throughout childhood;
H. Dyslipidemia screening for children at higher risk of lipid disorders;
I. Fluoride chemoprevention supplements for children without fluoride in their water source;
J. Gonorrhea preventive eye medication for all newborns;
K. Hearing screening for all newborns;
L. Height, weight and body mass index measurements for all children throughout development;
M. Hematocrit or hemoglobin screening for all children;
N. Hemoglobinopathies/sickle cell screening for all newborns;
O. Hepatitis B screening for adolescents at higher risk;
P. HIV screening for adolescents at higher risk;
Q. Hypothyroidism screening for all newborns;
R. Iron supplements for children ages 6 to 12 months at risk for anemia;
S. Immunizations and Vaccinations;
T. Lead screening for children at risk of exposure.

48. Preventive Care for Women
With respect to women age 18 and older, such additional Preventive Care and screenings not described under this section as provided for in comprehensive guidelines supported by the Health Resources and Services Administration of the US Department of Health and Human Service. Eligible Medical Expenses include:

A. Well-woman visits;
B. BRCA gene counseling about genetic testing for women at higher risk;
C. Breast Cancer Mammography screenings;
D. Breast Cancer Chemoprevention counseling for women at higher risk;
E. Screenings for Cervical Cancer and HIV for sexually active women;
F. Screenings for HPV, Chlamydia and/or Gonorrhea;
G. Counseling for sexually transmitted infections;
H. FDA approved contraceptive methods, sterilization procedures and patient education and counseling, as prescribed by a Physician;
I. Domestic and interpersonal violence screening and counseling for all women;
J. Folic Acid supplements for women who may become pregnant;
K. Osteoporosis Screening for women over age 60 depending on risk factors.

49. Prosthetics
Replacement of an artificial limb, eye or larynx which has been lost in an accidental Injury and/or surgically removed. Coverage expressly includes post-mastectomy breast prostheses. Prosthetics coverage does not include:

A. Dental prosthetics, except as expressly included under "Dental Benefit Summary" and/or in the Medical Limitations and Exclusions section;
B. Replacement of a prosthetic device except when Medically Necessary, such as when necessitated by the normal growth processes of a child or due to a change in the Covered Member's physical condition which makes the original device no longer functional; or,
C. Expenses for repair of a prosthetic.

50. Radiation Therapy
Radium and radioactive isotope therapy.

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

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

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

53. Skilled Nursing Facility
In-patient care in Skilled Nursing Facility, but only when the admission to the facility is Medically Necessary.

54. Speech Therapy
Services by a licensed or certified speech therapist to restore or rehabilitate a speech loss or impairment caused by Accidental Injury, Sickness or Developmental Delay. In the case of a congenital defect that can be corrected or improved with surgery, speech therapy is covered only if provided after surgery for the defect. Speech therapy provided to a child solely due to Developmental Delay will be covered at a maximum of 26 visits per Plan year.

55. Sterilization Procedures
A surgical procedure for sterilization (i.e., a vasectomy for a male or a tubal ligation for a female).

56. Substance Abuse
In-patient and out-patient treatment of substance abuse. Substance abuse is the physical and/or emotional dependence on drugs, narcotics, alcohol or other addictive substances to a debilitating degree. Dependence to tobacco or caffeinated drinks is not covered.

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

A. A Covered Member who is the recipient of a human organ or tissue transplant, not experimental or investigational in nature;
B. An organ donor if the donor is a Covered Member under the Plan; and,
C. An organ or tissue donor who is not a Covered Member to the extent such expenses are not covered under the donor's own coverage.

The following Transplant services are excluded from coverage:

A. Services provided in connection with purchasing or selling organs;
B. Transplants utilizing any animal organs;
C. Any transportation of the donor (as opposed to transportation of the donor organ only);
D. Artificial heart implantation;
E. Services for which government funding or other insurance coverage is available;
F. Any expenses for transportation, lodging, and meals for services associated with the transplant including evaluations and the transplant and post-transplant periods for the donor, donor's family, recipient, or recipient's family.

58. TMJ/Jaw Joint Treatment
Procedures, restorations or appliances for the treatment or for the prevention of temporomandibular joint dysfunction syndrome. Under no circumstances will braces for the mouth be covered.

59. Urgent Care Facilities

60. Varicose Veins
Removal of varicose veins deemed Medically Necessary. Cosmetic procedures to reduce the appearance of varicose veins is not covered.

61. Virtual Visits
Renown Virtual Visits is the only approved Virtual/Telecommunication PPO (with no coverage available for any Non-PPO), they are specifically identified in the Medical Benefit Summary as such to minimize any questions/confusion by members. Covered Member must reside in Nevada.

62. Weight Control
Any Surgery rendered for weight control or weight reduction for the treatment of morbid obesity which has been determined to be Medically Necessary by a Physician. A waiting period and/or counselling sessions are not required under this Plan.

63. Well Child Care to Age 18
Well child check-ups, sports physicals. See "Preventative Care for Children to Age 18" for a comprehensive list.

64. Wigs
The Plan will cover the purchase of a wig (no limitations) for hair loss resulting from medical treatment (i.e., chemotherapy).

MEDICAL LIMITATIONS & EXCLUSIONS

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

1. Air Purification Units
Air conditioners, air-purification units, humidifiers and electric heating units.

2. Biofeedback
Biofeedback, recreational, or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing.

3. Complications of Non-Covered Treatment
Care, services or treatment which are required to treat complications resulting from a treatment or surgery which is not or would not be covered under the terms of the Plan, unless expressly stated otherwise. For example, if breast implants were placed for cosmetic reasons, the subsequent removal of such implants would not be covered, even if such removal is considered Medically Necessary.

4. Cosmetic Surgery
Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly or any complications resulting therefrom, except for:

A. Services necessitated by an accidental injury;
B. Treatment or surgery which is incidental to or follows surgery for a sickness;
C. Breast reconstruction on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance.
D. Physical complications of all stages of a mastectomy, including lymphedemas. Coverage will be provided for such care as determined by the attending Physician in consultation with the patient;
E. Surgery which is necessary to correct a congenital abnormality in Covered Dependent child.

5. Custodial Care
Care or confinement primarily for meeting personal needs which could be rendered at home or by persons without professional skills or training. 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.

6. Dental Care
Care or treatment to the teeth, alveolar processes, gingival tissue, or for malocclusion except that the Plan will cover facility fees and anesthesia associated with Medically Necessary dental services provided Utilization Management determines that hospitalization is Medically Necessary to safeguard the health of a patient who:

A. Is under age seven (7), and has been diagnosed with extensive dental decay substantiated by X-rays and narrative by the treating dentist;
B. Has a documented illness such a hemophilia or prior tissue or organ transplant requiring a Hospital environment to monitor vital signs; or,
C. Has a documented mental or physical impairment requiring general anesthesia in a Hospital setting for the safety of the patient.

7. Diagnostic Hospital Admissions
Confinement in a Hospital for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting.

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

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

10. Exercise Equipment

11. Experimental Services & Drugs

Based on outcome data from randomized controlled clinical trials, recommendations from consensus panels, national medical associations or other technology evaluation bodies; and, from authoritative, peer-reviewed US medical or scientific literature, procedures or treatments are considered experimental or investigational and are not Covered Expenses as follows:

A. Insufficient evidence shows that the procedure or treatment is safe, effective, or superior to existing therapy;
B. Does not conclusively demonstrate that the service or therapy improves the net health outcomes for total appropriate population for whom the service might be rendered or proposed over the current diagnostic or therapeutic interventions, even when the service, drug, biological, or treatment may be recognized as a treatment or service for another condition, screening, or Illness;
C. If the procedure or treatment has not been deemed consistent with accepted medical practice by the National Institutes of Health, the Food and Drug Administration, or Medicare;
D. When the drug, biologic, device, product, equipment, procedure, treatment, service, or supply cannot be legally marketed in the United States without the final approval of the Food and Drug Administration or any other state or federal regulatory agency, and such final approval has not been granted for that particular indication, condition, or disease;
E. When a nationally recognized medical society states in writing that the procedure or treatment is experimental;
F. When the written protocols used by a facility performing the procedure or treatment state that it is experimental.

Clinical trials may still be covered even if the procedure or treatment is otherwise experimental or investigational. Refer to "Clinical Trials" in **Eligible Medical Expenses**.

NOTE: Experimental, ecological, or environmental medicine is excluded, including, but not limited to the use of chelation or chelation therapy except for acute arsenic, gold, mercury, or lead poisoning; orthomolecular substances; use of substance of animal, vegetable, chemical or mineral origin not FDA-Approved as effective for such treatment; electrodiagnosis; Hahnemannian dilution and succussion; prolotherapy, magnetically energized geometric patterns, replacement of metal dental fillings, laetrile, and gerovital.

12. Foot Care, Routine

Non-surgical treatment of calluses, toenails or other routine foot care unless the charges are for the removal of nail roots or for the treatment of a metabolic or peripheral-vascular disease.

Orthopedic shoes unless permanently attached to braces. Other supportive appliances for the feet except as expressly covered - see "Orthotics" in the list of **Eligible Medical Expenses**.

13. Gender Reassignment Surgery

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

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

14. Hair Restoration

Any surgeries, treatments, drugs, services or supplies relating to baldness or hair loss.

15. Holistic, Homeopathic or Naturopathic Medicine

Services, supplies, drugs or accommodations provided for holistic, homeopathic or naturopathic treatment.

16. Hypnotherapy

Treatment by hypnotism.

17. Impregnation
Prescription drugs, devices, donor expenses, donor egg/semen, or other facilities, procedures or supplies for facilitating impregnation. Such services and supplies include, but are not limited to:

A. In-vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, or ovarian transplant;
B. Egg, embryo or sperm cryostorage;
C. Cryopreservation or storage charges for collection and storage of biologic materials, including umbilical cord blood, for artificial reproduction or any other purpose;
D. Ovarian transplant; and,
E. Services of infertility donors.

18. Learning Disorders
Unless as defined as covered under eligible medical expenses, treatment of any type of learning disability. The Plan will provide coverage for Physician visits for medication management of ADD or ADHD.

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

20. Nicotine Addiction
Nicotine withdrawal programs, facilities or supplies. However, nicotine withdrawal drugs are covered under the prescription program. See **Appendix A.**

21. Non-Prescription Drugs
Drugs for use outside of a hospital or other Inpatient facility which can be purchased over-the-counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available. This exclusion will not apply to insulin, syringes and blood glucose test strips for diabetics or any approved drugs as stated in **Appendix A.**

22. Not Medically Necessary/Not Physician Prescribed
Services or supplies which are not Medically Necessary and not incurred on the advice of a Physician and/or not an acceptable standard of medical practice or applicable law - unless expressly included herein.

23. Nursing Services, Private Duty
Private-duty services of a registered, vocational or practical nurse. See “Home Health Care” in the list of **Eligible Medical Expenses** for nursing coverage information.

24. Personal Comfort or Convenience Items
Services or supplies provided for personal comfort and not necessary for treatment of covered Sickness, Accidental Injury or Pregnancy including, but not limited to, the purchase or rental of telephones, televisions, orthopedic mattresses, allergy-free pillows, blankets and/or mattress covers, non-hospital adjustable beds, waterbeds, motorized transportation equipment, elevators or escalators.

25. Prophylactic Surgery or Treatment
Prophylactic Surgery is a surgical procedure performed to: (1) avoid the possibility or risk of an illness, disease, physical or mental disorder or condition based on genetic information or genetic testing; or, (2) treat 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, even in its earliest stages.

An example of prophylactic surgery is a mastectomy performed on a woman diagnosed as having a genetic predisposition to breast cancer and/or has a history of breast cancer among family members when, at the time the surgery is to be performed, there is no objective medical evidence of the presence of the disease, even if there is medical evidence of a chromosomal abnormality or genetically transmitted characteristic indicating a significant risk of breast cancer coupled with a history of breast cancer among family

members of the woman. Medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery when the services, procedures, prescription of drugs, or prophylactic surgery is prescribed or performed for:

A. Avoiding the possibility of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results; or,
B. Treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of physical or mental disorder.

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

27. Sterilization Reversal Surgery
Reconstruction (reversal) of prior elective sterilization procedures.

28. Telecommunications, Travel
Advice or consultation given by or through any form of virtual/telecommunication services except Virtual Visits expressly included in the **Medical Benefit Summary** and **Eligible Medical Expenses**.

29. Vision
Orthoptics, vision therapy, or other special vision procedures, including procedures whose purpose is the correction of refractive error, such as radial keratotomy or any complications resulting from refractive surgery. This exclusion will not apply to the initial purchase of glasses or contact lenses following cataract surgery covered under this Plan.

Vision coverage is provided through a separate program. See **Appendix B**.

30. Vitamins or Dietary Supplements
Prescription or non-prescription organic substances used for nutritional purposes unless approved under **Appendix A or Appendix G**.

31. Vocational Testing or Training
Vocational testing, evaluation, counseling or training.

32. Weight Control
Services rendered for weight control or weight reduction or any complications thereof, except for surgery for the treatment of morbid obesity which has been determined by a Physician. See **Eligible Medical Expenses**.

DENTAL BENEFIT SUMMARY

Choice of Providers
Members have a choice of obtaining dental care from a Preferred Provider Organization (PPO) or Providers of their choice (Non-PPO providers). PPO's have agreed to provide services to members at negotiated rates, when a Covered Member uses a PPO, out-of-pocket costs may be reduced due to PPO Network negotiated fees.

PPO Allowable
If the City is billed by a non-PPO provider for expenses more than the PPO network's negotiated fee, the City will not be responsible for charges exceeding PPO negotiated rates. The member will be directly responsible for fees exceeding PPO negotiated rates.

Annual Plan Maximums	
Children up to age 19	Unlimited
All others	$2,500
Benefits for each Covered Member will not exceed the maximum shown. Preventive Services are provided in addition to the Annual Plan Maximum (except for mouth guards).	
Annual Deductibles	
Individual	$50
Family	$100
Individual Deductible - The Individual Deductible is an amount which a Covered Member must contribute toward payment of eligible dental expenses. In most instances, the deductible applies before the Plan begins to provide benefits. The Deductible is waived for Preventive Services and treatment of an Accidental Injury. Family Maximum Deductible - If $100 in eligible dental expenses is incurred collectively by family members during a Plan Year and is applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A "family" includes the Covered Member and Covered Dependents. Deductible Carry-Over - Eligible Expense incurred in the last 3 months of a Calendar Year and applied toward that year's Deductible can be carried forward and applied toward the Member's Deductible for the next Plan Year.	
Eligible Dental Expenses Summary	**Co-Insurance**
Preventive Services	100% - Deductible Waived
Limits applicable to Preventive Services: A. Routine oral exams, limited to 2 exams per Calendar Year; B. Routine cleanings, limited to 2 cleanings per Calendar Year; C. Application of fluoride, limited to once per Calendar Year; D. Sealants, limited to children under age 19; E. Routine full-mouth or panoramic X-rays, limited to once per 3-year period; F. Routine bitewing X-rays; G. Mouth guard, limited to annual dental maximum Benefits for Preventive Services do not reduce a Covered Member's Calendar Year Maximum Benefit except mouth guards.	
Basic Services	85% of PPO Allowable
Major Services	60% of PPO Allowable
Limits applicable to certain Major Services: A. Prosthetic replacement is limited to once in any 4-year period and only if the existing prosthetic cannot be made satisfactory; B. Denture relining is limited to 1 at any time after the initial placement of a denture once in any 4-year period thereafter.	

This is a summary only.
Please refer to the Eligible DENTAL Expenses and DENTAL Limitations and Exclusions sections for more information.

DENTAL BENEFITS

Dental Pre-Treatment Estimate
If extensive dental work is needed (proposed course of treatment will cost more than $300), a pre-treatment estimate may be required prior to the work being performed. Emergency treatments, oral examinations including prophylaxis, and dental X-rays will be considered part of the "extensive dental work" but may be performed before the pre-treatment estimate is obtained.

A pre-treatment estimate gives the patient and the dentist a good idea of benefit levels, maximums, limitations, etc., that might apply to the treatment program so that the patient's portion of the cost will be known; and, it offers the patient and dentist an opportunity to consider other avenues of restorative care that might be equally satisfactory and less costly. Most dentists are familiar with pre-treatment estimate procedures and the dental claim form is designed to facilitate pre-treatment estimate.

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

A pre-treatment estimate is not a guarantee of payment. Payment of plan benefits is subject to plan provisions and eligibility at the time the services are actually incurred. A pre-treatment estimate is only valid for six (6) months from the date the estimate is provided**.**

Eligible Dental Expenses
Eligible dental expenses are the Usual, Customary and Reasonable (UCR) charges received from a licensed dentist for the dental services and supplies listed below, which are:

A. For an appliance or modification of an appliance, on the date the final impression is taken;
B. For a crown, inlay, onlay or gold restoration, on the date the tooth is prepared;
C. For root canal therapy, on the date the pulp chamber is opened; or
D. For any other service, on the date the service is rendered.

Many dental conditions can be properly treated in more than one way. The Plan is designed to help pay for dental expenses, but not for treatment which is more expensive than necessary for good dental care.

If a Covered Member chooses a more expensive course of treatment, the Plan will pay benefits equivalent to the least expensive treatment that would adequately correct the dental condition.

DENTAL PREVENTIVE SERVICES

1. Appliances
Mouth guard or occlusal guard for habit-breaking such as grinding or night guards. Must be prescribed by a dentist. Limited to a Covered Member's annual maximum dental benefit.

2. Consults
Consultations by dental specialists upon referral by the patient's attending dentist.

3. Exams
Routine diagnostic oral examinations.

4. Fluoride
Topical application of stannous or sodium fluoride.

5. Prophylaxis
Routine cleaning and polishing of the teeth.

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

7. Space Maintainers
Fixed and removable appliances to retain the space left by a prematurely lost primary or "baby" tooth and to prevent movement of the surrounding teeth.

NOTE**:** See "**Orthodontia**" for coverage for appliances designed to move a tooth or teeth.

8. X-rays
Dental X-rays for diagnostic purposes, as well as routine "full mouth" X-rays or a panoramic X-ray, and routine bitewing X-rays.

DENTAL BASIC SERVICES

1. Anesthesia
General anesthesia when administered for oral surgery. Hypnosis and relative analgesia are covered only if the patient is completely anesthetized to a state of unconsciousness as with a general anesthetic. Separate charges for pre-medication, local anesthesia, analgesia or conscious sedation are not covered. Such services should be included in the cost of the procedure itself.

2. Crowns
A crown restoration when a tooth cannot be satisfactorily restored with a filling restoration. Coverage for a crown includes a post and core when necessary. Replacement of a crown, if the existing crown is at least five (5) years old and cannot be made serviceable.

Crowns placed for periodontal splinting are not covered. No benefits are payable for crowns placed on replanted or transplanted teeth. For children 12 years of age or under, only stainless-steel crowns will be covered.

Periapical x-rays must be submitted for all teeth requiring crowns.

3. Endodontia
Endodontic services, including but not limited to: root canal therapy, pulpotomy, apicoectomy and retrograde filling.

4. Extraction
See "Oral Surgery".

5. Fillings
Amalgam, silicate, composite and plastic restorations, including pins to retain a filling restoration when necessary. Replacement of a filling is limited to once in any 24-month period. Pulp capping is limited to one (1) per tooth.

No benefits are payable for restorations on replanted or transplanted teeth.

6. Implants
Includes titanium post, extractions and grafting necessary to prepare the tissue for implantation.

7. Injections
Injection of antibiotic drugs.

8. Inlays, Onlays & Gold Fillings
An inlay, onlay or gold restoration when a tooth cannot be satisfactorily restored with a less costly filling (amalgam, etc.) restoration. Replacement of an inlay, onlay or gold filling, if the existing restoration is at least five (5) years old and cannot be made serviceable.

9. Oral Surgery
Extraction of teeth, including simple extractions and surgical extraction of bone or tissue-impacted teeth. Surgical and adjunctive treatment of disease, injury and defects of the oral cavity and associated structures. Biopsy of oral tissue is covered only when performed by the attending dentist and benefits will be paid only for the surgery.

10. Palliatives
Emergency treatment for the relief of dental pain.

11. Periodontal
Nonsurgical periodontics including deep scaling, root planning and subgingival curettage. Surgical treatment of the gums and tissues of the mouth, including periodontal scaling and root planning, gingivectomy, osseous surgery and mucogingival surgery. Any allowance made for periodontal surgery includes all post-operative care for six (6) months following treatment.

DENTAL MAJOR SERVICES

1. Prosthetics

Placement of a full or partial denture or bridge. Any allowance made for a prosthetic includes necessary adjustments within six (6) months of placement.

A fixed bridge for a patient under sixteen (16) years of age is not covered. However, an allowance will be made for a partial denture.

Periapical x-rays must be submitted for teeth that are to be used as abutments for a bridge.

2. Repairs, Relines & Adjustments

Necessary repairs to bridgework or dentures.

Laboratory relining of dentures.

Adjustments to prosthetics, but only when provided more than six (6) months after placement.

3. Tooth Transplants/Replants

DENTAL LIMITATIONS & EXCLUSIONS

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

1. Appliances
Items solely intended for sport use such as athletic mouth guards. Appliances that can be purchased in a retail setting.

2. Congenital or Developmental Conditions
Treatment of congenital (hereditary) or developmental (following birth) malformations, unless expressly included.

3. Cosmetic Dentistry
Treatment rendered solely for cosmetic purposes. Except when necessitated by an Accidental Injury.

4. Customized Prosthetics
Precision or semi-precision attachments, overdentures, or customized prosthetics.

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

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

7. Duplicate Prosthetic Devices

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

9. Grafting
Grafting may be eligible when done in conjunction with another Eligible Expense. Extra oral grafts (grafting of tissue from outside the mouth to oral tissues) is not covered.

10. Hospital Expenses
See "Dental Care" in the list of **Medical Limitations and Exclusions** section for instances when Hospital expenses may be covered.

11. Lost or Stolen Prosthetics
Replacement of a prosthetic which has been lost, misplaced, or stolen.

12. Medical Expenses
Any dental services to the extent to which coverage is provided under the terms of the medical benefits sections of this Plan.

13. Myofunctional Therapy
Muscle training therapy or training to correct or control harmful habits.

14. Non-Professional Care
Services rendered by someone other than a:

A. DDS or DMD;
B. Dental hygienist, X-ray technician or other qualified technician who is under the supervision of a DDS or DMD; or,
C. Physician furnishing dental services for which they are licensed.

15. Occlusal Restoration
Procedures, appliances or restorations that are performed to alter, restore or maintain occlusion (i.e., the way the teeth mesh), including:

A. Increasing the vertical dimension;
B. Realignment of teeth;
C. Gnathological recording or bite registration or bite analysis;
D. Occlusal equilibration.

16. Oral Hygiene
Education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene instruction or plaque control. Charges for supplies normally used at home, including but not limited to toothpaste, toothbrushes, waterpiks, and mouthwashes unless covered by the Healthy Lifestyle Benefit.

17. Prescription Drugs
See **Appendix A**.

18. Splinting
Appliances and restorations for splinting teeth.

19. Temporary Restorations and Appliances
Excess charges for temporary restorations and appliances. The Eligible Expense for the permanent restoration or appliance will be the maximum covered charge.

20. TMJ/Jaw Joint Treatment
Any charges for jaw (mandibular) augmentation or reduction procedures; or procedures, restorations or appliances for the treatment or for the prevention of temporomandibular joint dysfunction syndrome.

ORTHODONTIA

Services or supplies for the correction of a handicapping malocclusion. Coverage is only available if prescribed by an orthodontist and a treatment plan has been approved by the Plan Administrator.

Plan Maximum	
Orthodontia Lifetime Maximum	$3,000
Benefits for each Covered Member will not exceed the maximum shown. The Orthodontia Maximum Benefit applies to all periods a Member is covered under the Plan. Claims paid prior to January 1, 2017 or services rendered prior to January 1, 2017 will not be considered for repayment under the plan.	

Eligible Orthodontia Expenses

A. Initial consultation, models, X-rays, photographs and other diagnostic services;
B. Initial banding or placement of orthodontic appliance(s);
C. Periodic adjustments; and,
D. Retainers.

If orthodontia services are terminated for any reason before completion of the treatment program, benefits will cease with payment through the end of the month in which such termination occurred.

Orthodontia Pre-Treatment Estimate

A pre-treatment estimate may be required prior to the work being performed. A pre-treatment estimate gives the patient and the orthodontist a good idea of benefit levels, maximums, limitations, etc., that might apply to the treatment program so that the patient's portion of the cost will be known; and, it offers the patient and orthodontist an opportunity to consider other avenues of treatment that might be equally satisfactory and less costly.

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

A pre-treatment estimate is not a guarantee of payment. Payment of plan benefits is subject to plan provisions and eligibility at the time the services are actually incurred. A pre-treatment estimate is only valid for six (6) months from the date the estimate is provided.

GENERAL PLAN EXCLUSIONS

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

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

2. Criminal Activities
Any injury resulting from or occurring during the Covered Member's commission or attempt to commit a felony. This exclusion does not apply if the services resulted from being the victim of an act of domestic violence or a documented physical and mental health condition.

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

4. Excess Charges
Charges for care, supplies, treatment, and/or services that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are more than the Usual and Customary amount; or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document.

5. Experimental/Investigational Treatment
Charges for care, supplies, treatment, and/or services that are Experimental or Investigational.

6. Forms Completion
Charges made for the completion of claim forms. Fees associated with the completing of FMLA forms. Forms for providing supplemental information.

7. Government-Operated Facilities
Services furnished to the Covered Member in any veterans' hospital, military hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments. This exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government hospital to dependents of active duty armed service personnel or armed service retirees and their dependents.

8. Late-Filed Claims
Claims which are not filed with within the required time periods as included in the **Claims Procedures** section.

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

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

11. No Charge/No Legal Requirement to Pay
Services for which no charge is made or for which a Covered Member is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. Where Medicare coverage is involved and this Plan is a "secondary" coverage, this exclusion will apply to those amounts which a Covered Member is not legally required to pay due to Medicare's "limiting charge" amounts.

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

GENERAL PLAN EXCLUSIONS…continued

12. Not Listed Services or Supplies
Any services, care or supplies not specifically listed in the Plan Document as Eligible Expenses are not covered under the Plan.

13. Other Coverage
Services or supplies for which a Covered Member is entitled, or could have been entitled if proper application had been made to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal, State, Dominion or Province or any political subdivision). However, this provision does not apply to Medicare Secondary payor or Medicaid Priority rules. Services or supplies received from a health care department maintained by or on behalf of an employer, mutual benefit association, labor union, trustees or similar Member or group.

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

15. Postage, Shipping, Handling Charges
Postage, shipping or handling charges which may occur in the transmittal of information to the Plan Administrator. Interest or financing charges.

16. Prior to Effective Date/After Termination Date
Charges incurred prior to an individual's effective date of coverage under the Plan or after coverage is terminated.

17. Relative or Resident Care
Any service rendered to a Covered Member by a relative or anyone who customarily lives in the Covered Member's household.

18. Self-Inflicted Injury
Any expenses resulting from voluntary self-inflicted injury or voluntary attempted self-destruction which occurred while sane or insane and regardless of whether the Covered Member was aware of or in control of their actions. This exclusion does not apply where such injury results from a documented physical or mental condition; or, a medical condition resulting from being a victim of an act of domestic violence.

19. Subrogation, Reimbursement, Third Party Responsibility
Charges for care, supplies, treatment and/or services that are of an Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

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

21. Veterans Administration
See "Government-Operated Facilities"

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

23. Work-Related Conditions
Any condition for which the Covered Member has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose. However, if the Plan provides benefits for any such condition, the Plan Sponsor will be entitled to establish a lien upon such other benefits up to the amount paid. Any expenses incurred by a Member whose condition is covered under Workers' Compensation when the Member does not utilize the Work Comp MCO Physicians. Any condition resulting from accidental injury arising during employment for wages or profit, including self-employment.

ELIGIBILITY REQUIREMENTS & EFFECTIVE DATES

Eligibility Requirements - Employees
An Eligible Employee is an employee that may participate in the health coverage of the Plan if active and regularly scheduled to work at least thirty (30) hours per week.

An Employee will be deemed "active" on each day actually performing services for the City of Sparks; or, on each day of a regular paid annual, paid holiday, paid personal day or any other approved leave with pay. An Employee will also be deemed "active" on a day when absent from work during approved FMLA. An exception applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on the first scheduled workday, Employee will not be considered as having commenced active employment.

Those Employees for whom the Employer cannot in good faith determine whether the Employee's hours are expected to average at least thirty (30) hours per week upon hire shall be considered Variable Hour Employees. Variable Hour Employees who average at least thirty (30) hours per week during an established measurement period as defined by the ACA, are eligible for benefits for during the subsequent stability period determined by this Plan Sponsor and in keeping with the rules of the ACA.

Effective Date - Employees
An Eligible Employee's coverage is effective on the first day of the month following date of hire for employment. For Variable Hour Workers who average at least thirty (30) hours per week during the determined measurement period, coverage is effective for the subsequent stability period, subject to an administrative period, if any.

Eligibility Requirements - Retirees
Eligible public employees retiring with the City of Sparks and the State of Nevada Public Employee Retirement System (PERS) may continue health coverage after retirement. A retiree who desires to continue coverage must make the necessary arrangements to pay the established premium to the City. Retirees will be required to enroll in Medicare Part A & B when eligible. See **"Coordination of Benefits"** and **"Effects on Benefits Under this Plan"**.

Effective Date - Retirees
An eligible Retiree's coverage is effective on the first day of the month following date of retirement.

Eligibility Requirements - Dependents
An eligible Dependent of a covered Employee or Retiree is:

A. A legally married spouse. Legally married means a legal union between two (2) people evidenced by a valid state issued marriage license. An eligible Spouse will not include:

   1) A common law spouse
   2) A domestic partner
   3) A spouse following legal separation or a final decree of dissolution or divorce
   4) A spouse eligible for Medicare coverage by reason of age and who has elected Medicare coverage in lieu of Plan coverage

B. A child who is under age 26. A dependent child is eligible to enroll in the Plan if:

   1) A biological child
   2) A legal stepchild
   3) A legally adopted child of the Covered Member and Member has a legal obligation for total or partial support of the child
   4) A child placed for legal guardianship with the Covered Member or placed for adoption prior to age 18. The Covered Member must have a legal obligation for total or partial support of the child; and, the legal process must have begun. Eligibility ends when the legal support obligation ends
   5) A child for whom the Covered Member or Covered Spouse is required to provide coverage due to a Medical Child Support Order (MCSO) and determined to be a Qualified Medical Child Support Order (QMCSO) by the Plan. A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and having the force and effect of state law.

An eligible Child does not need to:

A. Reside with the Covered Member
B. Be a student
C. Be a tax-code Dependent of the Covered Member or financially dependent on the Covered Member
D. Be unmarried
E. Be unemployed

A Dependent does not include any Member:

A. Who is on active duty in a military service, to the extent permitted by law;
B. Who is eligible and has enrolled as an Employee under the Plan;
C. Who is covered as a Dependent of another Employee under the Plan.

Proof of Dependent Status
Specific documentation to substantiate Dependent status will be required at time of enrollment or eligibility. Further, this documentation may be requested at any time to substantiate Dependent status. Proof of Dependent status may include any of the following:

A. Marriage Certificate - a copy of the certified marriage certificate or valid state marriage license;
B. Birth Certificate - a copy of the certified birth certificate;
C. Adoption Decree - a copy of the court order signed by the judge. Final adoption decree and/or birth record must be submitted to the Plan within thirty-one (31) days of issuance;
D. Legal Guardianship Order - a copy of the legal guardianship court order, signed by the judge, and a copy of the certified birth certificate;
E. Qualified Medical Child Support Order – which may include but is not limited to a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and having the force and effect of state law.

Effective Date - Dependents
A Dependent who is eligible and enrolled when the Employee or Retiree enrolls, will have coverage effective on the same date as the Employee or Retiree. Otherwise, a Dependent can be enrolled only in accordance with the "**Open Enrollment**" provision.

Dependents acquired later may be enrolled within thirty-one (31) days of their eligibility date and coverage will be effective as of their date of eligibility. See "**Special Enrollment Rights**" and "**Qualifying Life Events**".

Newborn Children - Limited Automatic 31-Day Benefit Period
NRS 689B.033 requires that the Plan provide coverage to a child of the Covered Member for eligible expenses of injury or sickness within 31 days after the moment of birth; or an adopted child from the date the adoption becomes effective, if the child was not placed in the home before adoption and a child placed with the Covered Member for adoption from the moment of placement as certified by the public or private agency making the placement.

This coverage includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, within the limits of the Plan, necessary transportation costs from place of birth to the nearest specialized treatment center.

During the limited 31-day benefit period, a newborn child is not a covered Dependent. Any extended coverage periods or coverage continuation options which are available to covered Dependents will not apply to a newborn child who is provided with these thirty-one (31) days of limited benefits and who is not enrolled within such 31-day period.

Beyond the 31-day period, coverage for the child will be available only if the Eligible Employee or Eligible Retiree is enrolled and completed the required forms within thirty-one (31) days after the child's birth, date of adoption or placement of adoption.

ENROLLMENT RIGHTS

Employees and Eligible Dependents
If an active Employee or Eligible Dependent is not enrolled when first eligible or if coverage is allowed to lapse, they may later enroll during an Annual Open Enrollment period. Plan coverage will be effective on the first day of the Plan Year.

Retirees and Eligible Dependents
Per NRS 287, a public Employee has the right to continue health coverage after retirement. A retiree who desires to continue coverage must make the necessary arrangements with the Plan Sponsor's Human Resources Department for payment of the established premium for such coverage. A Retiree's coverage is effective on the first day of the month following date of retirement.

If an eligible Dependent of an enrolled Retiree, is not enrolled when first eligible or if coverage is allowed to lapse, they may later enroll during an Annual Open Enrollment period. Plan coverage will be effective on the first day of the of the Plan Year.

When a retiree is eligible for Medicare, the retiree is required to enroll in Medicare Part A & B. Retiree's contribution may be reduced and benefits will be coordinated with Medicare benefits. See **Coordination of Benefits**.

If not enrolled at the time of retirement, a retiree can make application to come back to the plan pursuant to NRS 287. Retirees wishing to enroll outside of the provisions of NRS 287 must meet criteria established under Special Enrollment Rights.

Special Open Enrollment
The Plan, at its discretion, may hold a Special Open Enrollment period to meet any necessary business needs. Coverage will be effective the first day of the calendar month following the Special Open Enrollment period.

Qualifying Life Event - Acquiring New Dependent
If an Employee acquires an eligible Dependent through a qualifying life event, the Employee may apply for Dependent coverage if made within thirty-one (31) days of the date the new Dependent is acquired. For purposes of this Plan, a Qualifying Life Event for acquiring a new Dependent is:

A. Marriage.
B. Acquiring step-Child through Marriage.
C. Birth of a Child.
D. Adoption of a Child.
E. Placement of legal guardianship for a Child.
F. Court or Agency Ordered Coverage.

Eligibility Dates for Acquiring New Dependent
Dependents must be enrolled within thirty-one (31) days of their eligibility date and coverage will be effective as of their date of eligibility provided the Plan receives completed enrollment documentation and proof of Dependent status. For a newly-acquired Dependent to be enrolled under the terms of this provision, the Employee must be enrolled or must be eligible to enroll and must enroll concurrently. However, other Dependent children who were not enrolled when first eligible and are not considered to be newly acquired through a Qualifying Life Event, can only be enrolled in accordance with other enrollment allowances of the Plan.

If an Employee or an Employee's spouse is required to provide coverage for a child under a Medical Child Support Order, coverage for the child shall be effective as of the date specified in such order provided the Plan receives the completed enrollment documentation, proof of Dependent status and the request is made within 31 days from the date such order is determined to be qualified (QMCSO). A request to enroll the child may also be made by a State Agency on the child's behalf.

Reinstatement after an Approved Leave of Absence
If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines and FMLA, and during the leave Employee discontinued paying the required share of the cost of coverage causing coverage to terminate, such Employee and eligible Dependents may have coverage reinstated if Employee requests coverage be restored before approved FMLA expires. No waiting period requirement will be applied.

Reinstatement after Military Service
In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), eligible Employees who return to employment following active duty service as a member of the United States armed forces, will be reinstated to coverage under the Plan immediately upon returning from military service.

Reinstatement after City Layoff
If a previous Eligible Employee of the City returns to active employment within 24 months from being laid off from the City, that Employee and any covered dependents will not be subject to the waiting period requirements.

Transfer of Coverage
If legally married spouses are both Employees covered under this Plan and one employee terminates, the terminating spouse and any eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such new coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the Member was entitled while enrolled as the Employee or the Dependent of the terminated Employee. Transfer is not automatic. The remaining Employee must complete new enrollment forms for coverage to transfer and continue.

Special Enrollment Rights Due to Loss of Other Coverage
An individual who did not enroll in the Plan when eligible, will be allowed to apply for coverage later if the individual:

A. Was covered under another group health plan or other health insurance coverage (including Medicaid) at the time coverage was initially offered or available. "Health insurance coverage" means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;
B. Stated in writing at the time enrollment was offered or available, that other coverage was the reason for declining enrollment in the Plan. However, this only applies if the Plan Sponsor required such a written statement and provided the Member with notice of the requirement and the consequences of failure to comply with the requirement;
C. Lost the other coverage because of a certain event and the Employee requested Plan enrollment within thirty (31) days of termination of the other coverage. A loss of coverage event includes but is not limited to:

    1) Loss of eligibility because of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in number of hours of employment;
    2) Loss of eligibility when coverage is offered through an HMO or other arrangement in the market that does not provide benefits to individuals who no longer reside, live or work (whether or not within the choice of the individual); and no other benefit package is available to the individual;
    3) Loss of eligibility when an individual incurs a claim that would meet or exceed a lifetime limit on all benefits. An individual has a special enrollment right when a claim that would exceed a lifetime limit on all benefits is incurred, and the right continues at least until thirty (30) days after the earliest date that a claim is denied due to the operation of the lifetime limit;
    4) Loss of eligibility when a plan no longer offers any benefits to a class of similarly situated individuals. For example, if a plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility, even if the plan continues to provide coverage to other employees;
    5) Loss of eligibility when employer contributions toward the employee's or dependent's coverage terminates. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer;
    6) Loss of eligibility when COBRA continuation coverage is exhausted.

If the above conditions are met, Plan coverage will be effective on the first day of the first calendar month that begins after the date on which the Plan received the completed application.

TERMINATION OF COVERAGE

Termination of Coverage - Employee
Except as noted, an Employee's coverage under the Plan will terminate upon the earliest of the following:

A. Termination of the Plan;
B. At midnight on the last day of the month in which the covered Employee leaves or is dismissed from employment; or, ceases to be engaged in active employment for the required number of hours as specified in the **Eligibility and Effective Dates** and under the terms of any **Extension of Coverage** provision.

An eligible Employee validly enrolled under the Plan shall not be terminated from the Plan solely due to health status or need for health services.

Termination of Coverage - Retiree
Except as noted, an Employee's coverage under the Plan will terminate upon the earliest of the following:

A. Termination of the Plan;
B. At midnight on the last day of the month in which the covered Retiree fails to pay the required premium for such coverage.

An eligible Retiree validly enrolled under the Plan shall not be terminated from the Plan solely due to health status or need for health services.

Termination of Coverage – Eligible Dependents
Except as noted, a Dependent's coverage under the Plan will terminate upon the earliest of the following:

A. Termination of the Plan or Dependent coverage under the Plan;
B. Termination of the coverage of the Employee;
C. At midnight on the last day of the month in which the Dependent ceases to meet the eligibility requirements of the Plan, except when coverage is extended under any **Extension of Coverage** provision.
D. The date in which the placement of a legal guardian is disrupted prior to legal adoption and the child is removed from placement with the Employee;
E. The end of the period for which the Employee last made the required premium for such coverage, if Dependent's coverage is provided on a contributory basis. However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has replacement coverage which will take effect immediately upon termination.

An eligible Dependent validly enrolled under the Plan shall not be terminated from the Plan solely due to health status or need for health services.

EXTENSIONS OF COVERAGE

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

Extension of Coverage for Handicapped Dependent Children
If an already covered Dependent child is incapable of self-sustaining employment because of mental retardation, cerebral palsy, epilepsy, other neurological disorder or physical handicap, and:

A. Such condition commenced on or before the child attained the age that would otherwise terminate his eligibility; and,
B. The child's condition has been diagnosed by a Physician as a permanent or long-term dysfunction or condition; and
C. Such child is primarily dependent upon the Employee for support and maintenance,

then such child's status as a "Dependent" will not terminate solely due to attaining the limiting age and will continue to be considered a covered Dependent under the Plan so long as such condition continues, and otherwise conforms with the eligibility of a Dependent.

The Employee must submit proof of the child's incapacity within thirty-one (31) days of the child's attainment of the limiting age, and thereafter as may reasonably be required, but not more frequently than once a year after the two-year period following the child's attainment of such age.

Absence from Work
If an Employee fails to continue active employment but is not terminated from employment due to an approved leave or a temporary layoff, the Employee may be permitted to continue health coverage for themselves and Dependents. The Employee may be required to pay the full cost of coverage during such absence. Such extended coverage will be provided on a non-discriminatory basis.

Except when FMLA may apply, any coverage which is extended under the terms of this provision will automatically and immediately cease on the earliest of the following:

A. The date coverage terminates as specified in other Employer's personnel policies or other employee communications;
B. The end of the period for which the last contribution was paid, if such contribution is required;
C. The date of termination of this Plan.

Family Medical Leave Act (FMLA)
To the extent that the Employer is subject to FMLA, it intends to comply with the Act. Plan benefits may be maintained during FMLA at the levels and under the conditions that would have been present if employment was continuous. An Employee can obtain a complete description of FMLA rights from the Plan Sponsor's Human Resources Department. Any Plan provisions that are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

US Military Service
Regardless of an Employer's established termination or leave of absence policies, the Plan will always comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

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

To be protected by USERRA and to continue health coverage, an Employee must generally provide the Employer with advance notice of military service. An Employee can obtain a complete description of Military Service and notice requirements from the Human Resources Department as stated in the City's Policy. Any Plan provisions that are found to conflict with USERRA will be modified to comply with at least the minimum requirements of the Act.

EXTENSIONS OF COVERAGE…continued

If the Employee provides the Employer with advance notice of his military service but fails to elect continuation of coverage under USERRA, the Plan Administrator will continue coverage for the first thirty (31) days after Employee's departure from employment due to active military service. The Plan Administrator will terminate coverage if Employee's notice to elect coverage is not received by the end of the 31-day period. If the Employee subsequently elects to continue coverage while on active military service and within the time set forth in the subsection entitled "Maximum Period of Coverage" below, then the Employee will be retroactively reinstated in the Plan as of the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premium charges from the date Plan coverage terminated.

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

The maximum period of USERRA continuation coverage is the lesser of 24 months; or, the duration of Employee's active military service.

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

A. On the first full business day following completion of military service for military leave of 31 days or less; or
B. Within 14 days of completion of military service for military leave of 32-180 days; or,
C. Within 90 days of completion of military service for military leave of more than 180 days.

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

Retirees

If not enrolled at the time of retirement, pursuant to NRS 287 a Retiree or Surviving Spouse can make application to come back to the Plan if:

A. The City is notified of the intent to reinstate coverage no later than January 31st of an even-numbered year;
B. The City was the Employee's last State of Nevada public employer;
C. The enrollee accepts the City's current Plan;
D. The enrollee pays the current coverage cost in a timely manner;

Life insurance will not be made available. A retiree who desires to return to the Plan, must make the necessary arrangements to pay the established premium to the City. Retirees will be required to enroll in Medicare Part A & B when eligible. See **"Coordination of Benefits"** and **"Effects on Benefits Under this Plan"**.

Retirees wishing to enroll outside of the provisions of NRS 287 must meet criteria established under Special Enrollment Rights.

Surviving Dependents – Public Safety

Per NRS 287, the surviving spouse and any surviving child of a police officer or fire fighter killed in the line of duty may elect to continue Plan coverage. The entire cost of such coverage will be paid by the City. Coverage under the terms of this provision will continue for the surviving spouse, until their death; and, for a surviving child, until the child ceases meet the eligibility requirements.

COBRA CONTINUATION OF COVERAGE

To comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, which is available to certain Covered Members whose health care coverage under the Plan would otherwise terminate. This provision is intended to comply with that law, and if it is found to be incomplete or in conflict in any way with the law or changes to the law, the law will prevail. Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits are not eligible for continuation under COBRA.

If retired Employees are eligible and covered under the Plan, such retirees are also "Employees" for purposes of COBRA continuation coverage. Also, certain additional COBRA rights apply to such retirees and their covered Dependents with regard to an Employer's bankruptcy. Anywhere "retirees" are referenced herein, it means only those retired Employees who were covered under the Plan.

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

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

Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverage's the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

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

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

A. Voluntary or involuntary termination of Employee's employment for any reason other than Employee's gross misconduct;
B. Reduction in hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his portion of the cost of Plan coverage during the FMLA leave;
C. For an Employee's spouse or child, Employee's entitlement to Medicare. For COBRA, "entitlement" means the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that Medicare coverage is in effect;
D. For an Employee's spouse or child, the divorce or legal separation of the Employee and spouse;
E. For an Employee's spouse or child, the death of the covered Employee;
F. For an Employee's child, the child's loss of Dependent status;
G. For retirees and Dependent spouses and children, loss of Plan coverage due to the Employer's filing of a bankruptcy proceeding under Title 11 of the US Bankruptcy Code. In order for a Qualifying Event to occur, the Employee must have retired on or before the date of substantial elimination of the Plan's benefits and must be covered under the Plan on the day before the bankruptcy proceedings begin. "Substantial elimination" of the Plan's benefits must occur within 12 months before or after the bankruptcy proceedings begin.

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

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

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

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

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is a Dependent child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the Employee from their spouse. A Qualified Beneficiary is also responsible for other notifications. Upon receipt of a notice, the Plan Administrator must notify the Qualified Beneficiary of their continuation rights within 14 days.

COBRA Notification Procedures
It is the Plan Member's responsibility to provide the following Notices as they relate to COBRA Continuation Coverage:

A. Notice of Divorce or Separation - Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a covered Employee from legal spouse.
B. Notice of Child's Loss of Dependent Status - Notice of a Qualifying Event that is a child's loss of Dependent status under the Plan (e.g., a Dependent reaches maximum age limit).
C. Notice of a Second Qualifying Event - Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months.
D. Notice Regarding Disability - Notice that: a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage; or, a Qualified Beneficiary as described herein has subsequently been determined by the Social Security Administration to no longer be disabled.
E. Notice Regarding Address Changes - It is important that the Plan Administrator be kept informed of the current addresses of all Plan participants or beneficiaries who are or may become Qualified Beneficiaries.

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

Form or Means of Notification
Notification of the Qualifying Event must be provided to and received by the City of Sparks Human Resources. Notification must include any official documentation showing evidence that a Qualifying Event has occurred such as a copy of a divorce decree, a child's birth certificate, a copy of the Social Security Administration's disability determination, etc.

Time Requirements for Notification
In the case of a divorce, legal separation or a child losing dependent status, Notice must be delivered within 60 days from the later of: the date of the Qualifying Event; the date health plan coverage is lost due to the event; or, the date the Qualified Beneficiary is notified of the obligation to provide Notice through the Plan Sponsor's General COBRA Notice. If Notice is not received within the 60-day period, COBRA Continuation Coverage will not be available, except in the case of a loss of coverage due to foreign competition where a second COBRA election period may be available.

If an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, Notice must be delivered within 60 days from the later of: the date of the determination; the date of the Qualifying event; the date coverage is lost as a result of the Qualifying Event; or, the date the covered Employee or Qualified Beneficiary is advised of the Notice obligation through the SPD or the Plan Sponsor's General COBRA Notice. Notice must be provided within the 18-month COBRA coverage period.

Any such Qualified Beneficiary must also provide Notice within 30 days of the date he is subsequently determined by the Social Security Administration to no longer be disabled.

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

Election and Election Period
COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children. An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. If a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Plan Administrator.

Open enrollment rights which allow Non-COBRA Beneficiaries to choose among available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of HIPAA extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA. The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period. See the "Effect of the Trade Act" provision for information regarding a second 60-day election period allowance.

Effective Date of Coverage
COBRA continuation coverage, if elected within the period allowed, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period. See "Election and Election Period" for an exception when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

Level of Benefits
COBRA continuation coverage will be equivalent to coverage provided to similarly situated Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated Non-COBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to their deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

Cost of Continuation Coverage
The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the Employer for Non-COBRA Beneficiaries.

The initial premium payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary.

Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or date a COBRA waiver was revoked, if applicable).

Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Payment is considered to be made on the date it is sent to the Plan or Plan Sponsor. The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase if:

A. The cost previously charged was less than the maximum permitted by law;
B. The increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law which is 150% of the Plan's total cost of coverage; or,
C. The Qualified Beneficiary changes coverage options which results in a different coverage cost.

Timely payments which are not significantly less than the required amount are deemed to satisfy the Plan's payment requirement, unless the Plan notifies the Qualified Beneficiary of the deficiency and grants a reasonable period of time to make full payment.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically-indigent or due to a certain disability.

The Employer's Human Resources offices should be contacted for additional information. See the "Effect of the Trade Act" provision for additional cost of coverage information.

Maximum Coverage Periods
The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

A. If the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the Qualifying Event. With a disability extension the 18 months is extended to 29 months;
B. If the Qualifying Event occurs to a Dependent due to Employee's enrollment in the Medicare program before the Employee himself experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare;
C. In the case of a bankruptcy Qualifying Event with regard to a retiree, the maximum coverage period is to the date of the retired Employee's death. The maximum coverage period for a Qualified Beneficiary who is the spouse, surviving spouse or Dependent child of the retired Employee ends on the earlier of: (1) 36 months after the death of the retired Employee, or (2) the date of the Qualified Beneficiary's death;
D. For any other Qualifying Event, the maximum coverage period ends 36 months after the loss of coverage.

If a Qualifying Event occurs which provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment or a bankruptcy of the Plan Sponsor following any Qualifying Event will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period more than 36 months after the date of the first Qualifying Event, except in the case of a bankruptcy Qualifying Event with regard to a retiree where the maximum coverage period is to the date of the retired Employee's death.

COBRA entitlement runs concurrently with continuation of coverage under USERRA and does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

Disability Extension
An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the Qualifying Event or at any time during the first 60 days thereafter. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date which falls within the allowable periods described. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his or her family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled. If an individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period.

Termination of Continuation Coverage
Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of loss of coverage due to the Qualifying Event and ending on the earliest of the following dates:

A. The last day of the applicable maximum coverage period - see "Maximum Coverage Periods" above;
B. The date on which the Employer ceases to provide any group health plan to any Employee;
C. The date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain an exclusion or limitation with respect to any pre-existing condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary;
D. The date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his or her Medicare coverage is in effect;

E. in the case of a Qualified Beneficiary entitled to a disability extension, the later of:
   1) 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
   2) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;
   3) the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan can terminate, for cause, coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated Non-COBRA Beneficiaries for cause. If receiving COBRA coverage solely because of the Member's relationship to a Qualified Beneficiary, the Plan's obligation to make COBRA coverage available will cease when the Plan is no longer obligated to make coverage available to the Qualified Beneficiary.

Effect of the Trade Act

In response to Public Law 107-210, referred to as the Trade Act of 2002 ("TAA"), the Plan is deemed to be "Qualified Health Insurance" pursuant to TAA, the Plan provides COBRA coverage in the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, as amended.

Eligible Individuals - The Plan Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation ("PBGC"), pursuant to TAA as of or after November 4, 2002. The Plan Administrator shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement, federal income tax filings, etc. The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

Temporary Extension of COBRA Election Period Definitions

A. Non-electing TAA-Eligible Individual - A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA continuation coverage during the TAA-Related Election Period.
B. TAA-Eligible Individual - An eligible TAA recipient and an eligible alternative TAA recipient.
C. TAA-Related Election Period - with respect to a TAA-related loss of coverage, the 60-day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual.
D. TAA-Related Loss of Coverage - means, with respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

In the case of an otherwise COBRA Qualified Beneficiary who is a Non-electing TAA-Eligible Individual, such individual may elect COBRA coverage during the TAA-Related Election Period, but only if such election is made not later than 6 months after the date of the TAA-Related Loss of Coverage. Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period, and shall not include any period prior to the such individual's TAA-Related Election Period.

With respect to any TAA-Eligible Individual who elects COBRA as a Non-electing TAA Individual, the period beginning on the date the TAA-Related Loss of Coverage, and ending on the first day of the TAA-Related Election Period shall be disregarded for purposes of determining the 63-day break-in-coverage period pursuant to HIPAA rules regarding determination of prior creditable coverage.

Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA-Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in IRS regulations 54.4980B-8, A-5(d), the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.

CLAIMS PROCEDURES

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

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

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

Timely Filing of Claims
Except for Pre-Service claims, proof of loss for claim must be submitted to the claims office within twelve (12) months after the date a service is rendered. The 12-month time limit applies to an original claim submission and to any adjustments or re-processing requests on a previously-submitted claim. It is the Claimant's responsibility for timely submission of claims. Failure to furnish proof within the time required will not invalidate nor reduce a claim if it can be shown that it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as possible. Claims should be submitted to:

Hometown Health
830 Harvard Way
Reno, NV 89502

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

A Pre-Service Claim
A pre-service claim is a written or oral request for Inpatient Hospital benefits where the terms of the Plan condition benefits, in whole or in part, on prior approval of the proposed care (e.g., a utilization review requirement). See the Utilization Management Program section for that information. A Pre-Service Claim should be submitted to:

Hometown Health
830 Harvard Way
Reno, NV 89502

A Pre-Service Claim is to assess the Medical Necessity and appropriateness of care and delivery setting. A determination on a Pre-Service Claim is not a guarantee of benefits from the Plan. Plan benefit payments are subject to review upon submission of a claim to the Plan after medical services have been received and are subject to all related Plan provisions, including exclusions and limitations.

A Post-Service Claim
A post service claim is a written request for benefit determination after a service has been rendered and expense has been incurred. A Post-Service Claim must be submitted to the claims office within twelve (12) months after the date a service is rendered. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it can be shown that it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible. In accordance with federal law, the Centers for Medicare and Medicaid Services (CMS) have one (1) year to submit claims when CMS has paid as the primary plan and the Plan should have been primary. A Post-Service Claim should be submitted to:

Hometown Health
830 Harvard Way
Reno, NV 89502

Recovery of Payments
Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid per the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan, may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the Member or entity who received such payment and/or from other payers and/or the Covered Member or Dependent on whose behalf such payment was made.

A Covered Member, Dependent, Provider, another benefit plan, insurer, or any other Member or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The Member or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Member or entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of claims for benefits by the Covered Member and to deny or reduce future benefits payable (including payment for other injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan may also, in its sole discretion, deny or reduce future benefits (including payment for other injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other Member or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer.

Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within thirty (30) days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Member, Provider or other Member or entity to enforce the provisions of this section, then that Covered Member, Provider or other Member or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Covered Members and/or their Dependents, beneficiaries, estate, heirs, guardian, representative, or assigns (Covered Members) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Covered Member(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

A. In error;
B. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
C. Pursuant to a misstatement made to obtain coverage under this Plan within two (2) years after the date such coverage commences;
D. With respect to an ineligible Member;
E. In anticipation of obtaining a recovery if a Covered Member fails to comply with the Plan's Third Party Recovery, subrogation and reimbursement provisions; or,
F. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Covered Member or by any of his covered Dependents if such payment is made with respect to the Covered Member or any Member covered or asserting coverage as a Dependent of the Covered Member.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Member for any outstanding amount(s).

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

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

Benefit payments on behalf of a Covered Member who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Member, as created by an assignment of rights made by the Covered Member or his beneficiary as may be required by the state Medicaid plan.

Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable under the Plan.

CLAIMS DENIALS & APPEALS

The Plan shall provide adequate notice in writing to any Claimant whose claims for benefits under this Plan have been denied, written in a manner calculated to be understood by the Claimant, including:

A. The specific reason for the denial;
B. Specific reference to Plan provisions on which the denial is based;
C. Any additional material or information for further review of the claim; and
D. An explanation of the Plan's review procedure.

Further, the Plan shall afford a reasonable opportunity to any Claimant whose claim for benefits has been denied for a full and fair review of the decision denying the claim by the Member designated by the Employer for that purpose.

Appeal Procedures
If any type of eligible service as listed in this Plan Document has been denied in whole or in part by the Plan Administrator, the Claimant may appeal the determination of that claim under the lowest review level indicated below. If the denial is upheld, Claimant may appeal to the next highest level of review. This may be repeated until the entire appeals process has been exhausted.

Appeal Level I - Review of the Claim by the Plan Administrator
The Claimant may submit an appeal letter to the Plan Administrator within 180 days of the notice of denial from the Plan Administrator. The Claimant shall have an opportunity to present additional information and/or documentation to support the appeal. The Plan Administrator will review the claim for appropriateness based on the Plan Document and, if needed for medical interpretation or clarification, request a Physician review. Appeal letter and additional information and/or documentation must be submitted to:

Plan Administrator - Hometown Health
ATTN: Claims Manager
830 Harvard Way
Reno, NV 89502

A decision will be rendered within 60 days of receipt of the appeal letter and the Plan Administrator will notify, in writing, the City and the Claimant of the findings.

Appeal Level II - External Review
If after Level I, the Claimant is dissatisfied with the Plan Administrator's decision, the Claimant may submit a written appeal for an external review process. This step is not mandatory. If Plan Administrator based a denial, reduction, termination, or refusal to provide payment on a determination that an individual is not eligible under the Plan, no external review is available.

An independent third party with clinical and legal expertise and with no financial or personal conflicts with the Plan Sponsor or Plan Administrator will conduct all external reviews. The reviewer will not defer to the decisions made during the internal review process and will look at Claimant's claim anew. The reviewer will consider all the information and documents that it receives in a timely manner when making its decision.

Before the Claimant may submit a claim to the external review process, Claimant must first follow the claims procedures outlined above by filing an initial claim and a request for review of an adverse benefit determination to the Plan Administrator. Within 120 days of the date Claimant receives an adverse benefit determination from the Plan Administrator, Claimant or Claimant's authorized representative may file a request for external review. The request must be submitted to:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Phone: 1-888-866-6205 Fax: 1-888-866-6190

The Plan Administrator or the independent review organization will provide written notice of the final external review decision within 45 days after it receives the request for external review. If the independent review organization reverses the Plan Administrator's denial of Claimant's claim, the decision will be considered final and binding.

Claimant or Claimant's authorized representative may make a written or oral request for an expedited external review to the external review examiner if Claimant had filed a request for expedited appeal of an Urgent Care claim and Claimant had received an adverse benefit determination and Claimant had a medical condition where the time for completing the internal review process would seriously jeopardize Claimant's life, health or ability to regain maximum function; or, the adverse benefit determination concerns the admission, availability of care, continued stay, or health care item or service for which Claimant received services, but Claimant had not been discharged from a facility.

Claimant can initiate an expedited external review by calling Center for Consumer Information and Insurance Oversight (CCIIO), Centers for Medicare and Medicaid Services (CMS) at 877-549-8152. If the examiner determines that Claimant is not entitled to an expedited internal review, the examiner will notify both Claimant and Contract Administrator as expeditiously as possible.

Appeal Level III – Arbitration

If any dispute or controversy pertaining to the processing of a claim arises between the Plan and its agents and the Claimant or their agents and said dispute or controversy is not settled after completing Levels I and II, the dispute shall be settled by binding arbitration before an arbitrator selected from a panel of arbitrators of the American Arbitration Association in accordance with the Arbitration Rules of the American Arbitration Association, and a judgment upon the award entered in any court having jurisdiction. The Claimant is responsible for filing the necessary forms and filing fee with the American Arbitration Association within 60 days of the Level II decision. Arbitration costs shall be shared equally by the Claimant and the Plan. Claimant must submit a copy of the paid filing fee to the address below to receive reimbursement.

City of Sparks Human Resources Department
431 Prater Way
Sparks, NV 89431

If the Arbitrator reverses or upholds the Plan Administrator's original denial of Claimant's claim, the decision will be considered final and binding.

PRECERTIFICATION/PRIOR AUTHORIZATION APPEALS

If the precertification/prior authorization of a service or procedure has not been approved by the Utilization Management Organization and the service or procedure has not yet been rendered, a Claimant may appeal the determination under the lowest review level indicated below. If the determination is upheld, Claimant may appeal to the next highest level of review. This may be repeated until the entire appeals process has been exhausted. For services or procedure already rendered, Claimant will need to follow the "Claims Appeals" procedures outlined above.

Level I - Review of the Claim by the Utilization Management Organization
The Claimant may submit an appeal letter referencing the determination to the Utilization Management Organization. The Claimant shall have this opportunity to present additional information and/or documentation supporting this appeal. The Medical Director will review the information to determine medical necessity. Appeal letter and additional information and/or documentation must be submitted within 30 days of the original determination to:

Hometown Health
830 Harvard Way
Reno, NV 89502
(775) 982-4150

The Medical Director will render a decision within thirty (30) days of the date the appeal letter was received and will notify, in writing, the Plan Sponsor and Claimant of his findings. No deference will be given to the initial adverse benefit determination. Your Appeal will be decided by an individual(s) who did not take part in the initial adverse benefit determination and who is not subordinate of such a Member. If we receive insufficient information to decide your Appeal, we will notify you as soon as possible, but not later than 72 hours after receipt of the Appeal, of the specific information necessary to complete the Appeal. You will have a reasonable amount of time, considering the circumstances, but not less than 48 hours, to provide the specified information.

If your Appeal is denied, you will receive written (or electronic as permitted by law) notice, including the specific reasons, reference to the specific Plan provisions, and you may have access to all records that were used in reaching the decision. If any internal rule, guideline, protocol or other similar criterion was used in the Appeal denial, you will be told about it and may have a copy of it. If the denial is based on an analysis of Medical Necessity or Experimental treatment or the like, you may have a copy of whatever scientific or clinical explanation was used in the determination. You will also receive, free of charge, any new or additional rationale and/or evidence considered, relied on or generated by the Plan (or at the direction of the Plan) in connection with your Claim. You will receive this rationale and/or evidence sufficiently in advance of the date on which the notice of the Adverse Benefit Determination is required to give you a reasonable opportunity to respond prior to that date.

Level II: External Review of The Pre-Certification Denial
If, upon Level I denial, coverage is rescinded or claim is denied for benefits based all or in part on a medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), and Claimant disagrees with Plan Administrator decision, Claimant or Claimant's authorized representative may submit Claimant's preauthorization request to the external review process described below. This step is not mandatory. If Plan Administrator bases a denial, reduction, termination, or refusal to provide payment on a determination that an individual is not eligible under the Plan, no external review is available. Before Claimant may submit preauthorization request to the external review process, Claimant must first follow the claims procedures outlined above by filing an initial claim and a request for review of an adverse benefit determination to Plan Administrator.

Within 120 days of the date Claimant receives an adverse benefit determination or final internal adverse benefit determination, Claimant or Claimant's authorized representative may file a request for external review. The request should be sent to:

MAXIMUS Federal Services
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534
Phone: 1-888-866-6205 Fax: 1-888-866-6190

Your written request to the external review board should include:

- A specific request for an external review;
- Your name (or name of you and your Authorized Representative), address, and telephone number
- The service that was denied; and,
- Any new, relevant information that was not provided during the internal Appeal.

The entire External Review process and any associated medical records are confidential.

Plan Administrator or the independent review organization will provide written notice of the final external review decision within 45 days after it receives the request for external review.

If the independent review organization reverses Plan Administrator's denial of Claimant's claim, the decision will be considered final and binding.

Claimant or Claimant's authorized representative may make a written or oral request for an expedited external review to the external review examiner if Claimant has filed a request for expedited appeal of an Urgent Care claim and Claimant has received an adverse benefit determination and Claimant has a medical condition where the time for completing the internal review process would seriously jeopardize Claimant's life, health or ability to regain maximum function; or, the adverse benefit determination concerns the admission, availability of care, continued stay, or health care item or service for which Claimant received services, but Claimant has not been discharged from a facility.

Claimant can initiate an expedited external review by calling Center for Consumer Information and Insurance Oversight (CCIIO), Centers for Medicare and Medicaid Services (CMS) at 877-549-8152. If the examiner determines that Claimant is not entitled to an expedited internal review, the examiner will notify both Claimant and Contract Administrator as expeditiously as possible. An independent third party with clinical and legal expertise and with no financial or personal conflicts with Plan Administrator will conduct all external reviews. The reviewer will not defer to the decisions made during the internal review process and will look at Claimant's claim anew. The reviewer will consider all the information and documents that it receives in a timely manner when making its decision.

Level III – Arbitration
As a condition precedent to the right of action under the Plan, if any dispute or controversy pertaining to the processing of a claim shall arise between the Plan and its agents and the Claimant or his/her agents and said dispute or controversy is not settled after completing Levels I and II above, the dispute or controversy shall be settled by binding arbitration before one arbitrator selected from a panel of arbitrators of the American Arbitration Association in accordance with the Arbitration Rules of the American Arbitration Association, and a judgment upon the award entered in any court having jurisdiction. The Claimant is responsible for filing the necessary forms and filing fee with the American Arbitration Association within 60 days of the Level II decision. Arbitration costs shall be shared equally by the Claimant and the Plan. Claimant must submit a copy of the paid filing fee to the address below to receive reimbursement.

City of Sparks
Attn: Human Resources Department
431 Prater Way
Sparks, NV 89431

COORDINATION OF BENEFITS (COB)

Benefits provided under the Plan are subject to Coordination of Benefits as described below, unless specifically stated otherwise.

Other Plan
Any of the following that provides benefits or services for health care services:

A. Group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured). A "closed panel plan" is a plan that, except in an emergency, provides coverage only in the form of services obtained through a panel of providers that have contracted with or are employed by the plan;
B. Medical benefits under automobile and/or homeowner's insurance; and,
C. Medicare or other governmental benefits, as permitted by law.

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

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

This Plan
The coverages of this Plan.

Allowable Expense
The Usual and Customary charge for any Medically Necessary, Reasonable and eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations Section, herein, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

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

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

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

Facility of Payment
A payment made under an Other Plan may include an amount that should have been paid under This Plan. If it does, the Plan Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Plan will not have to pay that amount again.

COORDINATION OF BENEFITS (COB)…continued

Right of Recovery
In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the Maximum Amount of payment necessary at that time to satisfy the intent of this Article the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any Member to or with respect to whom such payments were made, or such Member's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Covered Member Dependents. Please see the Recovery of Payments provision for more details.

Effect on Benefits under This Plan
If Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be "primary" and This Plan will pay its benefits AFTER such Other Plan(s). This Plan's liability will be the lesser of: (1) its normal liability or (2) total Allowable Expenses minus benefits paid by the Other Plan(s).

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

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

Medicare as "Other Plan"
Medicare will be the primary, secondary or last payer in accordance with federal law. When Medicare is the primary payer, this Plan will determine its benefits based on Medicare Part A and Part B benefits that would have been paid or payable, regardless of whether the Member was enrolled for such benefits.

Failure to enroll in Medicare Part A and Part B when eligible will result in payment of 20% of allowable expenses under this Plan.

ORDER OF BENEFIT DETERMINATION RULES

Whether This Plan is the "primary" plan or a "secondary" plan is determined in accordance with the following rules. The first of the following rules that describes which pays its benefits first is the rule that will be used.

Application to Benefit Determinations
The plan that pays first per the rules in the section entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated based on a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan Deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under Persona Injury Protection (PIP) coverage with the automobile insurance carrier. In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

A. The Other Plan would, per its rules, determine its benefits after the benefits of this Plan have been determined; and
B. The rules in the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

Order of Benefit Determination
For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

A. A plan without a coordinating provision will always be the primary plan;
B. The benefits of a plan which covers the Member on whose expenses claim is based, other than as a Dependent, shall be determined before the benefits of a plan which covers such Member as a Dependent;
C. If the Member for whom claim is made is a Dependent Child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:

    1) When the parents are separated, or divorced, and the parent with the custody of the Child has not remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody will be determined before the benefits of a plan which covers the Child as a Dependent of the parent without custody; or,
    2) When the parents are divorced and the parent with custody of the Child has remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody shall be determined before the benefits of a plan which covers that Child as a Dependent of the stepparent, and the benefits of a plan which covers that Child as a Dependent of the stepparent will be determined before the benefits of a plan which covers that Child as a Dependent of the parent without custody.

Notwithstanding, if there is a court decree which would otherwise establish financial responsibility for the Child's health care expenses, the benefits of the plan which covers the Child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the Child as a Dependent Child; and, when the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the Member on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such Member the shorter period of time.

Active vs. Inactive Employee
The plan that covers the Claimant as an employee, who is neither laid off nor retired, is primary. The plan that covers a Member as a dependent of an employee, who is neither laid off nor retired, is primary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer vs. Shorter Length of Coverage
The benefits of the plan which has covered the Claimant for the longer period of time are determined before those of the plan which has covered that Member for the shorter period of time. If the preceding rules do not determine the primary plan, the Allowable Expenses shall be shared equally between This Plan and the Other Plan(s). However, This Plan will not pay more than it would have paid had it been primary.

SUBROGATION, REIMBURSEMENT & THIRD PARTY RECOVERY PROVISION

Payment Condition

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

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

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

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

Subrogation

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

If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan. If the Plan Participant(s) fails to file a claim or pursue damages against:

A. The responsible party, its insurer, or any other source on behalf of that party;
B. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
C. Any policy of insurance from any insurance company or guarantor of a third party;
D. Worker's compensation or other liability insurance company; or,
E. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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

SUBROGATION, REIMBURSEMENT & THIRD PARTY RECOVERY PROVISION…continued

Right of Reimbursement
The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

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

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

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

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

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

The Plan's benefits shall be excess to:

A. The responsible party, its insurer, or any other source on behalf of that party;
B. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
C. Any policy of insurance from any insurance company or guarantor of a third party;
D. Worker's compensation or other liability insurance company; or,
E. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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

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

SUBROGATION, REIMBURSEMENT & THIRD PARTY RECOVERY PROVISION…continued

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

A. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
B. To provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
C. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
D. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
E. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and,
F. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.

If the Plan Participant and/or their attorney fails to reimburse the Plan for all benefits paid or to be paid, because of said injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant will be responsible for all expenses associated with the Plan's attempt to recover such money from the Plan Participant.

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

Offset
Failure by the Plan Participant and/or their attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant may be withheld until the Plan Participant satisfies their obligation.

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

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

Language Interpretation
The Plan retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights.

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

DEFINITIONS

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

1. Accidental Injury
Any sudden bodily injury which is caused by external forces under unexpected circumstances and which is not excluded due to being employment-related. Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Accidental Injury for purposes of benefit determination.

2. Adverse Benefit Determination
Any of the following: A denial in benefits; a reduction in benefits; a recession of coverage; a termination of benefits; or, a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

3. Allowable Expenses
The Usual and Customary charge for any Medically Necessary, Reasonable, and eligible items of expense, at least a portion of which is covered under a Plan. When some other Plan pays first in accordance with the Application to Benefit Determinations Section herein, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

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

5. Birthing Center
A special room in a Hospital that exists to provide delivery and pre-natal and post-natal care with minimum medical intervention or a free-standing Outpatient facility which is in compliance with licensing and other legal requirements in the jurisdiction where it is located; is engaged mainly in providing a comprehensive birth service program to Members who are considered normal low-risk patients; has organized facilities for birth services on its premises; provides birth services which are performed by or under the direction of a Physician specializing in obstetrics and gynecology; has 24-hour-a-day registered nursing services; maintains daily clinical records.

6. Calendar (Plan) Year
The period commencing at 12:01 AM on January 1 of each year and ending at 12:00 AM on the next succeeding January 1. Each succeeding like period will be considered a new Calendar Year.

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

8. Co-Insurance
The percentage of Eligible Expenses that the Plan will pay after any required Deductible has been satisfied.

9. Plan Administrator
A company which performs all functions reasonably related to the general management, supervision and administration of the Plan in accordance with the terms and conditions of an administration agreement between the Plan Administrator and the Plan Sponsor. The Plan Administrator is not a fiduciary of the Plan and does not exercise any discretionary authority regarding the Plan. The Plan Administrator is not an insurer of Plan benefits, is not responsible for Plan financing and does not guarantee the availability of benefits under the Plan.

10. Co-Pay
An amount the Covered Member must pay. Co-Pays are usually paid to the provider at the time of service.

11. Covered Member
A covered Employee, a covered Dependent, a covered retiree, and a Qualified Beneficiary (COBRA).

12. Covered Provider
An individual who is: licensed to perform certain health care services which are covered under the Plan and who is acting within the scope of his license; or in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association; and who is a(n):

- Acupuncturist (CA)
- Audiologist
- Certified or Registered Nurse Midwife
- Certified Registered Nurse Anesthetist (CRNA)
- Chiropractor (DC)
- Dentist (DD or DMD)
- Licensed Clinical Psychologist (PhD or EdD)
- Licensed Social Worker
- Licensed Practical Nurse (LPN)
- Licensed Psychiatric Nurse
- Licensed Vocational Nurse (LVN)
- Nurse Practitioner
- Occupational Therapist (OTR)
- Optometrist (OD)
- Physical Therapist (PT or RPT)
- Physician - see definition of "Physician"
- Podiatrist or Chiropodist (DPM, DS., or DSC)
- Prosthetist, Prosthetist-Orthotist
- Registered Nurse (RN)
- Respiratory Therapist
- Speech Pathologist or Therapist

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

- facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, Birthing Centers;
- licensed Outpatient mental health facilities;
- freestanding public health facilities;
- hemodialysis and Outpatient clinics under the direction of a Physician (MD);
- enuresis control centers;
- portable X-ray companies;
- independent laboratories and lab technicians;
- blood banks;
- ambulance companies;
- dental labs and dental supply companies;
- speech and hearing centers;
- Easter Seal Society, American Cancer Society and Catholic Charities.

A Covered Provider does not include a Covered Member treating himself or any relative or Member who resides in the Covered Member's household - see "Relative or Resident Care" in the list of **General Plan Exclusions**.

13. Deductible
An amount which a Covered Member must contribute toward payment of Eligible Expenses. In most cases, the Deductible applies before the Plan begins to provide benefits.

14. Eligible Medical Expenses
Expense which is: (1) covered by a specific benefit provision of the Plan Document and (2) incurred while the Member is covered by the Plan Document.

15. Essential Health Benefits
Under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic Disease management; and pediatric services, including oral and vision care.

16. Fiduciary
A Fiduciary of the Plan has binding power to make decisions regarding Plan policies, interpretations, practices or procedures. A Fiduciary will thus include, but not be limited to, the Plan Administrator, officers and directors of the Plan Sponsor, investment committee members and Plan trustees, if any.

17. GINA - The Genetic Information Nondiscrimination Act of 2008
Prohibits group health plans, issuers of individual health care policies, and Employers from discriminating based on genetic information.

18. Home Health Care Agency
An agency or organization which: is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services; has policies established by a professional group associated with the agency or organization which includes at least one registered nurse (RN) to govern the services provided; provides for full-time supervision of such services by a Physician or by a registered nurse; maintains a complete medical record on each patient; has a full-time administrator.

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

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

20. Hospital
An institution which: complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located; Is primarily engaged in providing medical treatment to sick and injured Members as registered bed patients; is operated under the supervision of a staff of Physicians; continuously provides 24-hour-a-day nursing service by registered nurses; maintains a daily medical record for each patient; maintains facilities for diagnosis of injury or disease; maintains permanent facilities for major surgical operations on its premises (but this requirement is waived for mental health conditions); and, is not: (1) a rest home, nursing home, place for custodial care, home for the aged, or (2) an institution operated by a state, county or city for the care of the mentally ill, or any governmental agency of the United States or Canada.

21. Inpatient
A Member physically occupying a room and being charged for room and board in a Hospital which is covered by the Plan and to which the Member has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises.

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

23. Lifetime
The time an individual is covered under the Plan. It does not mean a Covered Member's entire lifetime.

24. Medically Necessary
Any health care treatment, service or supply determined by the Plan Administrator to meet each of the following requirements: it is ordered by a Physician for the diagnosis or treatment of a Sickness or Accidental Injury; the prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the Member's medical condition; it is furnished by a provider with appropriate training and experience, acting within the scope of his or her license, and it is provided at the most appropriate level of care needed to treat the particular condition.

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

The Plan Administrator will determine whether the above requirements are met based on: (1) published reports in authoritative medical and scientific literature, (2) regulations, reports, publications or evaluations issued by government agencies, (3) listing in the following compendia: *The American Hospital Formulary Service Drug Information* and *The United States Pharmacopoeia Dispensing Information*; and (4) other authoritative medical resources to the extent the Plan Administrator determines them to be necessary.

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

26. Mental Health Parity
Mental Health Parity Act (MHPA) of 1996 and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA refers to in a case of a group health plan that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

A. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and
B. The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

27. Mental or Nervous Disorder
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.

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

29. Physician
A Doctor of Medicine, (MD) or Doctor of Osteopathy, (DO) who is licensed to practice medicine or osteopathy where the care is provided. Christian Science practitioners practicing within their respective fields. The term "Physician" will not include the Covered Member, relatives or interns, residents, fellows or others enrolled in a graduate medical education program.

30. Plan
The benefits described by the Plan Document or incorporated by reference and including any prior statement of the Plan.

31. Plan Document
A formal written document which describes the plan of benefits and the provisions under which such benefits will be paid to Covered Members, including any amendments.

32. Prior to Effective Date or After Termination Date
Dates occurring before a Covered Member gains eligibility for the Plan, or dates occurring after a Covered Member loses eligibility from the Plan, as well as charges Incurred Prior to the Effective Date of coverage under the Plan or after coverage is terminated.

33. Reasonable
Services, supplies, or fees for services or supplies which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider. Determination that fees or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply.

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service and fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that result from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable. The Plan Administrator retains discretionary authority to determine whether services and/or fees are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for services and/or fees to be considered not Reasonable. Charges and/or services are not considered to be Reasonable, and as such are not eligible for payment, when they result from Provider errors and/or facility-acquired conditions deemed “reasonably preventable” through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

34. Substance Abuse
Any use of alcohol, any drug or narcotic (whether obtained legally or illegally), hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, alcohol or a drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of “Substance Use Disorder” is applied as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12-month period:

A. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home such as repeated absences or poor work performance; suspensions or expulsions from school; neglect of Children or household;
B. Recurrent substance use in situations in which it is physically hazardous such as driving when impaired by substance use;
C. Craving or a strong desire or urge to use a substance;
D. Continued substance use despite having persistent or recurrent social or personal problems caused or exacerbated by the effects of the substance such as arguments and physical fights;
E. The symptoms have never met the criteria for Substance Dependence for this class of substance.

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

36. Sickness
Sickness will mean bodily illness or disease (other than mental health conditions), and congenital abnormalities of a covered newborn child. Also, a condition must be diagnosed by a Physician to be considered a Sickness by this Plan.

37. Skilled Nursing Facility
An institution which: is duly licensed as a convalescent hospital, extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with the governing laws and regulations; is primarily engaged in providing accommodations and skilled nursing care 24-hours-a-day for convalescing Members; is under the full-time supervision of a Physician or a registered nurse; admits patients only upon the recommendation of a Physician (other than the patient's own Physician), maintains complete medical records, and has available at all times the services of a Physician; has established methods and procedures for the dispensing and administering of drugs; has an effective utilization review plan; is approved and licensed by Medicare; has a written transfer agreement in effect with one or more Hospitals; and is not, other than incidentally, a nursing home, a hotel, a school or a similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or Members with nervous disorders, or for the care of senile Members.

38. Urgent Care Facility
A facility which is engaged primarily in providing minor emergency and episodic medical care and which has: a board-certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance always; X-ray and laboratory equipment and a life support system. An Urgent Care Facility may include a clinic located at, operated in conjunction with, or which is part of a regular Hospital.

39. Usual, Customary and Reasonable (UCR)
Covered Expenses which are identified by the Plan Administrator, taking into consideration the fees which the Provider most frequently charges for the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same “area” by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term “same geographic locale” and/or “area” shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, Members or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

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

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

The term “Usual and Customary” does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Covered Member by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)

Commitment to Protecting Health Information
The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information set forth by the US Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Privacy Standards will be implemented and enforced by the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan. The Plan will protect Covered Members from:

Protected Health Information ("PHI")
Individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of Members living or deceased.

Breach
An unauthorized acquisition, access, use or disclosure of "PHI" or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

The Plan is required by law to take reasonable steps to ensure the privacy of the Covered Member's PHI, and inform them about:

A. The Plan's disclosures and uses of PHI;
B. The Covered Member's privacy rights with respect to PHI;
C. The Plan's duties with respect to PHI;
D. The Covered Member's right to file a complaint with the Plan and with the Secretary of HHS; and,
E. The Member or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

The Plan provides each Covered Member with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information.

How Health Information May be Used and Disclosed
In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount of an individual's PHI, without obtaining authorization, only if the use or disclosure is:

A. To carry out Payment of benefits;
B. For Health Care Operations;
C. For Treatment purposes; or
D. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes
In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

A. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law;
B. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
C. Establish safeguards for information, including security systems for data processing and storage;
D. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
E. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.

Disclosure of Summary Health Information to the Plan Sponsor
The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Member. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the Plan Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Primary Uses and Disclosures of PHI
Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Covered Member's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule;

The Plan contracts with individuals and Business Associates to perform various functions. In performance of these functions, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Member's information.

The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Covered Member, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) to coordinate benefits, if a Covered Member has coverage through another carrier.

Other Possible Uses and Disclosures of PHI
Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law. The Plan may use or disclose PHI when permitted for purposes of public health activities and public health and safety, including disclosures to:

A. An appropriate government authority authorized by law to receive reports of Child abuse or neglect;
B. Report reactions to medications or problems with products or devices regulated by the FDA or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities; including to locate and notify Members of recalls of products they may be using; and;
C. A Member who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition;
D. Disclose PHI to a government authority, when required or authorized by law, or with the Covered Member's agreement, if the Plan reasonably believes Member to be a victim of abuse, neglect, or domestic violence. The Plan will promptly inform the Covered Member that such disclosure has been or will be made unless the Plan believes the information would place Member at risk of serious harm. Disclosure generally may be made to a minor's parents or representative although there may be circumstances under Federal or State law when the parents or representative may not be given access to the minor's PHI;
E. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and activities necessary for appropriate oversight of a health care system, health care program, and compliance with certain laws;

F. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Covered Member's PHI may be disclosed in response to a subpoena, discovery requests, or required legal processes when the Plan is given satisfactory assurance that the requesting party has made a good faith attempt to advise the Covered Member of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards;
G. Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Covered Member's PHI in response to a law enforcement official's request if Member is or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises;
H. Decedents: The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for identifying a deceased Member, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years;
I. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions;
J. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public;
K. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law; and
L. Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

The Plan is required to disclose to a Covered Member most of the PHI in a Designated Record Set when the Covered Member requests access to this information. The Plan will disclose a Covered Member's PHI to an individual who has been assigned as representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of personal representation.

The Plan may elect not to treat the Member as the Covered Member's personal representative if it has a reasonable belief that the Covered Member has been, or may be, subjected to domestic violence, abuse, or neglect by such Member, it is not in the Covered Member's best interest to treat the Member as their personal representative, or treating such Member as a personal representative could endanger the Covered Member; and, Disclosures to the Secretary of the U.S. Department of Health and Human Services.

The Plan is required to disclose the Covered Member's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule. Instances when required authorization is needed from covered Members before disclosing PHI includes: uses and disclosures for marketing; sale of PHI; and other uses and disclosures not described in can only be made with authorization from the Covered Member. The Covered Member may revoke this authorization at any time.

Covered Member's Rights

The Covered Member has the following rights regarding PHI:

A. The right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Member may request the Plan restrict disclosures to family members, relatives, friends or other persons identified who are involved in their care or payment for care. The Plan is not required to agree to these requested restrictions;
B. The right to request communication regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Covered Member would like to be contacted. The Plan will accommodate all reasonable requests;
C. The right to receive a paper copy of the plan's Notice of Privacy Practices at any time.

D. The right to request an accounting of disclosures the Plan has made. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Member is entitled to such an accounting for the 6 years prior to their request. For each disclosure, the accounting will include: the date of the disclosure, the name of the entity or person who received PHI and, if known, the address of such entity or person; a description of the PHI disclosed, a statement of the purpose of the disclosure that reasonably informs the Covered Member of the basis of the disclosure, and certain other information.
E. The right to request the opportunity to look at or get copies of PHI maintained by the Plan about themselves in certain records maintained by the Plan. If the Covered Member requests copies, Member may be charged a fee to cover the costs of copying, mailing, and other supplies. A request to transmit PHI directly to another designated Member must be in writing, signed by the Covered Member and the recipient must be clearly identified. The Plan must respond to the Covered Member's request within 30 days. In some cases, the Plan can request a 30-day extension. In very limited circumstances, the Plan may deny the Covered Member's request. If the Plan denies the request, the Covered Member may be entitled to a review of that denial;
F. The right to request that the Plan change or amend their PHI. The Plan reserves the right to require this request be in writing. The Plan may deny the Covered Member's request in certain cases, including if it is not in writing or if they do not provide a reason for the request; and,
G. The Covered Member has the right to opt out of fundraising contacts.

Questions or Complaints
If the Covered Member wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated privacy rights, please contact the Plan using the following information.

The Covered Member may submit a written complaint to the US Department of Health and Human Services or with the Plan. The Plan will provide the Covered Member with the address to file the complaint with the US Department of Health and Human Services upon request.

The Plan will not retaliate against the Covered Member for filing a complaint with the Plan or the US Department of Health and Human Services.

HIPAA Security
The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA including the prevention of security incidents as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations
To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions, the Plan Sponsor agrees to:

A. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;
B. Ensure that adequate separation between the Plan and the Plan Sponsor is supported by reasonable and appropriate Security Measures;
C. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides ePHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the ePHI and report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI
The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI or ePHI is discovered, the Plan will notify the Covered Member that PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case, later than 60 calendar days after discovery of the breach. Breach Notification must be provided to individual by:

A. Written notice by first-class mail to Covered Member at last known address or, if specified by Covered Member, e-mail;
B. If Plan has insufficient or out-of-date contact information for the Covered Member, the Covered Member must be notified by a substitute form;
C. If an urgent notice is required, Plan may contact the Covered Member by telephone.

The Breach Notification will have the following content:

A. Brief description of what happened, including date of breach and date discovered;
B. Types of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);
C. Steps Covered Member should take to protect from potential harm;
D. What the Plan is doing to investigate the branch, mitigate losses and protect against further breaches;
E. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case, later than 60 calendar days after the date the breach was discovered;
F. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than five hundred individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each Calendar Year; and,
G. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected Covered Members may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

ADMINISTRATIVE PROVISIONS

Administration
The Plan benefits described herein are administered by a Plan Administrator under the terms and conditions of administration agreements between the Plan Sponsor and Plan Administrator. The Plan Administrator is not an insurance company.

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

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

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

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

A. Reduce, modify or terminate retiree health care benefits under the Plan, if any;
B. Alter or postpone the method of payment of any benefit;
C. Amend any provision of these administrative provisions;
D. Make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code or ERISA; and
E. Terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those benefits to which he has become entitled under the Plan.

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

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

Creditable Coverage Certificates
If Plan coverage or COBRA continuation coverage terminates (including termination due to exhaustion of all lifetime benefits under the Plan), the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the Member at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law. Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

Discrepancies
If there is a discrepancy between any separate booklet(s) provided to Employees ("Summary Plan Descriptions") and the Plan Document, the Plan Document will prevail.

Facility of Payment
Every Member receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. In the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

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

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

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

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

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

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

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

Illegality of a Provision
The illegality of any provision of the Plan Document will not affect the other provisions and the Plan Document will be construed in all respects as if such invalid provision were omitted.

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

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

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

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

A. An employee's cessation of active service for the employer;
B. A Plan participant's failure to pay his share of the cost of coverage, if any, in a timely manner;
C. Dependent ceases to meet the Plan's eligibility requirements;
D. A Plan participant is injured and expenses for treatment may be paid by or recovered from a third party;
E. A claim for benefits is not filed within the time limits of the Plan.

Material Modification
In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries are to be furnished a summary of the change not later than 60 days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety 90 days.

"Material modifications" are those which would be construed by the average Plan participant as being "important" reductions in coverage and generally would include any Plan modification or change that: eliminates or reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations; increases premiums, deductibles, coinsurance, copays, or other amounts to be paid by a Plan participant or beneficiary; or, establishes new conditions or requirements (i.e., preauthorization requirements) to obtaining services or benefits under the Plan.

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

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

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

Misuse of Identification Card
If Employee or covered Dependent permits any person who is not a Covered Member use any identification card issued, the Plan may give a Covered Member written notice coverage will be terminated at the end of thirty-one (31) days from the date notice is given.

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

A. A medical condition (whether physical or mental and including conditions arising out of acts of domestic violence)
B. Claims experience
C. Receipt of health care
D. Medical history
E. Evidence of insurability
F. Disability
G. Genetic information

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

Plan Administrator Discretion & Authority
The Plan Administrator has the exclusive authority, in its sole and absolute discretion, to take all actions necessary to or appropriate to interpret the terms of the Plan to make all determinations thereunder. The Plan Sponsor shall make determinations regarding coverage and eligibility. The Plan Administrator acting within the scope of its delegated authority on behalf of the Plan, shall make determinations regarding Plan benefits.

Privacy Rules & Security Standards & Intent to Comply
To the extent required by law, the Plan Sponsor certifies that the Plan will: comply with the Standards for Privacy of Individually Identifiable Health Information of HIPAA and; comply with HIPAA Security Standards with respect to electronic Protected Health Information. The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints regarding their privacy, and employees will not be required to give up their privacy rights to enroll or have benefits.

Purpose of the Plan
The purpose of the Plan is to provide certain health care benefits for eligible Employees, Retirees and their eligible Dependents.

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

Plan's Right to be Reimbursed for Payment in Error - When, because of error, clerical or otherwise, benefit payments have been made by the Plan more than the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Plan Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefor from the Covered Member or the provider of service in the event it is determined

such care or services are not covered. The Covered Member (parent, if a minor) will execute and deliver to the Plan Sponsor or the Plan Administrator all assignments and other documents necessary or useful for enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Plan Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

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

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

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

A. The Covered Member submits any claim that contains false or fraudulent elements under state or federal law;
B. A civil or criminal court finds that the individual has submitted claims that contain false or fraudulent elements under state or federal law;
C. An individual has submitted a claim that, in good faith judgment and investigation, knew or should have known, contained false or fraudulent elements under state or federal law.

Type of Plan
This Plan is not a plan of insurance. This Plan is a self-funded, nonfederal governmental group health plan that, for the most part, is exempt from the requirements of the Employee Retirement Income Security Act (ERISA). However, governmental plans are not automatically excluded from following amendments to ERISA: The Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns and Mothers Health Protection Act (NMHPA), and the Women's Health and Cancer Rights Act (WHCRA).

To be exempt from certain requirements of these laws, the Plan must make an affirmative written election to be excluded. Such election must be filed with the Centers for Medicare and Medicaid Services (CMS) prior to the beginning of each Plan Year, with notice provided to each Plan participant. Unless such written election is filed and participant notices are made, this Plan intends to fully comply with the above-stated federal laws.

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

APPENDIX A - PRESCRIPTION DRUGS

Prescription drug coverage is provided through separate agreements between the Plan Sponsor and WellDyne Rx. If there are any conflicts between the prescription information in this document and the terms of such agreement, the agreement will prevail.

The Third-Party Administrator for the City of Sparks prescription drug program is:

WellDyne Rx
1-844-635-7351
www.welldynerx.com

When a Covered Member presents a drug ID card at a participating pharmacy, the Covered Member pays a Co-Pay for each prescription and each refill. A list of pharmacies is available on request or can be obtained through the provider's website.

If the Covered Member does not present a drug ID card or goes to a non-participating pharmacy, benefits are limited to the contract rate for the expenses incurred, less the required Co-Pay. Contract rates are determined by the contract with the drug vendor. This benefit is payable only if the Covered Member files a properly completed claim form with the drug vendor within 365 days of the date of the purchase. Claim forms are available from Human Resources or www.welldynerx.com.

Annual Out-Of-Pocket Maximums	**PPO Providers**	**Non-PPO Providers**
Individual	$6,150	$6,150
Family	$12,300	$12,300
Individual Out-of-Pocket Maximum - Except as noted, a Covered Member will not be required to pay more than $6,150 in any Calendar Year toward their share of Eligible Expenses for prescription drugs that are not paid by the Plan. When this out-of-pocket maximum has been met, Eligible Expenses for prescription drugs will be paid at 100% for the balance of the Calendar Year. Family Out-of-Pocket Maximum - Except as noted, a covered family will not be required to pay more than $12,300 in any Calendar Year toward their Eligible Expenses for prescription drug obligations. Once the family has paid this out-of-pocket maximum, their Eligible Expenses for prescription drugs will be paid at 100% for the balance of the Calendar Year. The out-of-pocket maximums do not apply to or include expenses incurred for services which are not covered by the Plan.		
Prescription Drug Co-Pays **Retail Feature – 30 Day Supply**		
Generic Drug	$ 5.00 per prescription	
Preferred Brand-Name Drug	$15.00 per prescription	
Non-Preferred Brand-Name Drug	$40.00 per prescription when no generic is available	
Prescription Drug Co-Pays **Mail Order – 90 Day Supply**		
Generic Drug	$ 10.00 per prescription	
Preferred Brand-Name Drug	$30.00 per prescription	
Non-Preferred Brand-Name Drug	$80.00 per prescription when no generic is available	
Prescription Drug Co-Pays **Mail Order at any Pharmacy – 90 Day Supply**		
Generic Drug	$ 10.00 per prescription	
Preferred Brand-Name Drug	$30.00 per prescription	
Non-Preferred Brand-Name Drug	$80.00 per prescription when no generic is available	

DAW 2 Penalty
When a generic drug is available, but the pharmacy dispenses the non-preferred brand name drug at the member's request, the member will pay the difference between the brand and the generic discount. A DAW 2 Penalty will not be charged if the prescription is at the request of a licensed Physician.

Covered Drugs
Covered Drug expenses include:

A. Federal Legend Drugs;
B. Any drug product which bears the legend, "Caution Federal Law prohibits dispensing without a prescription";
C. Compound Medications - An extemporaneously prepared combination of two or more drug products containing at least one Federal Legend Drug in a therapeutic amount. Prior Authorization is required for compound medications over $75.00;
D. Selected Injectable Legend Drugs (including insulin);
E. Oral Contraceptives;
F. Immunizations and Vaccines;
G. Covered drugs and Preventative Medications as determined by the Affordable Care Act;
H. Immunizations.

The Covered Drugs or Medication must:

A. Be prescribed in writing by a Provider who is authorized to issue prescriptions and must be dispensed within one (1) year of such prescription;
B. Be approved for general use by the United States Food & Drug Administration;
C. Be for the direct care and treatment of the Covered Member's Sickness, Accidental Injury or condition. Dietary supplements and health aids are not included;
D. Be purchased from a licensed retail pharmacy or the mail-order pharmacy;
E. Not be used while Covered Member is an Inpatient in any facility, unless it is not usually supplied by or used in that facility.

Immunizations
The following vaccines are covered if provided by a Certified Immunizing Pharmacist or Physician:

Diphtheria	Tetanus	Pertussis
Hepatitis A	Hepatitis B	Human Papillomavirus (HPV)
Influenza	Haemophilus Influenza (Type b)	Inactivated Poliovirus Influenza
Measles	Mumps	Rubella
Meningococcal	Pneumococcal	Rotavirus
Varicella (Chicken Pox)	Zoster (Shingles)	Required Boosters
Typhoid	Yellow Fever	Any Other ACA Approved

Preventive Medications
There will be no co-pay for the following medications recommended by The Preventive Services Task Force (USPSTF) upon the Physician's order only at a participating retail or mail order pharmacy and with a prescription from a Physician.

A. Aspirin to prevent cardiovascular diseases (CVD): 45 years and older; quantity limit 1/day; generic only;
B. Sodium fluoride products (not in combination): 5 years old and younger, whose primary water source is deficient in fluoride; tablet 0.5mg, chewable tablet 0.25mg005mg, solution;
C. Folic Acid for all women planning or capable of pregnancy: Age limit 55 years old or younger; (not in combination); 0.4mg and 0.8mg; quantify limit 1/day; OTC;
D. Iron Supplements for asymptomatic children aged 6 to 12 months who are increased risk for iron deficiency anemia: Age limit 0-1 year; iron suspension, ferrous sulfate elixir, syrup and solution;
E. Tobacco Cessation for those who use tobacco products: Annual limit of 2 cycles (12 weeks per cycle); OTC generics only; generic Zyban only; Rx or OTC Nicotrol Inhaler and Nasal Spray; Nicotine polacriliex gum or lozenge; Nicotine TD patch 24-hour kits; Bupropion HC1 SR tabs; Varenicline (Chantix) tablets.

Prior Authorization
Certain classes of drugs require prior authorization. This authorization is obtained by the dispensing pharmacy in cooperation with the prescribing Physician and WellDyne Rx.

Certain classes of drugs may be subject to quantity limit restrictions in conformance with FDA standards. These limitations may be overridden by Medical Necessity, as communicated between the prescribing Physician and WellDyne Rx.

Non-Covered Drugs
Excluded Drugs include, but are not limited to, Drugs prescribed for:

A. Cosmetic use only;
B. Experimental or investigational drugs; except as such drugs may be part of a covered clinical study;
C. Fertility treatment;
D. Hair loss treatment;
E. Weight loss or control;
F. Nutritional supplements;
G. Over-the-counter medications, except as required under the Affordable Care Act;
H. Extemporaneously prepared combinations of raw bulk chemical ingredients (i.e. progesterone, testosterone or estrogen powders) or combinations of federal legend drugs in a non-FDA approved dosage form (i.e., capsules or suppositories made form DHEA, progesterone, testosterone or estrogen powders.

Coordination of Benefits
When a Covered Member has prescription drug coverage under any other plan and that plan is the Covered Member's primary plan as defined in the **Coordination of Benefits** section, the Other Plan is also the primary plan for the purchase of prescription drugs.

Claims for reimbursement of Co-Pays from such a primary plan may be made through WellDyne Rx on a properly completed claim form. This form is available from Human Resources or from the WellDyne Rx website.

Mail Order Prescription Service
WellDyne Rx provides a mail service pharmacy for on-going long term medication needs. A maximum 90-day supply of medication may be obtained by utilizing the mail order program.

Prescription Drug Coverage and Medicare Part D
Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans.

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

APPENDIX B - VISION SERVICES

The vision provider for the City of Sparks Group Health Plan is:

Vision Service Plan (VSP)
www.vsp.com
800-877-7195

VSP providers offer an examination and the prescribing and fitting of corrective lenses. To get the maximum benefit from this service, Covered Members should use Participating Providers. A current list of participating doctors is available on the VSP web site.

Vision Benefit Summary	VSP Provider	Non-Participating Provider
Examination	Covered in full every 12 months	Plan pays up to $46
Frames	Covered every 24 months with some restrictions as to cost	Plan pays up to $45
Lenses	Covered every 12 months with some restrictions. Patient is responsible for payment on tinted, blended or oversize lenses	Single vision -Plan pays up to $47 Bifocal -Plan pays up to $66 Trifocal -Plan pays up to $85 Lenticular -Plan pays up to $125
Contact lenses – Benefits are provided in lieu of all other Plan benefits	Covered every 12 months not to exceed an annual maximum of $217. The co-pay for the examination is $60. Necessary- Conditional, covered in full with prior approval	Covered every 12 months not to exceed an annual maximum of $105. The co-pay for the examination is $60. Necessary - Plan pays up to $250 (exam benefit is also available)

APPENDIX C - LIFE INSURANCE

The City has contracted with Symetra Life Insurance Company to provide life insurance coverage to employees, employee dependents and retirees. For detailed information, please refer to your Life Insurance Policy.

Life and Accidental Death & Dismemberment (AD&D) Insurance is provided in the following amounts:

Member Type	Life	AD&D
Employee	$25,000	$25,000
Retiree	$10,000	$10,000
Spouse of Active Employee	$2,500	N/A
Spouse of Retired Employee	N/A	N/A
Child of Active Employee		
Birth to 14 days	No Coverage	N/A
After 14 days	$2,500	N/A
Child of Retired Employee	N/A	N/A

NOTE**:** Accidental Dismemberment benefits provide additional coverage for accidental loss of specified body parts, vision, speech & hearing or in the event of paralysis as outlined in the Policy.

There are no AD&D benefits available for dependents.

Beneficiary Designation
The covered employee must complete an official beneficiary designation form. Designated beneficiaries may be changed at any time by completing a new form. Forms are available from Human Resources.

Claim Filing
Claims for benefits should be filed through the Human Resources Office. They will complete the required forms and assist in gathering the needed documentation for a claim. A certified death certificate will be required.

Payment will be issued directly to the assigned beneficiary. If no beneficiary is provided, the Plan will make payment to the Estate of the deceased.

Eligibility for Continuation of Coverage upon Retirement
Eligibility for Life Insurance is based on participation in the City's Medical & Dental Benefit Plan.

APPENDIX D - EMPLOYEE ASSISTANCE PROGRAM

What is the Employee Assistance Program (EAP)?
The Employee Assistance Program is a confidential counseling and life assistance program whose primary purpose is to provide support, resources and information for personal and work-life issues; including but not limited to:

A. Confidential Counseling for stress, anxiety and depression; grief and loss; job pressures; substance abuse; relationship and marital conflicts; and, problems with children
B. Financial Information and Resources including debt counseling; loan issues; tax questions; retirement planning; estate planning; and, saving for college
C. Legal Support and Resources such as divorce and family law; debt and bankruptcy; landlord/tenant issues; real estate transactions; civil and criminal actions; contracts
D. Work-Life Solutions for child and elder care; moving and relocation; making major purchases; college planning; pet care; home repair
E. Tobacco Cessation

Procedure for Making an Appointment
Guidance Resources is available 365 days per year, 24 hours per day. Simply call the number below.

Payment for EAP Counseling
Each City employee, retiree and their eligible dependents will receive five (5) free visits per calendar year. If you wish to continue after the five (5) free visits have been used, you may make fee arrangements with your counselor.

Employee Responsibility
It is the employee's responsibility to verify benefit coverage. Not all counselors you are referred to will be in our preferred network of providers. Always check the preferred provider list.

The website and phone number for the EAP is as follows:

Guidance Resources
www.guidanceresources.com
1-855-770-3190

APPENDIX E - GROUP HEALTH PLAN BENEFITS COMMITTEE

The Group Health Plan Benefits Committee was established through contract negotiations for the purpose of recommending to the City Council cost containment and benefit changes in the City's self-insured medical, dental, vision and life insurance plans.

The purpose of this Committee is to discuss cost containment measures and to recommend to the City Council any benefit changes to the City's self-insured, medical, dental, vision and life insurance plans. The Committee shall be comprised of five voting members; one from each of the following groups:

- Operating Engineers/Supervisory
- All Police Unions
- International Association of Firefighters
- Confidential
- All Management Groups/Appointed/Classified Chief Officers

Each group will name a representative and an alternate. In addition, one retired employee will serve as a non-voting member to provide input on the effect of any changes upon retirees. The Committee Chairperson will be appointed by the City Manager and will not have a vote on the Committee.

The representative of each recognized bargaining unit shall have the authority to bind said bargaining unit to any modification in benefits recommended to the City Council subject to ratification of at least two of the following three bargaining units: (Sparks Police Protective Association, Operating Engineers Local 3 and the International Association of Firefighters Local 1265). Any two of these three bargaining units (Local 3, Local 1265 and Police) can bind the remaining units to changes to the City's self-insured medical, dental, vision, and life insurance plans. Any modification in benefits agreed to by the City Council, based on recommendation of the committee, shall be binding upon each recognized bargaining unit or group.

APPENDIX F – EMERGENCY TRAVEL ASSISTANCE EXPENSES

MEDEX Travel benefits are an additional benefit under this plan. MEDEX provides a wide range of assistance to travelers (more than 100 miles from home) if they are faced with an emergency medical situation. Services available include, but are not limited to:

- Locating Medical Care: Assists you in locating medical care providers or local sources of medical care referrals
- Medical Insurance Assistance: Coordinates with insurance companies or managed care organization regarding emergency medical care situation, verifies policy enrollment and coverage and helps arrange any guarantee of medical payments
- Translation and interpreter services: Available 24/7 during emergency situations while traveling internationally
- Emergency evacuation to the nearest facility capable of providing appropriate care while traveling and adequate medical facilities are not available locally
- Medically necessary repatriation: Arranges and provides for your return to a preferred provider hospital or to home if it is medically necessary after initial treatment and stabilization. You will need to contact MEDEX to arrange this or it will not be covered
- Transportation for a family member or friend to join a hospitalized patient traveling alone
- Prescription transfer or replacement (prescription cost is employee's responsibility)
- Return of dependent children: If you are hospitalized for more than seven days, coordinates and pays for one-way economy airfare to return your dependent children under age 18 to their permanent residence, including an escort for young children if necessary
- Vehicle Return: Returns your non-commercial vehicle if it is left behind unattended in the event that you require evacuation of repatriation
- Pre-trip and general assistance services
- Emergency cash and payment assistance: Helps obtain and advance funds by coordinating with a friend, family member, bank or your credit card issuer in the event of a travel or medical emergency

To access these benefits call:

MEDEX Travel Assist
(800) 527-0218 - From within the United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda, or
(410) 453-6330 - Other locations worldwide (call collect)
operations@medexassist.com

MEDEX Travel Assist also has a website at www.medexassist.com which provides a wealth of information on travel restrictions and warnings, weather, information regarding countries and other pertinent facts.

These benefits are available to all active employees, retirees and their eligible dependents. If you do not have a MEDEX Travel Assist identification card in your wallet, Risk Management has ID cards and full information available.

APPENDIX G – HEALTHY LIFESTYLE BENEFIT

This benefit is subject to the approval of the Group Health Committee. Approved items include:

Gym Membership		
Massage Therapy		
Fishing & Hunting Licenses		
Weight Loss and Nutritional Counseling		
Wellness Education Classes		
Ancillary Medical, Dental & Vision Expenses After the applicable deductible has been met, Covered Members may use this benefit to cover additional medical, dental and vision expenses. Example: 3rd dental cleaning; purchase of frames; additional expenses associated with a physician visit, labs, x-rays, medical equipment.		
Electronic Devices The primary function of the device must be for health tracking, such as a Fitbit or pedometer. Smart Phones, Smart Watches, Music Devices and Headphones are not covered items.		
Lessons, Registration, Passes and/or Membership Fees for Activities that Promote a Healthy Lifestyle Equipment, clothing and shoes for these activities are not covered. This list is not all inclusive. Additional activities may be approved as determined by the City of Sparks Group Health Committee.		
Archery	Baseball	Basketball
Bowling	Boxing	Cheerleading
Dancing	Golf	Gymnastics
Horseback Riding	Ice Hockey	Football
Fencing	Field Hockey/Lacrosse	Flag Football
Kick Ball	Karate & Martial Arts	Dodgeball
Marching Band	Skating, all types	Swimming
Skiing	Running	Soccer
Softball	Skateboarding	Shooting
Rodeo	Tennis	Track & Field
Volleyball	Water Sports	Wrestling
Winter Sports	Waterslide	Weight Lifting

Covered Members age 6 and over, receive up to $150.00 per calendar year. A receipt must be provided for reimbursement.

A Healthy Lifestyle Reimbursement form must be submitted to Hometown Health and can be found on the City's website.

A check will be mailed to the Covered Member or Covered Adult Dependent.

Claims not considered to be medical, dental or vision coverage, will be subject to taxes per the IRS guidelines.

If a Healthy Lifestyle Claim is denied, and you wish to appeal the activity or item, you must present to your Group Health Committee Representative for consideration at the next scheduled Group Health Meeting.