

DOUGLAS COUNTY
DENTAL BENEFIT SUMMARY

CALENDAR YEAR MAXIMUM BENEFIT	\$1,500	
Plan benefits for each Covered Person will not exceed the maximum shown above.		
ANNUAL DEDUCTIBLES		
Individual Deductible, per Calendar Year	\$50	
Family Maximum Deductibles, per Calendar Year	Three	
<p>Individual Deductible – The Individual Deductible is an amount which a Covered Person must contribute toward payment of eligible dental expenses. In most instances, the deductible applies before the Plan begins to provide benefits.</p> <p>Family Maximum Deductibles – Three (3) Individual Deductibles must be satisfied by separate family members before the Family Maximum Deductible will be met. Members cannot combine amounts to satisfy the Family Maximum Deductible. A "family" includes a covered Employee and his/her covered Dependents.</p>		
ELIGIBLE DENTAL EXPENSES	Covered Person Pays	Plan Pays
Preventative Services	0%	100%
<p>Limits applicable to certain Preventative Services:</p> <ul style="list-style-type: none"> • Routine oral examinations and cleanings are limited to 2 exams/cleanings per Calendar Year. Periodontal cleanings (a Basic Service) will also apply to this maximum; • Fluoride application is limited to children under age 19 and to 1 application per Calendar Year; • A routine full-mouth series, vertical bitewings or a panoramic x-ray are limited to once per 3-year period; • Routine bitewing x-rays are limited to 2 films per Calendar Year. 		
Basic Services	20%	80%
<p>Limits applicable to certain Basic Services:</p> <ul style="list-style-type: none"> • Sealants are limited to children under age 17. Reapplication is limited to once per tooth, per 3-year period; • Full mouth debridement is limited to once per 5-year period; • Gingivectomy or gingivoplasty, gingival curettage, gingival flap procedure, osseous surgery and bone replacement grafts are limited to once in a 3-year period; • Pedicle soft tissue graft, free soft tissue graft or subepithelial connective tissue grafts are limited to 2 sites per quadrant, per 3-year period; • Stainless steel crowns are limited to individuals under age 19. 		
Major Services	50%	50%
<p>THIS IS A SUMMARY ONLY. PLEASE REFER TO THE ELIGIBLE DENTAL EXPENSES AND DENTAL LIMITATIONS AND EXCLUSIONS SECTIONS FOR MORE INFORMATION.</p>		



DOUGLAS COUNTY

DENTAL PLAN DOCUMENT

Effective: January 1, 2015

CONTRACT ADMINISTRATOR

CDS Group Health

PO Box 50190

Sparks, Nevada 89435-0190

775-352-6900

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PROVIDER NETWORK

The Plan Sponsor has contracted with Diversified Dental Services, a dental Preferred Provider (PPO). Dentists who are in the PPO provide their services at significant discounts. When a Covered Person obtains dental care from a PPO dentist, they are charged the reduced fees; which means they save money compared to obtaining the same services from a Non-PPO dentist. When obtaining dental care services, a Covered Person has a choice of using providers who are participating in the PPO network or any other Covered Provider of his choice (Non-PPO providers).

Non-PPO providers have no agreements with the Plan and are generally free to set their own charges for services or supplies. The Non-PPO provider's charge is subject to the Plan's Usual and Customary (U&C) allowable. The Covered Person will be responsible for any amounts in excess of the U&C (called balance billing). You can avoid potential balance billing by using a PPO provider.

PPO providers are added and dropped from the PPO network periodically throughout the year and it is your responsibility to verify if the provider is in the PPO network BEFORE seeking services from a PPO provider. A listing of PPO providers can be found on Diversified's website.

DIVERSIFIED DENTAL SERVICES

Phone: 866-270-8326

www.DDSPPO.com

DENTAL BENEFIT SUMMARY

Refer to the **ELIGIBLE DENTAL EXPENSES** and **DENTAL LIMITATIONS** and **EXCLUSIONS** sections for specific covered services and the items that are excluded or limited by the plan.

MAXIMUM CALENDAR YEAR BENEFIT	\$1,500
CALENDAR YEAR DEDUCTIBLE Individual Deductible Family Maximum Deductible	\$50 Three
<p>Individual Deductible – The Individual Deductible is an amount which a Covered Person must contribute toward payment of eligible dental expenses. In most instances, the deductible applies before the Plan begins to provide benefits.</p> <p>Family Maximum Deductibles – Three (3) Individual Deductibles must be satisfied by separate family members before the Family Maximum Deductible will be met. Members cannot combine amounts to satisfy the Family Maximum Deductible. A “family” includes a Covered Employee and his/her covered Dependents.</p>	
ELIGIBLE DENTAL EXPENSES	BENEFIT
Preventive Services (Deductible waived)	100%
<p>Limits applicable to certain Preventative Services:</p> <ul style="list-style-type: none"> - routine oral examinations and prophylaxis/periodontal cleanings are limited to two (2) each per Calendar Year. - fluoride application is limited to children under age 19 and to one (1) application per Calendar Year; - routine bitewing xrays are limited to two (2) films per Calendar Year; - Panoramic or full-mouth X-rays are limited to once per 3-year period. 	
Basic Services	80%
<p>Limits applicable to certain Basic Services:</p> <ul style="list-style-type: none"> - Sealants are limited to children under age 17. Reapplication is limited to once per tooth, per 3-year period; - Full mouth debridement is limited to once per 5-year period; - Gingivectomy or gingivoplasty, gingival curettage, gingival flap procedure, osseous surgery and bone replacement grafts are limited to once in a 3-year period; - Pedicle soft tissue graft, free soft tissue graft or sub epithelial connective tissue grafts are limited to two (2) sites per quadrant, per 3-year period; - Stainless steel crowns are limited to individuals under age 19. 	
Major Services	50%

DENTAL PRE-TREATMENT ESTIMATE

If extensive dental work is needed, the Contract Administrator recommends that a pre-treatment estimate be obtained prior to the work being performed if proposed expenses will exceed \$200. Emergency treatments, oral examinations including prophylaxis, and dental x-rays will be considered part of the "extensive dental work" but may be performed before the pre-treatment estimate is obtained.

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

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

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

NOTE: A PRE-TREATMENT ESTIMATE IS NOT A GUARANTEE OF PAYMENT. PAYMENT OF PLAN BENEFITS IS SUBJECT TO PLAN PROVISIONS AND ELIGIBILITY AT THE TIME OF THE SERVICE IS ACTUALLY INCURRED.

ELIGIBLE DENTAL EXPENSES

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

For benefit purposes, dental expenses will be deemed incurred as follows:

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

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

PREVENTATIVE CARE

1. **Exams and Cleanings, Routine** – Routine oral examinations and routine cleaning and polishing of teeth.
2. **Flouride** – Topical application of stannous or sodium fluoride.
3. **Habit-Breaking Appliance** – Fixed or removable appliances to correct thump sucking.
4. **Prophylaxis** – see "Exams and Cleanings, Routine".
5. **Space Maintainers** – Fixed or removable appliances to retain the space left by a prematurely lost primary or "baby" tooth and to prevent abnormal movement of the surrounding teeth. Re-cementing of a space maintainer.
6. **X-rays** – Dental x-rays for diagnostic purposes, as well as routine "full mouth" x-rays, vertical bitewings (7 to 8 films) or a panoramic x-ray, and routine bitewing x-rays.

BASIC SERVICES

1. **Anesthesia** – General anesthesia, intravenous sedation or analgesia when administered in connection with oral surgery or when deemed necessary by the dental provider for other covered dental services.
2. **Consultation** – Consultation by a dental specialist upon referral by the patient's attending dentist.

3. **Endodontia** – Endodontic services including but not limited to: root canal therapy (except for final restoration), pulpotomy, apexification/recalcification, apicoectomy, retrograde filling, root amputation, and hemisection.

NOTE: Retreatment of a root canal therapy is NOT covered within twelve (12) months of the root canal or a previous treatment.

4. **Exams, Non-Routine** – Oral examination for dental problems resulting from an Accidental Injury.

Office visits after regularly scheduled hours.

5. **Extraction** – See “Oral Surgery”.

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

7. **Oral Surgery** – Oral surgery including:

- Extraction of teeth, including simple extractions and surgical extraction of bone or tissue-impacting teeth;
- Surgical removal of residual or exposed roots;
- Closure of oral antral fistula;
- Reimplantation and or stabilization of an accidentally evulsed or displaced tooth and/or alveolus;
- Tooth transplantation;
- Surgical exposure of an impacted or unerupted tooth for orthodontia reasons or to aid eruption;
- Biopsy and histopathologic examination of oral tissue;
- Alveoloplasty;
- Vestibuloplasty;
- Excision or destruction of oral or odontogenic lesions, cysts or tumors;
- Removal of exostosis.

8. **Palliatives** – Emergency treatment for the relief of dental pain. Application of desensitizing resin to cervical and/or root surface.

9. **Periodontia** – Treatment of the gums and tissues of the mouth, including:

- Periodontal scaling and root planning (cleaning). Periodontal cleanings will apply toward the prophylaxis maximum of two (2) cleanings per Calendar Year, see “Preventative Services”;
- Localized delivery of chemotherapeutic agents;
- Occlusal adjustments;
- Gingivectomy or gingivoplasty;
- Gingival curettage;
- Gingival flap procedure;
- Osseous surgery;

- Bone replacement graft, pedicle soft tissue graft, or subepithelial connective tissue graft; distal or proximal wedge procedure when not performed in conjunction with surgical procedures in the same area.

NOTE: Subgingival curettage or root planning is not covered unless the presence of periodontal disease is confirmed by both X-rays and pocket depth summaries of each tooth involved.

10. Re-cementings, Relines & Repairs – Repairs to dentures or bridges.

Recementing of an inlay, crown or fixed partial denture.

Relining of a denture, but only when performed more than six (6) months after installation.

11. Sealants – Application of sealants to the pits and fissures to 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.

12. Stainless Steel & Resin Crowns – Stainless steel and prefabricated resin crowns for Covered Persons under age 19. See "Crowns" in Major Services for stainless steel and resin crowns for persons age 19 and over.

MAJOR SERVICES

1. Crowns – A gold, porcelain or composite crown restoration when a tooth cannot be satisfactorily restored with a filling restoration. A stainless steel or resin crown will also be a covered Major Service for individuals age 19 and over. Coverage for a crown includes a post and core when necessary.

Crown repair or replacement of a crown if the existing crown is at least five (5) years old and cannot be made serviceable.

See "Cosmetic Dentistry" in the list of Dental Limitations and Exclusions for restrictions on veneer or facing (i.e., "tooth colored") restorations. Crowns placed for periodontal splinting are not covered.

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

3. 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 or when part of a covered bridge or partial denture.

Replacement of an inlay, onlay or gold filling, if the existing restoration is at least five (5) years old and cannot be made serviceable.

4. Prosthetics – Initial placement of a full or partial denture or bridge when necessary because of the extraction of teeth while the individual is covered. Any allowance made for a prosthetic includes necessary adjustments within six (6) months of placement.

Replacement of, or addition of teeth to, an existing full or partial denture or bridgework, but only if:

The replacement or addition of teeth is required to replace one (1) or more teeth extracted after the existing denture or bridgework was installed and while the individual is covered;

The existing denture or bridgework is at least five (5) years old; or
Replacement is necessitated by an Accidental Injury.

Rebasing of a complete or partial denture.

5. Tissue Conditioning

DENTAL LIMITATIONS AND EXCLUSIONS

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

1. **Athletic Appliances** – Items intended for sport purposes, such as athletic mouthguards.
2. **Congenital or Developmental Conditions** – Treatment of congenital (hereditary) or developmental (following birth) malformations, unless expressly included.
3. **Cosmetic Dentistry** – treatment rendered for cosmetic purposes.
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 could be (could have been) performed to correct a dental condition, Plan benefits will be limited to the least costly procedure(s) which would produce a professionally satisfactory result.

Duplicate prosthetic devices or appliances.

7. **Experimental Procedures** – Services which are considered experimental or which are not approved by the American Dental Association.
8. **Grafting** – Extra oral grafts (grafting of tissue from outside the mouth to oral tissues).
9. **Hospital Expenses**
10. **Implant Removal** – The removal of implants.
11. **Lost or Stolen Prosthetics or Appliances** – Replacement of a prosthetic or any other type of appliance which has been lost, misplaced, or stolen.
12. **Medical Expenses** – Any dental services to the extent to which coverage is provided under any medical or other coverages offered by the Plan Sponsor.
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 dentist (D.D.S. or D.M.D.);
- A dental hygienist, X-ray technician or other qualified technician who is under the supervision of a dentist; or
- A physician furnishing dental services for which he is 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:

- Increasing the vertical dimension;
- Replacing or stabilizing tooth structure lost by attrition;
- Realignment of teeth;
- Gnathological recording or bite registration or bite analysis;
- Occlusal equilibration.

16. Oral Hygiene Counseling, Etc. – 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, water picks, and mouthwashes.

17. Orthodontia, Etc. – Orthodontia procedures, appliances or restorations used to increase vertical dimension or to restore occlusion.

18. Personalization or Characterization of Dentures

19. Prior to Effective Date / After Termination Date – Courses of treatment which were begun prior to the Covered Person's effective date, including crown, bridges or dentures which were ordered prior to the effective date.

Expenses incurred after termination of coverage, except that benefits will be provided for prosthetic appliance ordered prior termination and delivered not more than ninety (90) days after termination.

20. Splinting – Appliances and restorations for splinting teeth.

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

22. 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.

(See also General Exclusions section)

GENERAL EXCLUSIONS

No benefits will be payable under the Plan for:

1. **Criminal Activities** – Any injury resulting from or occurring during the Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation.
2. **Excess Charges** – Charges in excess of the Usual, Customary and Reasonable fees.
3. **Forms Completion** – Charges made for the completion of claim forms or for providing supplemental information.
4. **Late-Filed Claims** – Claims which are not filed with Contract Administrator for handling within the required time periods as included in the **Claims Procedures** section.
5. **Missed Appointments** – Expenses incurred for failure to keep a scheduled appointment.
6. **No Charge / No Legal Requirement to Pay** – Services for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. However, this exclusion does not apply to any benefit or coverage which is available through the Medical Assistance Act (Medicaid).
7. **Not Listed Services or Supplies** – Any services, care or supplies not specifically listed as Eligible Expenses.
8. **Other Coverage** – Services or supplies for which a Covered Person is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof).
9. **Outside United States** – Charges incurred outside of the United States if the Covered Person traveled to such a location for the sole purpose of obtaining such services, drugs or supplies.
10. **Postage, Shipping, Handling Charges, Etc.** – Any postage, shipping or handling charges which may occur in the transmittal of information to the Contract Administrator. Interest or financing charges.
11. **Prior Coverages** – Services or supplies for which the Covered Person is eligible for benefits under the plan which this Plan replaces.
12. **Relative or Resident Care** – Any service rendered to a Covered Person by a relative (i.e., a spouse, or a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

GENERAL EXCLUSIONS, continued

- 13. Telecommunications** – Advice or consultation given by or through any form of telecommunication.
- 14. War or Active Duty** – Conditions resulting from insurrection, war (declared or undeclared or any act of war and any complications there from, or service (past or present) in the armed forces of any country.
- 15. Work-related Conditions** – Any condition for which the Covered Person has or had a right to compensation under any Worker' 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 condition which arises from or is sustained in the course of any occupation or employment for compensation, profit or gain.

COORDINATION OF BENEFITS (COB)

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

DEFINITIONS

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

Other Plan – Any following that provides benefits or services for dental services:

- Group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured). A “closed panel plan” is a plan that, except in an emergency, provides coverage only in the form of services obtained through a panel of providers that have contracted with or are employed by the plan:
- Medicare or other governmental benefits, as permitted by law.

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

NOTE: 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 – A dental service or expense, including deductibles and copayments, that is covered at least in part by any of the plans (i.e., This plan or Other Plan(s)) covering the Claimant. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

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”).

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

EFFECT ON BENEFITS UNDER THIS PLAN

When Other Plan Does Not Contain a COB Provision – If an Other Plan does not contain a 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 an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the “order of Benefit Determination Rules” below. If, in accordance with those rules, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability or (2) total Allowable Expenses minus benefits paid by the Other Plan(s).

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

ORDER OF BENEFIT DETERMINATION RULES

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.

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

Child Covered Under More Than One Plan – When the Claimant is a dependent child, the primary plan is the plan of the parent who birthday is earlier in the year if (1) the child’s parents are married or are not separated (whether or not they have ever married), or (2) a court decree awards joint custody without specifying that one party has the responsibility to provide dental coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

When the Claimant is a dependent child and specific terms of a court decree state that one of the parents is responsible for the child’s dental expenses or dental coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Claim Determination Periods or plan years commencing after the plan is given notice of the court decree.

When the Claimant is a dependent child whose father and mother are not married, are separated (whether or not they even have been married) or are divorced, the order of benefits is:

- The plan of the Custodial Parent;
- The plan of the spouse of the Custodial Parent;
- The plan of the noncustodial parent; and then
- The plan of the spouse of the noncustodial parent.

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

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

OTHER INFORMATION ABOUT COORDINATION OF BENEFITS

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

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

Right of Recovery – If the amount of the payments made by the Plan is more than it should have paid under this COB section, the Plan may recover the excess from one or more of the persons it has paid or for whom it has paid – or any other person or organization that may be responsible for the benefits or services provided for the Claimant. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

ELIGIBILITY PROVISIONS

Contact Human Resources for Eligibility, Effective Date and Termination of Coverage Provisions.

CLAIMS PROCEDURES

Administrative Processes and Safeguards

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

Authorized Representative May Act for Claimant

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

Benefit Determinations

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

Timely Filing of Claims

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

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

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

Submitting a Claim

A claim is a request for a benefit determination which is made, in accordance with the Plan's procedures, by a Covered Person or his authorized representative. A claim must be received by the Contract Administrator for handling on behalf of the Plan so that the claim review and benefit determination process can begin. A claim must name the Plan, a specific Claimant, a 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.

Submit Claim to:

CDS Group Health
P. O. Box 50190
Sparks, NV 89435-0190
Phone: (775) 352-6900
Fax: (775) 352-6992

Assignment to Providers

All Eligible Expenses reimbursable under the Plan will be paid to the covered Employee except that: (1) assignments of providers of service will be honored, and (2) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

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

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

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

APPEAL PROCEDURES

Claim Denials (Adverse Benefit Determination)

If a claim is wholly or partially denied, the Covered Person will be given written notice for the reason of the denial, written in a manner calculated to be understood by the Covered Person, including:

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

If the Covered Person is not satisfied with the handling of the claim, the claimant may appeal to the Plan for Pre-Service and Post-Service claims by following the **INTERNAL APPEAL PROCEDURES** below.

Internal Appeal Procedures

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

Concurrent Care Claims - If you have been approved for a course of treatment, and that course of treatment is reduced or terminated before it has been completed, or if you wish to extend the course of treatment beyond what was agreed upon, you may file a Concurrent Care Claim seeking to restore the remainder of the treatment regimen previously agreed to or seeking to extend the course of treatment. All Concurrent Care Claims will be decided in sufficient time so that, should your claim be denied (in whole or in part), you will be able to seek a review of that decision before the course of treatment is scheduled to terminate.

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

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

LEVEL I – Review by Contract Administrator

The Covered Person may submit an appeal letter, within one-hundred and eighty (180) days of the date he received the Explanation of Benefits (EOB) or letter with the initial claim determination. Failure to request a review in a timely manner will be deemed to be a waiver of any further right of review of appeal. The appeal letter must include the Claimant's name, social security number or member identification number along with a detailed written explanation why the claim is being appealed. The Covered Person shall have this opportunity to present additional information and/or documentation supporting this appeal. The Contract Administrator will review the claim for appropriateness based on the Plan Document and, if needed for medical interpretation or clarification, request a Physician review.

Appeal letter and additional information and/or documentation must be submitted to:

CDS Group Health
Attn: Appeals Coordinator
1625 East Prater Way, Building C, Suite 101
PO Box 50190
Sparks, Nevada 89435-0190

The Contract Administrator will render a decision within thirty (30) days of receipt of the appeal letter and will notify, in writing, the Claimant of the findings. If the Claimant is dissatisfied with the Level 1 appeal decision he/she may file a Level II appeal. See below.

LEVEL II – Review by Plan Sponsor

If the Covered Person is dissatisfied with the Level I appeal decision he may, within thirty-five (35) days of receiving the Level I decision, appeal his claim to the Plan Sponsor for review. The Covered Person shall have this opportunity to present additional information and/or documentation supporting his appeal. Any information or documents provided to the Plan Sponsor will be considered Protected Health Information (PHI). Information or documents provided will not be returned to the Covered Person and will be discarded in accordance with Privacy Rules.

Appeal letter and additional information and/or documentation must be submitted to:

Douglas County
c/o CDS Group Health
Attn: Level II Appeal
PO Box 50190
Sparks, Nevada 89435-0190

The Covered Person will be notified in writing of the decision within fourteen (14) days of the date the decision was made.

DEFINITIONS

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

1. **Calendar Year** – The period of time commencing at 12:01 A.M. on January 1 of each year and ending at 12:01 A.M. on the next succeeding January 1.
2. **Claimant** – Any Covered Person for whom a claim is submitted for benefits under the Plan.
3. **Contract 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 Contract Administrator and the Plan Sponsor.
4. **Covered Person** – A covered Employee, a covered Dependent, and a Qualified Beneficiary (COBRA). See **Eligibility and Effective Dates and Continuation of Coverage Option (COBRA)** sections for further information.
5. **Dentist** – An individual who is duly licensed to practice dentistry or perform oral surgery in the state where the dental service is performed and who is operating with the scope of his license. A physician (M.D.) will be considered to be a Dentist when performs any dental services within the operating scope of his license.
6. **Dependent** – See **Eligibility and Effective Dates** section
7. **Eligible Expenses(s)** – Expense which is (1) covered by specific benefit provision of the Plan Document and (2) incurred while the person is covered by the Plan document.
8. **Employee** – see **Eligibility and Effective Dates** section
9. **Employer** – An Employer participating in the Plan.
10. **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.
11. **Participating Employer** – An Employer who is participating in the coverages of the Plan. See **General Plan Information** section for the identity of the Participating Employer(s).
12. **Plan** – The benefits described by the Plan Document or incorporated by reference and including any prior statement of the Plan. The name of the Plan is shown in the **General Plan Information** section.
13. **Plan Administrator** – see “Plan Sponsor”

- 14. Plan Document** – A formal written document which describes the plan of benefits and the provisions under which such benefits will be paid to Covered Person, including any amendments.
- 15. Plan Sponsor** – The entity sponsoring this Plan. The Plan Sponsor may also be referred to as the Plan Administrator. See **General Plan Information** section for further information.
- 16. Usual, Customary and Reasonable** – A charge made by a provider which does not exceed the general level of charges made by other providers in the area or community who have similar experience and training for the treatment of dental conditions comparable in severity and nature to the dental condition being treated. The term “area” as it would apply to any particular service, medicine, or supply means a county or such greater area as it is necessary to obtain a representative cross section of the level of charges.

GENERAL PLAN INFORMATION

Name of Plan:	Douglas County Self-funded Dental Plan
Plan Sponsor / Plan Administrator:	Douglas County
Address:	P.O. Box 218 Minden, NV 89423
Phone Number:	(775) 782-9860
Participating Employer:	Douglas County
Plan Sponsor ID Number (EIN)	88-6000031
Plan Benefits;	Dental Coverage
Contract Administrator	CDS Group Health
Address:	P.O. Box 50190 Sparks, NV 89435-0190
Phone Number:	(775) 352-6900

FUNDING – SOURCES AND USES

Contribution Determinations

The Plan Sponsor will, from time to time, evaluate the costs of the Plan and determine the amount to be contributed by the Employer(s) and the amount to be contributed (if any) by each Employee.

Employer contributions and those paid by Employee, if any, will be placed in a special account or accounts administered by the Contract Administrator to provide the non-insured benefits under the Plan.

Plan Funded Benefits

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

Administration Expenses

Contributions will also be used to pay administrative expenses of the Plan in accordance with the terms and conditions of an administration agreement between the Plan Sponsor and the Contract Administrator(s).

Taxes

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

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

ADMINISTRATIVE PROVISIONS

Administration

Certain benefits of the Plan are administered by Contract Administrator(s) under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator(s).

Amendment or Termination of the Plan

The Plan Sponsor expects the Plan to be permanent, but since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right:

- To determine eligibility for benefits or to construe the terms of the Plan;
- To alter or postpone the method of payment of any benefit; and
- To amend any provision of these administrative provisions; and
- To 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; and
- To terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis if necessary.

NOTE: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's board of directors, or by written amendment which is signed by at least one Fiduciary of the Plan.

Anticipation, Alienation, Sale or Transfer

Except for assignments to providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; no 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.

Entire Contract

The Plan Document, any amendments, and the individual applications, if any, of Covered Persons will constitute the entire contract between the parties. The Plan does not constitute a contract of employment or in any way affect the rights of an Employer to discharge any Employee.

Facility of Payment

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

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

Fiduciaries

Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. The Plan Sponsor may at any time and from time to time remove any Fiduciary or appoint new Fiduciaries. Any Fiduciary may resign at any time upon 30 days' notice in writing delivered to the Plan Sponsor. Fiduciaries may act at a meeting or without a meeting, by a majority of the Fiduciaries at the time in office. The Fiduciaries may appoint a member as its secretary who will have such powers and responsibilities relating to the administration of benefits under the Plan as the Fiduciaries may delegate.

Fiduciary Responsibility, Authority and Discretion

Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

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

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Plan document 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.

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

Force Majeure

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

Gender and Number

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

Illegality of Particular Provision

The illegality of any particular provision of the Plan Document will not affect the other provisions, but 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 also the right to take the lead in any action which may be liable as an indemnitor.

Legal Actions

No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under the Plan will be resolved by the Plan Sponsor under and pursuant to the Plan Document. No action may be brought for benefits provided by the Plan or an amendment or modification thereof, or to enforce any right thereunder, until after the claim has been submitted to and determined by the Plan and then action may only be brought within one year after the date of such decision.

Misstatement of Age

If the age of a Covered Person has been misstated in an enrollment form and if the amount of the contribution required of an Employer with respect to such Covered Person is based on age, an adjustment of such contribution amount will be made based on the Cover Person's true age. Contributions so affected will be adjusted on the contribution due date next following the date of the discovery of such misstatement.

If age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of age of a Covered Person in an enrollment form or claims filing, his eligibility or amount of benefits, or both, will be adjusted in accordance with his true age. Upon the discovery of a Covered Person's misstatement of age, benefits affected by such misstatement will be adjusted immediately.

Any misstatement of age will neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force.

Misuse of Identification Card

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

Purpose of the Plan

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

Reimbursements

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

Right of Recovery

Whenever any benefit payment shave been made by the Plan in excess of the maximum amount required under the terms of the Plan Document, the Plan will have the right to recover all such excess amounts from any persons, insurance companies or other payees, and the Employee or Dependent will make a good faith attempt to assist the Contract Administrator in such recovery.

The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered hereunder. The Covered Person (parent, if a minor) will execute and deliver to the Plan all assignments and other documents necessary or useful to the Plan Sponsor or contact Administrator for the purpose of enforcing the Plan's rights under this provision.

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.

Substitution

The Plan Sponsor will be substituted for all rights of an Employee to recover attorney fees against any adverse party. Employees will do nothing to prejudice such rights of the Plan Sponsor and further they agree to do all acts necessary to preserve and take advantage of such rights. If payment has been made by the Plan in such instances and if the adverse party reimburses the Employee directly, the Plan will have the right to recover such payment from an Employee.

Titles or Headings

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

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.

PRIVACY AMENDMENT

On and after April 14, 2004, the Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") of the Health Insurance Portability and Accountability Act (HIPAA). Such standards control the dissemination of Protected Health Information (herein also "PHI") of Plan participants. PHI is individually identifiable health information that relates to a person's physical or mental health, to the health care of that person, or to the payment for that health care, whether that information is transmitted by electronic media, maintained in any electronic medium, or transmitted or maintained in any other form or medium.

Certification - The Plan hereby certifies the following:

- (1) That Protected Health Information (PHI) will be used by and/or disclosed to the Plan Sponsor/Employer consistent with the Privacy Rules. Specifically, the Plan will be permitted or required to disclose PHI to the Plan Sponsor/Employer, without individual authorization(s), for the purpose of Plan administrative functions including:
 - (a) Quality assurance and monitoring;
 - (b) Claims processing, including the handling of claims appeals;
 - (c) Auditing (i.e., to audit payments for claims incurred under the Plan);
 - (d) Providing and conducting administrative functions related to payment and healthcare operations for and on behalf of the Plan;
 - (e) Requesting proposals for services to be provided to or on behalf of the Plan;
 - (f) Investigating fraud or other unlawful acts related to the Plan and committed or reasonably suspected to have been committed by a Plan participant.

 - (2) That the Plan will disclose PHI to the Plan Sponsor/Employer only on receipt of a certification by the Plan Sponsor/Employer that the Plan document(s) have been amended to incorporate the following provisions and that the Plan Sponsor/Employer agrees to:
 - (a) Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;
 - (b) Ensure that any outside parties to whom it provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor/Employer;
 - (c) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan;
 - (d) Report to the Plan any known inconsistent use or disclosure of the information;
 - (e) Make internal practices, books, and records related to PHI available to the Department of Health and Human Services for purposes of determining compliance; and
 - (f) If feasible, return or destroy all PHI that the Employer still maintains in any form and retain no copies of such information.

 - (3) That the Plan Sponsor/Employer shall be entitled to receive PHI from:
 - (a) Any business associate of the Plan;
 - (b) Any person or entity that contracts with any such business associate;
-

- (c) Any person or entity that contracts with the Plan Sponsor/Employer to provide services to on behalf of the Plan;
 - (d) Any health insurer, health insurance issuer or other entity that provides coverage or services to or on behalf of the Plan;
 - (e) Any healthcare clearinghouse that provides services or to on behalf of the Plan or with respect to Plan participants;
 - (f) Any other person or entity that maintains, or has authority to direct the disclosure of, PHI related to any Plan participant.
- (4) That Plan participants may:
- (a) access their PHI, including copying it,
 - (b) amend the information,
 - (c) receive an accounting, on request, of all their PHI disclosures, and
 - (d) follow a specific process to address complaints.
- (5) That the Plan will ensure availability to the Department of Health and Human Services (HHS) of the Plan's internal practices, books and records on uses and disclosures of Protected Health Information (PHI).

Separation of Plan & Plan Sponsor/Employer - To provide adequate separation ("firewalls") between the Plan and the Plan Sponsor/Employer in order to assure protection of PHI, the Plan is amended to reflect that:

- (1) Only the Human Resources Manager will be given access to PHI received from the Plan;
- (2) Access to and use of PHI by the employees identified above is restricted to Plan administration functions that the Plan Sponsor/Employer performs for the group health plan;
- (3) Any issues of noncompliance by the employees identified above will be resolved in one or more of the following manners as may be deemed appropriate by the Privacy Officer:
 - (a) Additional or remedial privacy training;
 - (b) Counseling by a supervisor;
 - (c) Notation in personnel files;
 - (d) Letter of reprimand from the supervisor;
 - (e) Removal from within the firewall;
 - (f) Removal from current position;
 - (g) Suspension from current position;
 - (h) Termination of employment;
 - (i) As otherwise deemed appropriate by the Privacy Officer.

Regardless of whether a person is disciplined or terminated pursuant to this provision, the Plan reserves the right to direct that the Plan Sponsor, and upon receipt of such direction the Plan Sponsor shall, modify or revoke any person's access to or use of PHI.

The privacy officer will keep a record of all disciplinary actions taken for six (6) years following the action.

The Plan will take all practical steps to reduce the harmful effects caused by uses or disclosures of PHI in violation of its policies or procedures and the HIPAA Privacy Rules.

NOTE: The above sanctions do not apply to violations that are disclosures by whistleblowers and work-force member crime victims or in the case of retaliatory or intimidating actions taken against individuals for asserting their privacy rights. Complaints about these actions will be directed to the Department of Health and Human Services Office of Civil Rights.

- (4) Except as expressly listed herein or with specific written individual authorization, only summary information (information which has been de-identified) may be provided to the Plan Sponsor/Employer.
- (5) When using or disclosing PHI or when requesting PHI from another party, the Plan Sponsor/Employer will make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purposes of the use or disclosure and will limit any request for PHI to the minimum necessary to satisfy the purpose of the request.

HIPAA SECURITY STANDARDS

This amendment is intended to bring the Plan into compliance with the requirements of 45 C.F.R. § 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162, and 164 (the regulations are referred to herein as the "HIPAA Security Standards") by establishing Plan sponsor's obligations with respect to the security of Electronic Protected Health Information. The obligations set forth below are effective on the later of April 21, 2005 (April 21, 2006 for small health plans), or the effective date of this Amendment.

The Plan Documents of the Plan are hereby amended as follows:

I. Definitions

- A. Electronic Protected Health Information - The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.
- B. Plan - The term "Plan" means the Plan as named above.
- C. Plan Documents - The term "Plan Documents" means the group health plan's governing documents and instruments (i.e., the documents under which the group health plan was established and is maintained), including but not limited to The Reno-Tahoe Airport Authority Group Health & Welfare Benefit Plan.
- D. Plan sponsor - The term "Plan sponsor" means the entity as defined in section 3(16)(B) of ERISA, 29 U.S.C. § 1002(16)(B). The Plan sponsor is The Reno-Tahoe Airport Authority.
- E. Security Incidents - The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

II. Plan Sponsor Obligations

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan sponsor on behalf of the Plan, the Plan sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

- A. Plan sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan sponsor creates, receives, maintains, or transmits on behalf of the Plan.
- B. Plan sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures.

- C. Plan sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information.
- D. Plan sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - 1. Plan sponsor shall report to the Plan within a reasonable time after Plan sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and
 - 2. Plan sponsor shall report to the Plan any other Security Incident on an aggregate basis every calendar quarter, or more frequently upon the Plan's request.

HIPAA PRIVACY

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.
- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Covered Persons. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Covered Person's PHI, and inform him/her about:

the Plan's disclosures and uses of PHI;

the Covered Person's privacy rights with respect to his/her PHI;

the Plan's duties with respect to his/her PHI;

the Covered Person's right to file a complaint with the Plan and with the Secretary of HHS; and

the person or office to contact for further information about the Plan's privacy practices.

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

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is:

to carry out Payment of benefits;

for Health Care Operations;

for Treatment purposes; or

if the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

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

not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);

ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

establish safeguards for information, including security systems for data processing and storage;

maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;

receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;

not use or disclose genetic information for underwriting purposes;

not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);

make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);

make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);

make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;

train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;

if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

the following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

in the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance and to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

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

Disclosure of Certain Enrollment Information to the Plan Sponsor

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

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

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

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

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

Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Person's information; and

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

Other Possible Uses and Disclosures of PHI

Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law;

Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

A public health authority or other appropriate government authority authorized by law to receive reports of Child abuse or neglect;

Report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;

Locate and notify persons of recalls of products they may be using; and

A person who may have been exposed to a communicable Disease or may otherwise be at risk of contracting or spreading a Disease or condition, if authorized by law;

The Plan may disclose PHI to a government authority, except for reports of Child abuse or neglect, when required or authorized by law, or with the Covered Person's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Covered Person that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI;

Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws;

Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Covered Person's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Covered Person of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards;

Law Enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Covered Person's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises;

Decedents: The Plan may disclose PHI to family members or others involved in decedent's care or payment for care, a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years;

Research: The Plan may use or disclose PHI for research, subject to certain limited conditions;

To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public;

Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law; and

Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

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

The Plan may elect not to treat the person as the Covered Person's personal representative if it has a reasonable belief that the Covered Person has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Covered Person's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Covered Person; and

Disclosures to the Secretary of the U.S. Dept. of Health and Human Services: The Plan is required to disclose the Covered Person's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Instances When Required Authorization Is Needed From Covered Persons Before Disclosing PHI

most uses and disclosures of psychotherapy notes;

uses and disclosures for marketing;

sale of PHI; and

other uses and disclosures not described in can only be made with authorization from the Covered Person. The Covered Person may revoke this authorization at any time.

Covered Person's Rights

The Covered Person has the following rights regarding PHI about him/her:

Request Restrictions: The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions;

Right to Receive Confidential Communication: The Covered Person has the right to request that he/she receive communications regarding PHI in a certain manner or at a

certain location. The request must be made in writing and how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests;
Right to Receive Notice of Privacy Practices: The Covered Person is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator;

Accounting of Disclosures: The Covered Person has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Person is entitled to such an accounting for the 6 years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Covered Person of the basis of the disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Privacy Compliance Coordinator;

Access: The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI, or to have a copy of your PHI transmitted directly to another designated person, contact the Privacy Compliance Coordinator. A request to transmit PHI directly to another designated person must be in writing, signed by the Covered Person and the recipient must be clearly identified. The Plan must respond to the Covered Person's request within thirty (30) days (in some cases, the Plan can request a thirty (30) day extension). In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial;

Amendment: The Covered Person has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Covered Person's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request; and

Fundraising contacts: The Covered Person has the right to opt out of fundraising contacts.

Questions or Complaints

If the Covered Person wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Covered Person may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Covered Person with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

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

Contact Information

Compliance/Legal Department
Douglas County
PO Box 218
Minden, NV 89423
Phone: 775-782-9860