

**CITY OF HENDERSON  
SELF-FUNDED INSURANCE COMMITTEE MEETING**

**MINUTES  
July 10, 2013**

**I. Call to order**

Chairman Fred Horvath called the City of Henderson Insurance Committee meeting to order at 10:06 a.m., in the Westgate Conference Room, 1<sup>st</sup> Floor, City Hall, 240 Water Street, Henderson, Nevada.

**II. Confirmation and posting**

Ms. Neilson confirmed the meeting had been posted in accordance with the Open Meeting Law by posting the agenda three working days prior to the meeting at City Hall, Multigenerational Center, Whitney Ranch Recreational Center, and Fire Station No. 86.

**Roll Call**

**PRESENT:** Chairman Fred Horvath  
                  Connie Kershaw  
                  Norm "Doc" Halliday  
                  Priscilla Howell  
                  Ken Kerby  
                  Jayne Mazurkiewicz  
                  Tim O'Neill  
                  Mike Charlton (for Dan Pentkowski)

**ABSENT:** Dan Pentkowski (excused)

**STAFF:** Bob Osip, Risk Manager  
                  Travis Buchanan, Senior Assistant City Attorney  
                  Alysa Neilson, Employee Benefits Coordinator  
                  Tedio Jackson, Minutes Clerk

**ALSO PRESENT:** Shawn Adkins, GBS  
                  Bill Bixler, The Loomis Company  
                  Pam Levy, Sierra Healthcare Options  
                  Amber Hubber, HPN  
                  Tom Chiello, HPSA (left at 12:58 p.m.)

**III. Acceptance of Agenda**

(Motion) Mr. Halliday introduced a motion to accept the agenda as submitted, seconded by Mr. O'Neill. The vote favoring approval was unanimous. Chairman Horvath declared the motion carried.

**IV. Public Comment**

There were no comments presented by the public.

**V. Unfinished Business**

**A. Discussion regarding combined out-of-pocket maximum accumulation**

Shawn Adkins, GBS, reported that effective January 1, 2014, the plan will be required to have a combined out-of-pocket maximum for medical and prescription drugs which will include deductible and co-pays.

Amber Hubber, HPN, reported that HPN has a co-payment maximum of \$5,700.00. She noted that prescription drug co-payments will be affected as they will be included in the out-of-pocket maximum. She said underwriting is mapping the current plan to the 2014 plan. Ms. Hubber will provide options for the committee to discuss at the next meeting.

Responding to a question by Mr. Adkins as to whether the out-of-pocket maximum cost for medical and Rx will be embedded or separated out, Ms. Hubber said the plan is to have them combined; however, it depends on what the system can support. She does not believe they can run the system both ways.

A discussion ensued regarding out-of-pocket maximum amounts. Mr. Adkins noted that replacing co-pays with co-insurance would save the Plan a significant amount of money.

Ms. Hubber commented that the City's HPN plan is a rich benefit plan. She suggested the committee review the plan design to see how money could be saved.

Regarding a comment by Mr. Adkins that the City is not required to offer HPN to members, Chairman Horvath said he thought State of Nevada mandated employers to offer an HMO to members.

**B. Revision to the plan document to allow employees to waive coverage**

Bob Osip, Risk Manager, reported that the PPACA requirement to cover employees who work 30-hours per week or more was deferred from January 1, 2014, to January 1, 2015, so this decision can be continued to a later date. Part-time employees will then be eligible for medical insurance; however, they may want to opt out of coverage.

Shawn Adkins, GBS, explained three options for the committee to consider: 1) let any employees opt out of the plan; 2) let any employees opt out of the plan if they prove they have other coverage; or 3) offer incentive for people to opt out of plan.

Bill Bixler, The Loomis Company, commented that the second option is the most common. He noted that this is difficult to administer through Loomis and the City liaison.

Mr. Adkins estimated that the second option could save the plan \$50,000.00 to \$75,000.00 per year. He noted that increasing spousal coverage will drive spouses to take insurance from their work.

(Motion) Mr. O'Neill introduced a motion to not allow employees to waive coverage.

Following a brief discussion, there was a consensus to not change the language in the Plan at this time. It was noted that a motion is not necessary if the Plan language remains the same.

(Motion Withdrawn) Mr. O'Neill withdrew his motion to not allow employees to waiver coverage, as the language will remain the same.

**C. Lifesigns contract for primary care services**

Bob Osip, Risk Manager, reviewed backup information on Lifesigns, and reported that there is enough interest from police and fire personnel to expand the current contract.

Mike Charlton, representing the International Association of Firefighters, commented that members favor Lifesigns because they offer a one-stop shop.

Ms. Kershaw stated that the City currently has a contract for physical exams and expressed concern about having a direct contract with another company.

Staff will research costs, savings, and state law mandates, and report back at the next meeting.

**D. Establishment of funding rates for plan years 2014 and 2015**

Bob Osip, Risk Manager, referred to the back-up material entitled "Contribution Analysis" and reminded committee members that Model B was the most popular; however, the concern was the low fund balance at end of 2015.

Chairman Horvath reported on issues regarding Dignity Healthcare. He explained that if the committee adopts the rates under Model B and joins the Hospital Coalition, the reserve balance at the end of 2015 would be \$1.2 million. He noted that staff must also coordinate the setting of rates with the collective bargaining agreements.

Mr. Halliday asked to have a separate conversation regarding the rates for the Henderson Police Officers Association.

Mr. O'Neill commented that he is opposed to the model that increases the employee's rates almost 50 percent.

This item will be continued to the next meeting. Committee members can make a better informed decision based on information from the Hospital Coalition and Dignity Healthcare negotiations.

Note: A lunch recess was taken from 11:12 a.m. to 11:45 a.m.

**VI. New Business**

**A. Approval of Minutes for the regular meeting of June 13, 2013**

(Motion) Mr. Halliday introduced a motion to approve the minutes of June 13, 2013, as presented, seconded by Ms. Kershaw. The vote favoring approval was unanimous. Chairman Horvath declared the motion carried.

**B. Presentation of the Plan's Financial Status Report as of June 20, 2013**

Connie Kershaw, Accounting Manager, distributed and reviewed the Self-Funded Health Insurance Fund as of June 20, 2013. She noted a loss of \$500,000.00 and a decrease in Delta Dental claims.

**C. Loomis Monthly Claims Report**

Bill Bixler, The Loomis Company, reviewed the monthly claims report. He noted that five new large claimants hit a \$40,000.00 threshold in June and two members breached the specific deductible.

Mr. Bixler reported that last month the Plan paid 100 percent on an out-of-network claim because that member reached their out-of-pocket maximum.

**D. Sierra Healthcare Options Monthly Report – hospital length of stay and provider network update**

Pam Levy, SHO, distributed and reviewed the 2013 monthly average length of stay report and said the average in June was 2.15 days.

**E. Gallagher Benefit Services Status Report**

Shawn Adkins, GBS, reviewed current and proposed PPACA changes outlined on a paper entitled "Welcome to Healthcare Reform." He noted that claims information compared against Gallagher's established rates indicate the Plan is on track for a loss of \$1.2 million by the end of 2013.

Responding to a question by Chairman Horvath as to Summary Plan Description modifications for January 2014, Mr. Adkins suggested modification to the maximum out of pocket, the 90-day waiting period, and cross accumulation of co-pays. He believes it should be easy for Loomis to build these modifications into their system.

**F. Review plan design changes to the medical and prescription drug plans to reduce plan expenses**

Shawn Adkins, GBS, reviewed the working draft plan modifications dated July 10, 2013 and suggested potential design plan changes.

Referring to the discussion on Unfinished Business D, Chairman Horvath reported that he just received information that the Hospital Coalition will exclude Dignity Healthcare from their network due to pricing differences. Dignity Healthcare is asking for eight percent and the Hospital Coalition will only go up four percent.

Responding to a question by Mr. Adkins regarding whether students covered under the Plan should be tied to where their parents live, it was suggested to let the parents make that decision. An option is that at open enrollment each year, students could default to the parent's network or offered a new network. Loomis can provide a separate card for a separate group.

Mr. Adkins reviewed pages 4 and 5 of the Working Draft Plan Modifications handout provided in the back-up material regarding proposed plan changes for Rx.

Following further discussion, Chairman Horvath stated that there needs to be serious changes to out-of-network benefits. The changes outlined on page 5, 3(b) are not enough to make a difference.

Chairman Horvath said he made a commitment to Dan Pentkowski that the committee would not make significant design changes at this meeting since Mr. Pentkowski is not present. This item will be continued to the next meeting.

Mr. Adkins reviewed the rest of the proposed Plan design changes in the packet, and a discussion ensued regarding other opportunities and ways to achieve savings. It was noted that the Plan is paying a lot of extra money in out-of-network claims and the issue is getting out of control. The members should make the choice to pay out-of-pocket rather than the Plan bearing that cost.

**G. Create separate out-of-area plan for members residing outside the PPO service area**

This item was reviewed by Mr. Adkins under the previous item.

(Motion) Mr. O'Neill introduced a motion to accept the Plan changes as outlined in the Working Draft Plan Modification packet on page 3, Plan Changes, Network Only, Creation of Out-of-Sierra Service Area, with the use of Cigna; to be effective January 1, 2014, seconded by Mr. Kerby. The vote favoring approval was unanimous. Chairman Horvath declared the motion carried.

**H. Plan change to reduce or exclude coverage for non-network hospitals or residential facilities**

This item was continued to the next meeting.

**I. Plan changes to comply with the Patient Protection and Affordable Care Act (PPACA) requirements effective January 1, 2014.**

**1. Revision to the Schedule of Medical Benefits to cross accumulate co-pays and deductible to the out-of-pocket maximum**

Shawn Adkins, GBS, reported that GBS is tracking these changes that have to be updated throughout the PPACA. He explained that this relates to having the absolute maximum amount out of pocket. If we keep the current maximum out of pocket as it is (\$1,500.00 or \$1,800.00 with the deductible), it will cost the plan about \$60,000.00. He can present options at the next meeting that would offset this cost.

Mr. Osip commented that the Summary Plan Description language needs to change to cross accumulate.

(Motion) Mr. Halliday introduced a motion to amend the Summary Plan Description to comply with the requirements for cross accumulation for co-pays and deductibles for in-network benefits only, to be effective January 1, 2014, seconded by Ms. Howell. The vote favoring approval was unanimous. Chairman Horvath declared the motion carried.

**2. Revision to Eligibility Provisions to include part-time employees working 30 hours per week**

This item was determined to be moot until next year.

**3. Revision to the 90-day initial waiting period for new hires under Eligibility Provisions**

Shawn Adkins, GBS, explained that under PPACA, you have to cover people by or on 90 days. He recommended amending the language in the Summary Plan Description from 90 days to 30 days.

Mr. Osip suggested the language read "first of the month following 30 days," to cover the months that have 31 days.

(Motion) Mr. O'Neill introduced a motion to change the eligibility requirement to first of the month following 30 days of employment, effective January 1, 2014, seconded by Mr. Kerby. The vote favoring approval was unanimous. Chairman Horvath declared the motion carried.

**4. Remove pre-existing conditions language**

Staff reported that pre-existing conditions language was previously removed for children and needs to be removed for adults, to be effective January 1, 2014.

(Motion) Ms. Mazurkiewicz introduced a motion to eliminate pre-existing conditions language for adults, to be effective January 1, 2014, seconded by Mr. O'Neill. The vote favoring approval was unanimous. Chairman Horvath declared the motion carried.

**J. Discussion regarding the Supreme Court decision on the Defense of Marriage Act**

Travis Buchanan, Senior Assistant City Attorney, reported that per State constitution, Nevada does not recognize same sex marriages.

Mr. Osip noted the Plan requires domestic partners to register with the City.

**K. International Foundation of Employee Benefit Plans (IFEBP) membership and annual conference attendance**

Bob Osip, Risk Manager, informed committee members that the International Foundation of Employee Benefit Plans conference will be held in Las Vegas, Nevada, from October 20-23, 2013, at the Mandalay Bay Hotel and Casino. Any members interested in attending this conference should contact Mr. Osip. The cost is \$1,500.00 per person.

**VII. Public Comment**

There were no public comments presented.

**VIII. Chairman/Committee Member/Committee Staff Comment**

Chairman Horvath reported that the Nevada Supreme Court issued a ruling that City of Sparks employees working for municipal court are not considered City of Sparks employees. This ruling causes the City of Henderson to amend language pertaining to non-employees of the City of Henderson, and complicates issues relating to municipal court personnel who are members of the Teamsters Collective Bargaining Agreement. Staff is going to draft a memorandum of agreement to address this issue in a way to be as seamless as possible to employees.

**IX. Set Next Meeting Date**

The next meeting was set for August 14, 2013, from 10:00 a.m. to 2:00 p.m.

**X. Adjournment**

There being no further business to come before the Committee,  
Chairman Horvath adjourned the meeting at 1:30 a.m.

Respectfully submitted,

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Tedie Jackson, Minutes Clerk



2013 Plan Year - Paid Claims Analysis  
 City of Henderson  
 Claims Paid thru 7/31/2013

MONTH	YEAR	EES*	Med/Dent/Rx TOTAL AMOUNT PAID	Stop Loss Reimb.
Jan	2013	1,177	\$726,298	-\$78,782
Feb	2013	1,174	\$916,801	\$0
Mar	2013	1,171	\$985,649	\$0
Apr	2013	1,173	\$1,270,304	\$0
May	2013	1,152	\$1,073,092	\$0
June	2013	1,150	\$976,190	\$0
July	2013	1,148	\$925,366	\$0
<b>GRAND TOTAL - 2013 YTD -</b>			<b>\$6,873,700</b>	<b>-\$78,782</b>
<b>2013 STOP LOSS REIMBURSEMENTS</b>			<b>-\$78,782</b>	
<b>TOTAL NET - 2013 YTD</b>			<b>\$6,794,918</b>	
<b>GRAND TOTAL YEAR 2012</b>			<b>\$11,095,050</b>	
<b>2012 STOP LOSS REIMBURSEMENTS</b>			<b>-\$194,153</b>	
<b>TOTAL NET - 2012</b>			<b>\$10,900,897</b>	

EES\* number represents medical lives

## Paid Summary

5/1/13 - 7/31/13

MONTH	YEAR	CATEGORY	TOTAL AMOUNT PAID	Stop Loss Reimb.
MAY		2013 DENTAL	\$56,563	
MAY		2013 MEDICAL	\$813,441	
MAY		2013 PRESCRIPTION	\$203,088	
<b>MAY</b>		<b>2013</b>	<b>\$1,073,092</b>	<b>\$0</b>
JUNE		2013 DENTAL	\$46,449	
JUNE		2013 MEDICAL	\$725,562	
JUNE		2013 PRESCRIPTION	\$204,179	
<b>JUNE</b>		<b>2013</b>	<b>\$976,190</b>	<b>\$0</b>
JULY		2013 DENTAL	\$59,353	
JULY		2013 MEDICAL	\$643,951	
JULY		2013 PRESCRIPTION	\$222,422	
<b>JULY</b>		<b>2013</b>	<b>\$925,726</b>	<b>\$0</b>
<b>ROLLING THREE MONTHS</b>			<b>\$2,975,008</b>	<b>\$0</b>

5/1/12 - 7/31/12

MONTH	YEAR	CATEGORY	TOTAL AMOUNT PAID	Stop Loss Reimb.
MAY		2012 DENTAL	\$46,214	
MAY		2012 MEDICAL	\$565,029	
MAY		2012 PRESCRIPTION	\$101,034	
<b>MAY</b>		<b>2012</b>	<b>\$712,277</b>	<b>\$0</b>
JUNE		2012 DENTAL	\$62,396	
JUNE		2012 MEDICAL	\$463,378	
JUNE		2012 PRESCRIPTION	\$201,027	
<b>JUNE</b>		<b>2012</b>	<b>\$726,801</b>	<b>\$0</b>
JULY		2012 DENTAL	\$79,951	
JULY		2012 MEDICAL	\$660,742	
JULY		2012 PRESCRIPTION	\$233,590	
<b>JULY</b>		<b>2012</b>	<b>\$974,283</b>	<b>\$0</b>
<b>ROLLING THREE MONTHS</b>			<b>\$2,413,361</b>	<b>\$0</b>

**City Of Henderson Claims Analysis**

**1/1/12 - 12/31/12**

**2012 Plan Year - Paid Claim Basis**

Month	Year	Med Ees	Dent Ees	Medical	Dental	Rx	Totals	Stop Loss Reimb.	Adjusted Total	Avg Cost Med/Rx PEPM	Avg Cost Dent PEPM
Jan	2012	1,162	1,224	650,208	75,056	174,122	899,386	-\$135,219	764,167	\$593	\$61
Feb	2012	1,158	1,220	555,734	76,977	208,047	840,758	-\$38,593	802,165	\$626	\$63
Mar	2012	1,158	1,221	898,583	79,874	225,521	1,203,978	-\$6,114	1,197,864	\$965	\$65
Apr	2012	1,170	1,049	522,098	98,818	244,480	865,396	-\$23,304	842,093	\$635	\$94
May	2012	1,173	1,053	565,029	46,214	191,034	802,277	\$0	802,277	\$645	\$44
June	2012	1,172	1,052	463,378	62,396	201,027	726,801	\$0	726,801	\$567	\$59
July	2012	1,169	1,044	660,742	74,951	233,590	969,283	\$0	969,283	\$765	\$72
Aug	2012	1,173	1,043	737,290	56,620	186,674	980,584	-\$67,753	912,832	\$730	\$54
Sept	2012	1,175	1,044	755,993	51,869	190,366	998,228	-\$2,759	995,469	\$803	\$50
Oct	2012	1,178	1,045	704,882	72,278	219,798	996,958	\$26,608	1,023,566	\$808	\$69
Nov	2012	1,178	1,046	468,947	46,284	201,614	716,845	\$49,463	766,308	\$611	\$44
Dec	2012	1,177	1,046	784,344	86,399	223,812	1,094,555	\$3,518	1,098,073	\$860	\$83
<b>Grand Totals</b>	<b>2012</b>	<b>14,043</b>	<b>13,087</b>	<b>7,767,229</b>	<b>827,737</b>	<b>2,500,084</b>	<b>11,095,050</b>	<b>-\$194,153</b>	<b>10,900,897</b>	<b>\$717</b>	<b>\$63</b>

**City Of Henderson Claims Analysis**

**1/1/13 - 12/31/13**

**2013 Plan Year - Paid Claim Basis**

Month	Year	Med Ees	Dent Ees	Medical	Dental	Rx	Totals	Stop Loss Reimb.	Adjusted Total	Avg Cost Med/Rx PEPM	Avg Cost Dent PEPM
Jan	2013	1,177	1,008	503,226	24,665	198,407	726,298	-\$78,782	647,516	\$529	\$24
Feb	2013	1,174	1,007	710,929	42,897	162,975	916,801	\$0	916,801	\$744	\$43
Mar	2013	1,171	1,003	718,222	75,144	192,283	985,649	\$0	985,649	\$778	\$75
Apr	2013	1,173	1,004	894,106	67,603	308,523	1,270,232	\$0	1,270,232	\$1,025	\$67
May	2013	1,152	984	813,441	56,563	203,088	1,073,092	\$0	1,073,092	\$882	\$57
June	2013	1,150	979	725,561	46,449	204,179	976,189	\$0	976,189	\$808	\$47
July	2013	1,148	970	643,591	59,353	222,422	925,366	\$0	925,366	\$754	\$61
Aug	2013										
Sept	2013										
Oct	2013										
Nov	2013										
Dec	2013										

<b>Grand Totals 2013</b>	<b>8,145</b>	<b>6,955</b>	<b>5,009,076</b>	<b>372,674</b>	<b>1,491,877</b>	<b>6,873,627</b>	<b>-\$78,782</b>	<b>6,794,845</b>	<b>\$788</b>	<b>\$54</b>
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**City of Henderson  
 Large Claim Summary - Claims over \$40,000 - Medical Only  
 Paid: 1/1/2013 thru 7/31/2013**

	Total Members	Total Paid	PMPY TOTAL
# of claimants > \$40,000 - < \$100,000	11	\$681,873	\$61,988
# of claimants > \$100,000	4	\$505,554	\$126,389
<b>GRAND TOTAL</b>	<b>15</b>	<b>\$1,187,427</b>	<b>\$79,162</b>

Total June Large claim costs - \$1,042,118      13 total members  
 Total \$ Paid Increase June to July - \$145,309      15 total members

\$0



### 2013 Monthly Average Length of Stay

<i>City of Henderson</i>	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Yr. avg.	
avg length of stay	3.08	3.73	4.88	10.09	3.36	2.15	14.25						<b>5.26</b>	
avg daily census	1.29	2.00	2.68	3.70	1.52	0.93	3.68						<b>1.32</b>	Yr. total
Direct														<b>0</b>
Elective	3	6	9	4	10	8	1							<b>41</b>
ER	10	9	8	7	4	5	7							<b>50</b>
Observation														<b>0</b>
Obstetrical														<b>0</b>
Pediatric														<b>0</b>
total # admit	13	15	17	11	14	13	8							<b>91</b>
total # beddays	40	56	83	111	47	28	114							<b>479</b>

### Length of Stay Summary

as of 07/31/2013

	2008	2009	2010	2011	2012	2013
<i>City of Henderson</i>						
avg length of stay	<b>2.46</b>	<b>3.38</b>	<b>3.29</b>	<b>2.57</b>	<b>3.45</b>	<b>5.26</b>
total # admit	147	136	120	118	149	91
total # beddays	361	489	395	303	513	479

### 2013 Inpatient Utilization

GROUP NAME: *City of Henderson*

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD TOT	YTD AVG
<b>Facility</b>														
Boulder City Hospital														
Centennial Hills	1												1	1
Desert Springs	1		1										2	1
Healthsouth														
Kindred														
Las Vegas Recovery		1											1	1
Montevista					3								3	3
Mountain View Hospital				1									1	1
North Vista Hospital			1										1	1
Out of Area/Other	1		5	2	3	2	1						14	2
Rancho Rehab														
Southern Hills						1							1	1
Spring Mtn Treatment	1	2					1						4	1
Spring Valley Hospital	1	1	1	2									5	1
St. Rose Delima	1	2	2		1		2						8	2
St. Rose San Martin	2	2		1		2							7	2
St. Rose Siena	4	5	5	4	7	8	4						37	5
Summerlin			1	1									2	1
Sunrise		1	1										2	1
UCLA														
UMC	1	1											2	1
Valley														
<b>Monthly Total</b>	<b>13</b>	<b>15</b>	<b>17</b>	<b>11</b>	<b>14</b>	<b>13</b>	<b>8</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>91</b>	<b>15</b>







**SOUTHERN NEVADA QUARTERLY PROVIDER REPORT**

report period: 2013

Primary Care Provider	April	May	June
Family Practice	387	388	388
General Practice	44	45	46
Gynecology	6	6	6
Internal Medicine	547	546	549
OB/GYN	172	172	172
Pediatrics	205	203	204
<b>Total Primary Care Providers</b>	<b>1361</b>	<b>1360</b>	<b>1365</b>

Specialists Care Provider	April	May	June
Allergy/Immunology	11	11	11
Anesthesiology	273	277	280
Anesthesiology -CRNA	31	32	34
Audiology	17	17	17
Cardiology	122	122	122
Cardiology - Pediatric	16	16	16
Cardiovascular/Thoracic Surgery	25	23	25
Chiropractic	91	93	93
Colon/Rectal Surgery	7	7	7
Dermatology	48	48	48
Emergency Medicine	16	16	16
Emergency Medicine - Pediatric	17	17	17
Endocrinology	22	22	21
Endocrinology - Pediatric	5	5	5
Endocrinology - Reproductive	7	7	6
Gastroenterology	54	54	55
Gastroenterology - Pediatric	7	7	7
General Surgery	81	80	80
General Surgery - Pediatric	6	6	6
General Vascular Surgery	5	5	5
Genetics	1	1	1
Geriatrics	6	6	6
Gynecological Oncology	8	8	8
Hand Surgery	10	10	10
Hematology/Oncology	53	53	53
Hematology/Oncology - Pediatric	11	11	11
Infectious Disease	23	23	23
Infectious Disease - Pediatric	4	4	4
Intensive Care - Pediatric	25	26	28
Neonatology	59	61	61
Nephrology	70	68	69
Nephrology - Pediatric	3	3	3
Neurology	52	51	52
Neurology -Pediatric	4	4	4
Neuropsychology	4	4	4
Neurosurgery	29	29	28

Specialists Care Provider	April	May	June
Neurosurgery - Pediatric	1	1	1
Occupational Medicine	1	1	1
Ophthalmology	67	67	67
Ophthalmology - Pediatric	2	2	2
Oral Surgery	10	10	10
Orthopedic Surgery	121	121	121
Orthopedic Surgery - Pediatric	6	6	6
Otolaryngology	30	30	30
Pain Management	49	51	52
Pathology	48	49	50
Perinatology	18	18	18
Physical Medicine/Rehab	27	28	27
Plastic Surgery	12	12	11
Podiatry	49	49	49
Pulmonology	37	37	37
Pulmonology - Pediatric	4	4	4
Radiation Therapy	18	18	18
Radiology	193	194	194
Rheumatology	16	16	16
Rheumatology - Pediatric	1	2	2
Speech Pathology	26	26	26
Therapy - Occupational	20	20	20
Therapy - Physical	37	37	37
Urology	29	31	32
Urology - Pediatric	6	6	6
<b>Total Specialists Care Providers</b>	<b>2051</b>	<b>2063</b>	<b>2073</b>

Dental Provider	April	May	June
Endodontist	20	20	20
General Dentistry	480	482	484
Oral Surgery	20	20	20
Orthodontist	53	53	52
Pediatric Dentist	42	42	42
Periodontist	13	13	13
<b>Total Dental Providers</b>	<b>628</b>	<b>630</b>	<b>631</b>

Mental Health Provider	April	May	June
Facility	18	18	18
Masters	151	151	151
Psychiatry	79	79	83
Psychology	65	64	64
Social Worker	151	151	152
<b>Total Mental Health Providers</b>	<b>464</b>	<b>463</b>	<b>468</b>



**MOHAVE QUARTERLY PROVIDER REPORT**

report period: 2013

Primary Care Provider	April	May	June
Family Practice	36	30	31
General Practice	10	10	10
Internal Medicine	54	54	56
OB/GYN	10	9	11
Pediatrics	7	5	5
<b>Total Primary Care Providers</b>	<b>117</b>	<b>108</b>	<b>113</b>

Specialists Care Provider	April	May	June
Allergy/Immunology	2	2	2
Anesthesiology	18	18	18
Audiology	1	1	1
Cardiology	10	13	15
Cardiovascular/Thoracic Surgery	6	4	4
Chiropractic	6	6	6
Colon/Rectal Surgery	1	1	1
Dermatology	2	2	2
Emergency Medicine	1	1	1
Endocrinology	3	2	2
Gastroenterology	3	3	3
General Surgery	8	9	9
Hematology/Oncology	6	6	6
Infectious Disease	1	1	1
Nephrology	15	14	14
Neurology	4	4	4
Neurosurgery	1	1	1
Occupational Medicine	1	1	1
Ophthalmology	16	16	16
Orthopedic Surgery	12	10	13
Otolaryngology	4	4	4
Pain Management	7	7	7
Pathology	3	4	5
Physical Medicine/Rehab	2	2	2
Plastic Surgery	1	0	0
Podiatry	2	2	2
Pulmonology	3	3	4
Radiology	7	7	8
Rheumatology	1	1	1
Speech Pathology	1	1	1
Therapy - Occupational	3	3	3
Therapy - Physical	3	3	3
Urology	5	4	4
<b>Total Specialists Care Providers</b>	<b>159</b>	<b>156</b>	<b>164</b>



**NORTHERN NEVADA QUARTERLY PROVIDER REPORT**

report period: 2013

Primary Care Provider	April	May	June
Family Practice	277	279	280
General Practice	13	15	15
Gynecology	9	9	9
Internal Medicine	190	193	194
OB/GYN	65	67	67
Pediatrics	57	58	59
<b>Total Primary Care Providers</b>	<b>611</b>	<b>621</b>	<b>624</b>

Specialists Care Provider	April	May	June
Allergy/Immunology	8	8	8
Anesthesiology	88	88	91
Anesthesiology -CRNA	8	8	8
Audiology	13	14	14
Cardiology	61	62	64
Cardiology -Pediatric	14	15	15
Cardiovascular/Thoracic Surgery	7	7	7
Chiropractic	49	50	49
Colon/Rectal Surgery	5	5	5
Dermatology	25	25	26
Emergency Medicine	25	25	25
Emergency Medicine -Pediatric	2	2	2
Endocrinology	11	11	11
Endocrinology -Pediatric	2	2	2
Endocrinology - Reproductive	2	2	2
Gastroenterology	39	39	39
General Surgery	62	62	62
General Vascular Surgery	5	5	5
Genetics	1	1	1
Geriatrics	3	3	3
Gynecological Oncology	1	1	1
Hematology/Oncology	14	14	14
Hematology/Oncology -Pediatric	7	7	7
Infectious Disease	4	4	4
Infectious Disease -Pediatric	2	2	2
Intensive Care -Pediatric	9	10	11
Neonatology	13	13	13
Nephrology	14	14	14
Nephrology - Pediatric	1	1	1
Neurology	21	21	21
Neurology -Pediatric	6	6	6
Neurosurgery	32	32	30
Occupational Medicine	1	1	0

Specialists Care Provider	April	May	June
Ophthalmology	27	27	27
Ophthalmology -Pediatric	2	2	2
Orthopedic Surgery	57	57	58
Otolaryngology	15	15	15
Pain Management	19	19	19
Pathology	36	36	36
Perinatology	2	2	2
Physical Medicine/Rehab	30	30	30
Plastic Surgery	7	7	7
Podiatry	23	23	23
Pulmonology	3	3	6
Pulmonology -Pediatric	4	4	4
Radiation Therapy	11	12	12
Radiology	105	106	106
Rheumatology	8	8	7
Rheumatology -Pediatric	1	2	2
Speech Pathology	15	15	15
Therapy - Occupational	19	19	19
Therapy - Physical	57	57	59
Urology	17	17	17
<b>Total Specialists Care Providers</b>	<b>1013</b>	<b>1021</b>	<b>1029</b>

Dental Provider	April	May	June
Endodontist	3	3	3
General Dentistry	88	93	94
Oral Surgery	4	4	4
Orthodontist	4	4	4
Pediatric Dentist	10	10	10
Periodontist	0	0	0
<b>Total Dental Providers</b>	<b>109</b>	<b>114</b>	<b>115</b>



City of Henderson

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2013 GBS Funding Rates	Self Funded Medical & Rx			Self Funded	
	Active	Early Retiree	MCR Retiree	Dental	Vision
Employee (EE)	\$398.40	\$398.40	\$346.06	\$28.88	\$6.62
Employee + Spouse	\$816.72	\$816.72	\$692.13	\$59.20	\$13.58
Employee + Child(ren)	\$717.12	\$717.12	\$664.78	\$51.98	\$11.92
Employee + Family	\$1,135.44	\$1,135.44	\$1,010.85	\$82.31	\$18.88

This analysis is for illustrative purposes only, and is not a guarantee of future expenses, claims costs, managed care savings, etc. There are many variables that can affect future health care costs including utilization patterns, catastrophic claims, changes in plan design, health care trend increases, etc. This analysis does not amend, extend or alter the coverage provided by the actual insurance policies and contracts. Please see your policy or contact us for specific information or further details in this regard.

**City of Henderson**  
**Development of Projected Paid Claims - Medical & Rx**  
**For Plan Year January 1, 2014 through December 31, 2014**

	Best Estimate			Optimistic Est. Medical & Rx
	Medical	Rx	Medical & Rx	
Paid Claims (07/01/12 thru 06/30/13)	\$8,529,480	\$2,519,313	\$11,048,794	\$11,048,794
Less Claims in Excess of \$150,000	(\$219,696)	\$0	(\$219,696)	(\$219,696)
Net Claims Paid	\$8,309,784	\$2,519,313	\$10,829,098	\$10,829,098
Benefit Adjustment	1,000	1,000	1,000	1,000
Net Benefit Adjusted Claims Paid	\$8,309,784	\$2,519,313	\$10,829,098	\$10,829,098
Average No. of EE's Covered (06/01/12 thru 05/31/13)	1,172	1,172	1,172	1,172
Claim Cost / EE / Month	\$590.77	\$179.11	\$769.88	\$769.88
Trend Factor <sup>(1)</sup>	13.5%	13.5%	13.5%	9.0%
Trended Claim Cost / EE / Month	\$670.53	\$203.29	\$873.81	\$839.17
Projected No. of EE's	1,150	1,150	1,150	1,150
<b>Total Projected Paid Claims for (01/01/14 thru 12/31/14)</b>	<b>\$9,253,245</b>	<b>\$2,805,347</b>	<b>\$12,058,592</b>	<b>\$11,580,498</b>

<sup>(1)</sup> Annual Trend Factors  
Months of Trend

**6.0%**  
18.0

**9.0%**  
18.0

**9.0%**  
18.0

**9.0%**  
18.0

**City of Henderson  
Fixed Cost Analysis  
For Plan Year January 1, 2014 through December 31, 2014**

	Vendor	Covered Units	Current 1/13 - 12/13	Renewal 1/14 - 12/14	Percent Change
<b>Medical Fixed Costs</b>					
Specific Stop-Loss at \$150,000	Sun Life				
Single		254	\$22.79	\$29.63	Est 30%
Family		896	\$62.78	\$81.61	Est 30%
Monthly Premium			\$62,040	\$80,651	
Annual Premium			<b>\$744,474</b>	<b>\$967,817</b>	
<b>Other Administration Fees</b>					
Transitional Research Fee <sup>(1)</sup>	IRS	1,150	\$0.00	\$15.80	Act 4%
Administration Fee - Medical	Loomis	1,150	\$14.25	\$14.85	Act 4%
Administration Fee - Rx <sup>(2)</sup>	Express Scripts	1,150	\$2.36	\$2.36	Est 0%
Estimated Rx Rebates	Express Scripts	1,150	(\$13.86)	(\$13.86)	Est 0%
Network Access Fee - Medical	Sierra Health	1,150	\$9.84	\$9.84	Act 0%
Utilization Management	Sierra Health	1,150	\$4.37	\$4.37	Act 0%
Total Monthly Fees			\$19,508	\$38,371	
Total Annual Fees			<b>\$234,092</b>	<b>\$460,447</b>	
<b>Total Monthly Self-Funded Medical &amp; Rx Fixed Costs</b>					
			<b>\$81,547</b>	<b>\$119,022</b>	
<b>Total Annual Self-Funded Medical &amp; Rx Fixed Costs</b>					
			<b>\$978,567</b>	<b>\$1,428,264</b>	
<b>Other Fixed Costs &amp; Offsetting Revenue</b>					
Interest Income			Est \$135,000	\$130,425	(3)
<b>Administrative Costs:</b>					
Salaries, wages & benefits			Est \$115,000	\$118,450	3%
Consulting			Act \$87,750	\$90,385	3%
Miscellaneous Costs			Est \$20,000	\$20,000	0%
Administrative Fee-GF			Est \$25,000	\$25,000	0%
Total Administrative Costs			<b>\$247,750</b>	<b>\$253,835</b>	
<b>Total of Other Fixed Costs &amp; Offsetting Revenue</b>					
			<b>(\$112,750)</b>	<b>(\$123,410)</b>	

(1) Transitional research fee (part of PPACA) = \$63 PMPY for 2014, \$42 PMPY for 2015. 3.01 members per employee assumed. We did not include the \$2 PMPY PCORI fee in the above, since that f

(2) This is \$1.15 per script & assumes 28,371 scripts, which was the 2012 script count.

(3)

Interest Income was estimated assuming a 2.15% interest rate on estimated working capital of \$6,066,000. Any shortfalls in the estimated interest rate assumption will be paid from reserves.

**City of Henderson**  
**Summary of Recommended IBNR Reserves**

**IBNR - Incurred But Not Reported Claims** - represents the estimated claim liability to the Plan Sponsor in the event the Plan ceases operation for claims incurred prior to the termination date of the plan, but paid after that date. Insurance industry standards generally equate this liability to 1.5 to 2.0 months of mature, expected claims. For our purposes, we have used a mid-range figure of 1.75 months or 14.6% of claims for Medical, .5 months or 4.2% of claims for Rx, 1 month or 8.3% of claims for Dental, and .5 months or 4.2% of claims for Vision

**Suggested Medical & Rx Reserves as of 12/31/13**

	<u>Medical</u>	<u>Rx</u>	<u>Dental</u>	<u>Vision</u>	<u>Total</u>
1. Projected Net Paid Claims for 1/13 - 12/13	\$8,489,216	\$2,573,712	\$684,625	\$166,423	\$11,913,976
2. Claim Lag Factor	14.6%	4.2%	8.3%	4.2%	11.8%
3. IBNR Liability	<u>\$1,238,011</u>	<u>\$107,238</u>	<u>\$57,052</u>	<u>\$6,934</u>	<u>\$1,409,235</u>
4. Claim Fluctuation Reserve of 5.0%	\$486,361	\$134,048	\$37,084	\$8,668	\$666,161
5. Claims Administration of Runout (3 months)	\$58,523	\$0	\$6,080	\$6,152	\$70,755
6. Total Suggested IBNR Reserves (# 3 + # 4 + # 5)	<b>\$1,782,895</b>	<b>\$241,286</b>	<b>\$100,215</b>	<b>\$21,754</b>	<b>\$2,146,151</b>

**Suggested Medical & Rx Reserves as of 12/31/14**

	<u>Medical</u>	<u>Rx</u>	<u>Dental</u>	<u>Vision</u>	<u>Total</u>
1. Projected Net Paid Claims for 1/14 - 12/14	\$9,253,245	\$2,805,347	\$718,856	\$173,912	\$12,951,360
2. Claim Lag Factor (immature factors)	14.6%	4.2%	8.3%	4.2%	11.8%
3. IBNR Liability	<u>\$1,349,432</u>	<u>\$116,889</u>	<u>\$59,905</u>	<u>\$7,246</u>	<u>\$1,533,472</u>
4. Claim Fluctuation Reserve of 5.0%	\$530,134	\$146,112	\$38,938	\$9,058	\$724,242
5. Claims Administration of Runout (3 months)	\$60,593	\$0	\$6,373	\$6,152	\$73,119
6. Total Suggested IBNR Reserves (# 3 + # 4 + # 5)	<b>\$1,940,159</b>	<b>\$263,001</b>	<b>\$105,216</b>	<b>\$22,457</b>	<b>\$2,330,832</b>

**City of Henderson**  
**Development of Needed Annual Funding**  
**For Plan Year January 1, 2014 through December 31, 2014**

<b>EXPECTED COSTS</b>	<b>Best Estimate Medical &amp; Rx</b>	<b>Optimistic Est. Medical &amp; Rx</b>
Projected Paid Claims	\$12,058,592	\$11,580,498
Projected Savings moving to GBS Coalition (Rx)	(\$97,500)	(\$97,500)
Projected Fixed Costs	\$1,428,264	\$1,428,264
<b>Total Projected Costs</b>	<b>\$13,389,356</b>	<b>\$12,911,262</b>
Projected Funding at Current Rates	\$12,091,389	\$12,091,389
<b>% Change to Meet Projected Total Costs</b>	<b>10.7%</b>	<b>6.8%</b>
<b>Recommended Change to Meet projected Total Costs</b>	<b>10.7%</b>	<b>6.8%</b>

<b>Active</b>	<b># Covered</b>	<b>Current Rates</b>
Employee	224	\$398.40
Employee + Spouse	139	\$816.72
Employee + Child(ren)	131	\$717.12
Employee + Family	570	\$1,135.44
<b>Total Monthly</b>	<b>1,064</b>	<b>\$943,909</b>
<b>Annual Funding</b>		<b>\$11,326,910</b>

<b>Pre 65 Retirees</b>	<b># Covered</b>	<b>Current Rates</b>
Employee	29	\$398.40
Employee + Spouse	29	\$816.72
Employee + Child(ren)	5	\$717.12
Employee + Family	21	\$1,135.44
<b>Total Monthly</b>	<b>84</b>	<b>\$62,668</b>
<b>Annual Funding</b>		<b>\$752,020</b>

<b>Post 65 Retirees</b>	<b># Covered</b>	<b>Current Rates</b>
Employee	1	\$346.06
Employee + One (both over 65)	1	\$692.13
Employee + One (1 over 65 & 1 under 65)	0	\$664.78
Employee + Two or more	0	\$1,010.85
<b>Total Monthly</b>	<b>2</b>	<b>\$1,038</b>
<b>Annual Funding</b>		<b>\$12,458</b>

City of Henderson

Summary of GBS Medical & Rx Funding Rates - Current Tiers & Actuarial Equivalents  
For Plan Year January 1, 2014 through December 31, 2014

**Plan Costs at \$150,000 Specific Stop Loss**

**GBS Expected Cash Costs** **\$13,389,356** (From Development of Needed Annual Funding Exhibit)

<b>GBS Funding Rate Analysis - Best Estimate</b>					
	Estimated Enrollment (June 2013)	Current Tier Ratio	PY 2013 Current Rates	PY 2014 Rates	(COBRA Rates) Actuarial Equivalent
<b>Active</b>					
Employee	224	1.00	\$398.40	\$441.17	\$449.99
Employee + Spouse	139	2.05	\$816.72	\$904.39	\$922.48
Employee + Child(ren)	131	1.80	\$717.12	\$794.10	\$809.98
Employee + Family	570	2.85	\$1,135.44	\$1,257.33	\$1,282.48
Total Monthly	1,064		\$943,909	\$1,045,237	
			<b>\$11,326,910</b>	<b>\$12,542,850</b>	

**Pre 65 Retirees**

Employee	29	1.00	\$398.40	\$441.17	N/A
Employee + Spouse	29	2.05	\$816.72	\$904.39	N/A
Employee + Child(ren)	5	1.80	\$717.12	\$794.10	N/A
Employee + Family	21	2.85	\$1,135.44	\$1,257.33	N/A
Total Monthly	84		\$62,668	\$69,396	
Annual Funding			<b>\$752,020</b>	<b>\$832,748</b>	

**Post 65 Retirees**

One Over 65	1	1.00	\$346.06	\$383.21	N/A
Two Over 65	1	2.00	\$692.13	\$766.43	N/A
One Over 65 + One Under 65	0	1.92	\$664.78	\$736.14	N/A
One Over 65 + Two or more under 65	0	2.92	\$1,010.85	\$1,119.36	N/A
Total Monthly	2		\$1,038	\$1,150	
Annual Funding			<b>\$12,458</b>	<b>\$13,796</b>	

**Total Annual Funding** **\$13,389,394**

**Percent Change** **10.7%**



City of Henderson

Summary of Dental & Vision GBS Funding Rates - Current Tiers Ratios  
For Plan Year January 1, 2014 through December 31, 2014

**Dental**

**Suggested GBS Funding Rates - At Current Tier Ratios**

	Estimated Enrollment (June 2013 actual)	Current Tier Ratio	Current Rates	PY 2014 Rates
Employee	224	1.00	\$28.88	\$28.88
Employee + Spouse	140	2.05	\$59.20	\$59.20
Employee + Child(ren)	114	1.80	\$51.98	\$51.98
Employee + Family	501	2.85	\$82.31	\$82.31
<b>Total Monthly</b>	<b>979</b>		<b>\$61,920</b>	<b>\$61,920</b>
<b>Annual Funding</b>			<b>\$743,042</b>	<b>\$743,042</b>
<b>Suggested Change</b>				<b>0.0%</b>

**Vision**

**Suggested GBS Funding Rates - At Current Tier Ratios**

	Estimated Enrollment (June 2013 actual)	Current Tier Ratio	Current Rates	PY 2014 Rates
Employee	282	1.00	\$6.62	\$6.62
Employee + Spouse	183	2.05	\$13.58	\$13.58
Employee + Child(ren)	143	1.80	\$11.92	\$11.92
Employee + Family	620	2.85	\$18.88	\$18.88
<b>Total Monthly</b>	<b>1,228</b>		<b>\$17,762</b>	<b>\$17,762</b>
<b>Annual Funding</b>			<b>\$213,146</b>	<b>\$213,146</b>
<b>Suggested Change</b>				<b>0.0%</b>

(1) Add 60% adult ortho with a \$1,000 lifetime maximum.

**City of Henderson**  
**Global Budget - Total GBS Needed Funding Rate Analysis**  
**For Plan Years 2013 through 2015**

Total Actuarial Rates - PY 2013	Counts	Medical/Rx <sup>(1)</sup>	Dental <sup>(2)</sup>	Vision	LTD	Life/AD&D	EAP	Total
Employee Only	224	\$386.40	\$28.88	\$6.62	\$13.57	\$8.67	\$2.50	\$458.64
Employee + Spouse	152	\$816.72	\$59.20	\$13.58	\$13.57	\$8.67	\$2.50	\$914.24
Employee + Child(ren)	123	\$717.12	\$51.98	\$11.92	\$13.57	\$8.67	\$2.50	\$805.76
Employee + Family	576	\$1,135.44	\$82.31	\$18.88	\$13.57	\$8.67	\$2.50	\$1,261.37
<b>Total Annual Benefit Cost</b>	<b>1,075</b>	<b>\$11,467,227</b>	<b>\$831,259</b>	<b>\$190,657</b>	<b>\$175,053</b>	<b>\$111,843</b>	<b>\$32,250</b>	<b>\$12,808,289</b>

Total Actuarial Rate - PY 2014	Counts	Medical/Rx <sup>(1)</sup>	Dental <sup>(2)</sup>	Vision	LTD <sup>(3)</sup>	Life/AD&D <sup>(3)</sup>	EAP	Total
Employee Only	224	\$441.17	\$28.88	\$6.62	\$14.00	\$9.00	\$2.50	\$502.17
Employee + Spouse	152	\$904.39	\$59.20	\$13.58	\$14.00	\$9.00	\$2.50	\$1,002.67
Employee + Child(ren)	123	\$794.10	\$51.98	\$11.92	\$14.00	\$9.00	\$2.50	\$883.50
Employee + Family	576	\$1,257.33	\$82.31	\$18.88	\$14.00	\$9.00	\$2.50	\$1,384.02
<b>Total Annual Benefit Cost</b>	<b>1,075</b>	<b>\$12,698,229</b>	<b>\$831,259</b>	<b>\$190,657</b>	<b>\$180,600</b>	<b>\$116,100</b>	<b>\$32,250</b>	<b>\$14,049,095</b>

Total Actuarial Rate - PY 2015	Counts	Medical/Rx <sup>(1)</sup>	Dental <sup>(2)</sup>	Vision	LTD <sup>(3)</sup>	Life/AD&D <sup>(3)</sup>	EAP	Total
Employee Only	224	\$476.46	\$30.03	\$6.62	\$14.00	\$8.67	\$2.50	\$538.28
Employee + Spouse	152	\$976.74	\$61.55	\$13.58	\$14.00	\$8.67	\$2.50	\$1,077.04
Employee + Child(ren)	123	\$857.63	\$54.04	\$11.92	\$14.00	\$8.67	\$2.50	\$948.76
Employee + Family	576	\$1,357.92	\$85.57	\$18.88	\$14.00	\$8.67	\$2.50	\$1,487.54
<b>Total Annual Benefit Cost</b>	<b>1,075</b>	<b>\$13,714,103</b>	<b>\$864,211</b>	<b>\$190,657</b>	<b>\$180,600</b>	<b>\$111,843</b>	<b>\$32,250</b>	<b>\$15,093,664</b>

<sup>(1)</sup> This represents the GBS estimated rate for the self-funded plan (using an 8% trend).

<sup>(2)</sup> This represents the GBS estimated rate for the self-funded plan.

<sup>(3)</sup> GBS estimated a 3.5% increase for Life and Disability for 2014/2015

City of Henderson  
City/Employee Contribution Analysis  
For Plan Years 2013 through 2015

Self Funded Plan - Loomis Co

Total Funding Rate - PY 2013	Counts	Total Rate	City	Employee	Subsidization
Employee Only	224	\$458.64	\$630.00	\$41.28	\$571,576
Employee + Spouse	139	\$914.24	\$847.04	\$82.28	\$25,153
Employee + Child(ren)	131	\$805.76	\$847.04	\$78.52	\$188,326
Employee + Family	570	\$1,261.37	\$847.04	\$122.66	(\$1,995,023)
<b>Total Annual Funding</b>	<b>1,064</b>	<b>\$12,652,202</b>	<b>\$10,231,603</b>	<b>\$1,210,632</b>	<b>(\$1,209,967)</b>

Self Funded Plan - Loomis Co

Total Funding Rate - PY 2014	Counts	Total Rate	City	Employee	Subsidization
Employee Only	224	\$502.17	\$875.00	\$52.53	\$1,143,368
Employee + Spouse	139	\$1,002.67	\$875.00	\$104.70	(\$38,314)
Employee + Child(ren)	131	\$883.50	\$875.00	\$99.91	\$143,697
Employee + Family	570	\$1,384.02	\$875.00	\$156.08	(\$2,414,110)
<b>Total Annual Funding</b>	<b>1,064</b>	<b>\$13,877,845</b>	<b>\$11,172,000</b>	<b>\$1,540,486</b>	<b>(\$1,165,359)</b>
<b>Difference</b>	<b>N/A</b>	<b>\$1,225,643</b>	<b>\$940,397</b>	<b>\$329,854</b>	<b>\$44,608</b>

Self Funded Plan - Loomis Co

Total Funding Rate - PY 2015	Counts	Total Rate	City	Employee	Subsidization
Employee Only	224	\$538.28	\$900.00	\$63.78	\$1,143,744
Employee + Spouse	139	\$1,077.04	\$900.00	\$127.12	(\$83,267)
Employee + Child(ren)	131	\$948.76	\$900.00	\$121.30	\$114,033
Employee + Family	570	\$1,487.54	\$900.00	\$189.50	(\$2,722,594)
<b>Total Per Unit Cost</b>	<b>1,064</b>	<b>\$14,909,624</b>	<b>\$11,491,200</b>	<b>\$1,870,340</b>	<b>(\$1,548,083)</b>
<b>Difference</b>	<b>N/A</b>	<b>\$1,031,778</b>	<b>\$319,200</b>	<b>\$329,854</b>	<b>(\$382,724)</b>

Fully Insured - HPN

Counts	Total Rate	City	Employee	Subsidization
23	\$416.88	\$439.40	\$30.96	\$14,760
11	\$828.63	\$757.30	\$61.72	(\$1,269)
10	\$730.60	\$749.30	\$58.90	\$9,312
28	\$1,142.36	\$847.04	\$92.00	(\$68,316)
<b>72</b>	<b>\$695,943</b>	<b>\$595,769</b>	<b>\$54,672</b>	<b>(\$45,512)</b>

Fully Insured - HPN

Counts	Total Rate	City	Employee	Subsidization
23	\$442.61	\$875.00	\$47.28	\$132,389
11	\$880.58	\$875.00	\$94.23	\$11,702
10	\$776.31	\$875.00	\$89.92	\$22,633
28	\$1,214.29	\$875.00	\$140.47	(\$66,804)
<b>72</b>	<b>\$739,556</b>	<b>\$756,000</b>	<b>\$83,476</b>	<b>\$99,920</b>
<b>N/A</b>	<b>\$43,613</b>	<b>\$160,241</b>	<b>\$28,804</b>	<b>\$145,432</b>

Fully Insured - HPN

Counts	Total Rate	City	Employee	Subsidization
23	\$478.02	\$900.00	\$57.40	\$132,309
11	\$951.03	\$900.00	\$114.41	\$8,367
10	\$838.41	\$900.00	\$109.17	\$20,491
28	\$1,311.43	\$900.00	\$170.55	(\$80,937)
<b>72</b>	<b>\$798,720</b>	<b>\$777,600</b>	<b>\$101,350</b>	<b>\$80,230</b>
<b>N/A</b>	<b>\$59,164</b>	<b>\$21,600</b>	<b>\$17,874</b>	<b>(\$19,691)</b>

**City of Henderson**  
**Reserve Impact Analysis <sup>(1)</sup>**  
**For Plan Years 2013 through 2015**

Impact Analysis	PEPM	
	PY 2013	PY 2013
Total Needed Funding	(\$13,348,145)	(\$979,18)
City Funding - Self Funded Plan	\$10,231,603	\$801.35
City Funding - Health Plan of Nevada	\$595,759	\$689.54
Employee - Self Funded Plan	\$1,210,632	\$94.82
Employee - Health Plan of Nevada	\$54,672	\$63.28
Estimated Delta Dental Surplus / (Deficit)	(\$31,334)	(\$2.30)
<b>Reserve Impact - PY 2013</b>	<b>(\$1,286,813)</b>	<b>(\$94.40)</b>

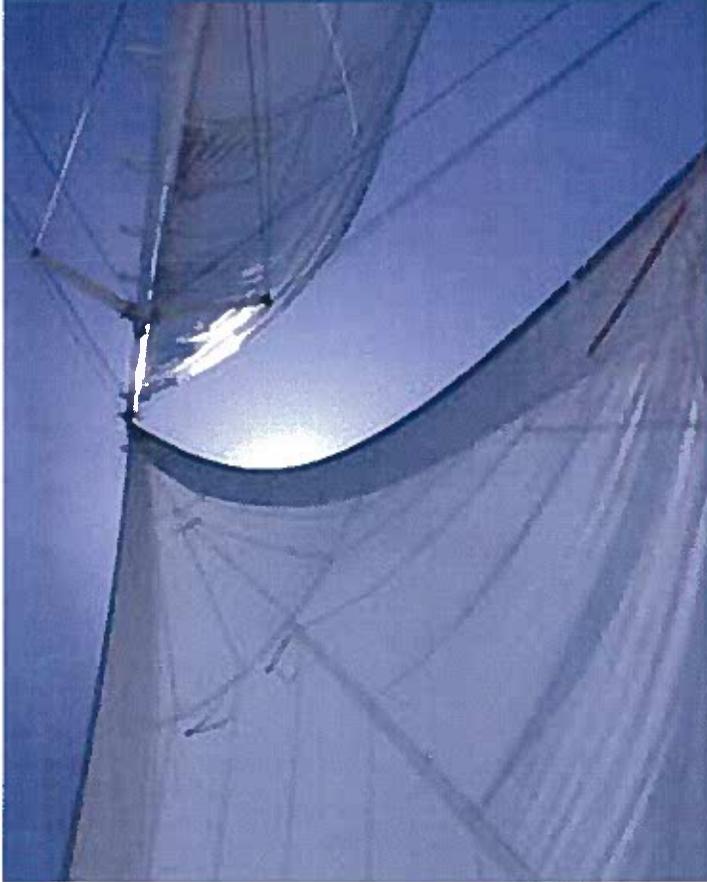
Impact Analysis	PEPM	
	PY 2014	PY 2014
Total Needed Funding	(\$14,617,401)	(\$1,072.29)
City Funding - Self Funded Plan	\$11,172,000	\$875.00
City Funding - Health Plan of Nevada	\$756,000	\$875.00
Employee - Self Funded Plan	\$1,540,486	\$120.65
Employee - Health Plan of Nevada	\$83,476	\$96.62
Estimated Delta Dental Surplus / (Deficit)	(\$58,142)	(\$4.27)
<b>Reserve Impact - PY 2014</b>	<b>(\$1,123,581)</b>	<b>(\$82.42)</b>

Impact Analysis	PEPM	
	PY 2015	PY 2015
Total Needed Funding	(\$15,708,344)	(\$1,152.31)
City Funding - Self Funded Plan	\$11,491,200	\$900.00
City Funding - Health Plan of Nevada	\$777,600	\$900.00
Employee - Self Funded Plan	\$1,870,340	\$146.49
Employee - Health Plan of Nevada	\$101,350	\$117.30
Estimated Delta Dental Surplus / (Deficit)	(\$58,142)	(\$4.27)
<b>Reserve Impact - PY 2015</b>	<b>(\$1,525,995)</b>	<b>(\$111.94)</b>

Unencumbered Reserve Analysis	PEPM	
	Ending 2015	Ending 2015
12/31/2012 Reserve Balance	\$4,023.34	\$335.28
2013 Surplus/(Deficit)	(\$1,132.76)	(\$94.40)
2014 Surplus/(Deficit)	(\$989.07)	(\$82.42)
2015 Surplus/(Deficit)	(\$1,343.31)	(\$111.94)
<b>Estimated 12/31/2015 Reserve Balance</b>	<b>\$558.20</b>	<b>\$46.52</b>

<sup>(1)</sup> Note the above analysis is based on the active employee population, which currently subsidizes the retiree population (the active population is budgeted to post a budget surplus of approximately \$325,000 while the retiree population posts a budgeted deficit of approximately \$325,000 - this equates to approximately 2.75% load in the active rates).





# City of Henderson

Working Draft - Plan Modifications

July 10, 2013



Gallagher Benefit Services, Inc.

t h i n k i n g   a h e a d

[www.gallagherbenefits.com](http://www.gallagherbenefits.com)



# 1. Current Plan Design

Medical Benefits:	In-Network	Out-of-Network	Out-of-Area
Deductible	\$300	\$300	
Coinsurance	90%	70%	90%
Maximum OOP (per family)	\$1,500 (x2)	\$2,000 (x2)	
Inpatient	90% after \$100 copay	70% after \$500 copay	90% after \$500 copay
Outpatient	90%	70%	90%
Primary Care Office Visit	\$15 copay	70%	90%
Specialist Office Visit	\$25 copay	70%	90%
Urgent care Facility	\$25 copay	70%	90%
Emergency Room - Emergent		90% after \$75 copay	
Emergency Room - Non-emergent	Ded + 90% after \$100 copay	Not Covered	Ded + 90% after \$125 copay
<b>Pharmacy Benefits:</b>			
Generic (mail order)	\$5 copay (\$10)	Not Covered	Not Covered
Preferred Brand (mail order)	\$20 copay (\$50)	Not Covered	Not Covered
Non-Preferred Brand (mail order)	\$40 copay (\$100)	Not Covered	Not Covered
Specialty Drug (mail order)	\$100 copay (\$250)	Not Covered	Not Covered

- No plan design changes have been made to date
- Estimated Savings of GBS Coalition: \$97,500 (approved for 1/1/2014)
- (TBD) Estimated Savings of Hospital Coalition: \$800,000



## 2. Plan Changes – Network Only

<b>Proposed Plan Design Effective 1/1/2014</b>	<b>(Members Residing In Sierra Service Area)</b>	
	<b>In-Network (Sierra)</b>	<b>Out-of-Network</b>
<b>Medical Benefits:</b>		
Deductible	\$300	\$300
Coinsurance	90%	70%
Maximum OOP (per family)	\$1,500 (x2)	\$2,000 (x2)
Inpatient	90% after \$100 copay	70% after \$500 copay
Outpatient	90%	70%
Primary Care Office Visit	\$15 copay	70%
Specialist Office Visit	\$25 copay	70%
Urgent care Facility	\$25 copay	70%
Emergency Room - Emergent	90% after \$75 copay	
Emergency Room - Non-emergent	\$100 copay	Not Covered
<b>Pharmacy Benefits:</b>		
Generic (mail order)	\$5 copay (\$10)	Not Covered
Preferred Brand (mail order)	\$20 copay (\$50)	Not Covered
Non-Preferred Brand (mail order)	\$40 copay (\$100)	Not Covered
Specialty Drug (mail order)	\$100 copay (\$250)	Not Covered

<b>(Members Residing Out of Sierra Service Area)</b>	
<b>In-Network (CIGNA)</b>	<b>Out-of-Network</b>
\$300	\$300
90%	70%
\$1,500 (x2)	\$2,000 (x2)
90% after \$100 copay	70% after \$500 copay
90%	70%
\$15 copay	70%
\$25 copay	70%
\$25 copay	70%
90% after \$75 copay	
\$100 copay	Not Covered
\$5 copay (\$10)	Not Covered
\$20 copay (\$50)	Not Covered
\$40 copay (\$100)	Not Covered
\$100 copay (\$250)	Not Covered

- Designed to make the self-funded plan to be more network efficient
  - Members keep the current plan design
  - Only members residing outside of the Sierra service area would be impacted
    - Primarily retirees and students (84 total members)
- Estimated Savings: \$60,000 (could be higher)



# 3a. Plan Changes – \$150,000 in Rx Savings

Medical Benefits:	(Members Residing in Sierra Service Area)	
	In-Network (Sierra)	Out-of-Network
Deductible	\$300	\$300
Coinsurance	90%	70%
Maximum OOP (per family)	\$1,500 (x2)	\$2,000 (x2)
Inpatient	90% after \$100 copay	70% after \$500 copay
Outpatient	90%	70%
Primary Care Office Visit	\$15 copay	70%
Specialist Office Visit	\$25 copay	70%
Urgent care Facility	\$25 copay	70%
Emergency Room - Emergent	90% after \$75 copay	
Emergency Room - Non-emergent	\$100 copay	Not Covered
<b>Pharmacy Benefits:</b>		
Deductible	\$100 (Preferred & Non-Preferred Only)	
Generic (mail order)	\$5 copay (\$10)	Not Covered
Preferred Brand (mail order)	20% - \$60 max (\$60)	Not Covered
Non-Preferred Brand (mail order)	30% - \$120 max (\$120)	Not Covered
Specialty Drug (mail order)	30% - \$150 max (\$250)	Not Covered

(Members Residing Out of Sierra Service Area)	
In-Network (CIGNA)	Out-of-Network
\$300	\$300
90%	70%
\$1,500 (x2)	\$2,000 (x2)
90% after \$100 copay	70% after \$500 copay
90%	70%
\$15 copay	70%
\$25 copay	70%
\$25 copay	70%
90% after \$75 copay	
\$100 copay	Not Covered
\$100 (Preferred & Non-Preferred Only)	
\$5 copay (\$10)	Not Covered
20% - \$60 max (\$60)	Not Covered
30% - \$120 max (\$120)	Not Covered
30% - \$150 max (\$250)	Not Covered

- Designed to make the Rx plan more consumeristic and drive higher generic utilization
  - Would still retain the new out of area plan
- Estimated Plan Design Savings: \$150,000
- Estimated Net Savings (w/ GBS Coalition): \$247,500



## 3b. Plan Changes – \$150,000 in Savings

Medical Benefits:	(Members Residing In Sierra Service Area)	
	In-Network (Sierra)	Out-of-Network
Deductible	\$300	\$1,000
Coinsurance	90%	70%
Maximum OOP (per family)	\$2,000 (x2)	\$4,000 (x2)
Inpatient	90% after \$100 copay	70% after \$500 copay
Outpatient	90%	70%
Primary Care Office Visit	\$15 copay	70%
Specialist Office Visit	\$25 copay	70%
Urgent care Facility	\$25 copay	70%
Emergency Room - Emergent	90% after \$75 copay	
Emergency Room - Non-emergent	Ded & Coinsurance	Ded & Coinsurance
<b>Pharmacy Benefits:</b>		
Generic (mail order)	\$5 copay (\$10)	Not Covered
Preferred Brand (mail order)	\$20 copay (\$50)	Not Covered
Non-Preferred Brand (mail order)	\$40 copay (\$100)	Not Covered
Specialty Drug (mail order)	\$100 copay (\$250)	Not Covered

(Members Residing Out of Sierra Service Area)	
In-Network (CIGNA)	Out-of-Network
\$300	\$1,000
90%	70%
\$2,000 (x2)	\$4,000 (x2)
90% after \$100 copay	70% after \$500 copay
90%	70%
\$15 copay	70%
\$25 copay	70%
\$25 copay	70%
90% after \$75 copay	
Ded & Coinsurance	Ded & Coinsurance
\$5 copay (\$10)	Not Covered
\$20 copay (\$50)	Not Covered
\$40 copay (\$100)	Not Covered
\$100 copay (\$250)	Not Covered

- Designed to steer higher in-network utilization
  - Would still retain the new out of area plan
  - Does not build in the Rx changes illustrated in 3a
- Estimated Plan Design Savings: \$150,000
- Estimated Net Savings (w/ GBS Coalition): \$247,500











## 6. Plan Changes – \$750,000 in Savings

Changes to Save \$750,000	(Members Residing In Sierra Service Area)		(Members Residing Out of Sierra Service Area)	
	In-Network (Sierra)	Out-of-Network	In-Network (CIGNA)	Out-of-Network
<b>Medical Benefits:</b>				
Deductible	\$500	\$1,000	\$500	\$1,000
Coinsurance	90%	70%	90%	70%
Maximum OOP (per family)	\$2,250 (x2)	\$4,500 (x2)	\$2,250 (x2)	\$4,500 (x2)
Inpatient	90% after \$100 copay	70% after \$500 copay	90% after \$100 copay	70% after \$500 copay
Outpatient	90%	70%	90%	70%
Primary Care Office Visit	\$25 copay	70%	\$25 copay	70%
Specialist Office Visit	\$50 copay	70%	\$50 copay	70%
Urgent care Facility	\$50 copay	70%	\$50 copay	70%
Emergency Room - Emergent	90% after \$125 copay		90% after \$125 copay	
Emergency Room - Non-emergent	Ded & Coinsurance	Ded & Coinsurance	Ded & Coinsurance	Ded & Coinsurance
<b>Pharmacy Benefits:</b>				
Deductible	\$100 (Preferred & Non-Preferred Only)		\$100 (Preferred & Non-Preferred Only)	
Generic (mail order)	\$5 copay (\$10)	Not Covered	\$5 copay (\$10)	Not Covered
Preferred Brand (mail order)	20% - \$60 max (\$60)	Not Covered	20% - \$60 max (\$60)	Not Covered
Non-Preferred Brand (mail order)	30% - \$120 max (\$120)	Not Covered	30% - \$120 max (\$120)	Not Covered
Specialty Drug (mail order)	30% - \$150 max (\$250)	Not Covered	30% - \$150 max (\$250)	Not Covered

- Designed to steer higher in-network and generic utilization, begins to incrementally take other cost sharing components higher
  - Would still retain the new out of area plan
- Estimated Plan Design Savings: \$750,000
- Estimated Net Savings (w/ GBS Coalition): \$847,500



# 7. Plan Changes – \$1,000,000 in Savings

Changes to Save \$1,000,000	(Members Residing In Sierra Service Area)	
	In-Network (Sierra)	Out-of-Network
<b>Medical Benefits:</b>		
Deductible	\$500	\$1,000
Coinsurance	85%	60%
Maximum OOP (per family)	\$2,500 (x2)	\$5,000 (x2)
Inpatient	85% after \$100 copay	60% after \$500 copay
Outpatient	85%	60%
Primary Care Office Visit	\$25 copay	60%
Specialist Office Visit	\$50 copay	60%
Urgent care Facility	\$50 copay	60%
Emergency Room - Emergent	90% after \$125 copay	
Emergency Room - Non-emergent	Ded & Coinsurance	Ded & Coinsurance
<b>Pharmacy Benefits:</b>		
Deductible	\$100 (Preferred & Non-Preferred Only)	
Generic (mail order)	\$5 copay (\$10)	Not Covered
Preferred Brand (mail order)	20% - \$60 max (\$60)	Not Covered
Non-Preferred Brand (mail order)	30% - \$120 max (\$120)	Not Covered
Specialty Drug (mail order)	30% - \$150 max (\$250)	Not Covered

(Members Residing Out of Sierra Service Area)	
In-Network (CIGNA)	Out-of-Network
\$500	\$1,000
85%	60%
\$2,500 (x2)	\$5,000 (x2)
85% after \$100 copay	60% after \$500 copay
85%	60%
\$25 copay	60%
\$50 copay	60%
\$50 copay	60%
90% after \$125 copay	
Ded & Coinsurance	Ded & Coinsurance
\$100 (Preferred & Non-Preferred Only)	
\$5 copay (\$10)	Not Covered
20% - \$60 max (\$60)	Not Covered
30% - \$120 max (\$120)	Not Covered
30% - \$150 max (\$250)	Not Covered

- Fundamentally changes the plan design to achieve budgetary goals
  - Would still retain the new out of area plan
- Estimated Savings: \$1,000,000
- Estimated Net Savings (w/ GBS Coalition): \$1,097,500



# Next Steps







# **City of Henderson 2014 HPN Renewal Overview**

August 14, 2013





## **City of Henderson**



- **Renewal**
- **Product Changes for 2014**
- **Customized Plan Suggestions**
- **NowClinic**
- **OptumRx transition 10/1/13**





# 2014 PPACA Related Benefit Changes



1. NV Specific Changes include:
  - Bariatric Surgery - \$ limit removed, one per lifetime implemented
  - Home health care - Unlimited
  - Hospice - Unlimited
  - TMJ – \$ limit removed
  - Hearing Aids: \$ limit removed and purchases are limited to single type of device once every 3 years.
  - Autism: \$ limit removed, visit limits are 250 visits not to exceed 750 hours per Calendar Year.
  
2. Out of Pocket Maximum accrual
  1. Out of Pocket Maximum at HSA level – \$6,350/12,700 in 2014
  2. All member cost-sharing (including RX and copayments under the plan accumulate to OOPM)



# Product Changes

## Medical Plan:

- Specialist is more expensive than PCP
- Urgent Care is more expensive than Tele-Health or Convenience Care
- Outpatient surgery at an Inpatient facility more expensive than at Outpatient facility
- Lab and X-ray cost differential – Labs less expensive than X-ray

## Rx Plan:

- New Preferred Drug List
  - Use Tier nomenclature rather than preferred generics, preferred brand
- Mail order is now 2.5x



## Suggested Customization

### Medical Plan HPN Solutions HMO 15:

- Specialist copayment: \$25
- Emergency Room copayment: \$100 or \$150
- Inpatient Surgery copayment: \$250 per admission
- Outpatient Hospital copayment: \$75 or \$100

### Rx Plan:

- \$5/\$25/\$45 to match current copayment
- Mail order would change to new standard 2.5x



# What is NowClinic - Medicine and Care Online

*NowClinic = system + network of providers + administration*

*1-1-2014*

Online tool that brings healthcare delivery online -- where consumers can access providers 24/7/365 via webcam, secure chat, phone or mobile device. Providers may be nurses, coaches, fitness trainers, doctors, etc.

**“The healthcare provider will see you now”  
....It's time that technology allowed just that**

**Extends traditional healthcare into people's homes**



**Meets patients where they want to be met**

**A technology for bringing healthcare services online**

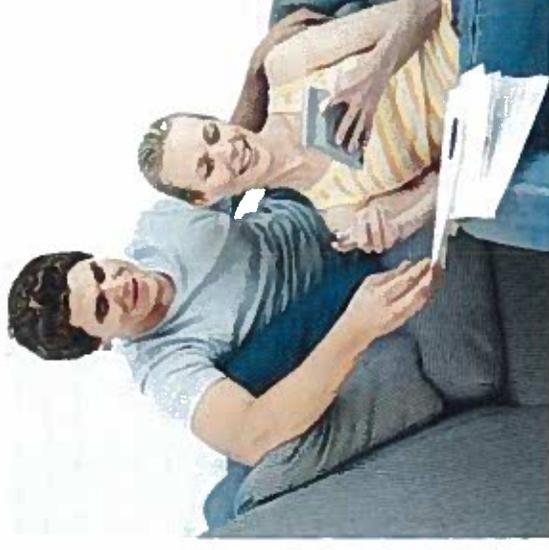
**● Live interaction between patients and available providers and other clinicians**



# What Do People Use NowClinic For?

## **NowClinic is appropriate for a diverse range of issues:**

- Anytime you can't see your PCP
- For consults on what type of specialist you should see or for a second opinion
- For direction and support on preventive care and/or age- and gender-appropriate screenings
- Follow-up appointments (review lab results, answer questions, etc.)



## **NowClinic may be able to help with:**

- Allergies
- Bladder infection
- Bronchitis
- Cough/cold
- Diarrhea
- Fever
- Nausea
- Pink eye
- Rash
- Seasonal flu
- Sinus infection
- Sore throat
- Viral illness



# Online Conversation with Providers – Webcam (HD and Standard), Secure Chat, Phone and Mobile Coming In 2014...

**NowClinic**

You are now connected to Robert Curtin, OB/GYN

Time Remaining: 9:00 **END CONVERSATION**

**Video**

**Chat**

**Provider Entries**

**Provider Notes**

**Prescriptions**

**Diagnoses & Procedures**

**Follow-Up Suggestions**

**Phone**

Phone Number: 617-564-7865  
Phone PIN: 1234

Call Now Save

Hi, I have  
How man  
About 6-7  
How man  
I work ar  
Robert C  
Entries

Need to make sure her PCP is informed of the situation.

Code	Description
00603-2362	Cyclobenzaprine HCL 10mg Tab TID 30
492	Diabetes - gestational

Adult onset diabetes (Diabetes type II - Non-Insulin dependent)  
Conversation with Health Coach

Two Way Web Cam

Live Instant Chat

Phone

Complete record of conversation that can be printed or e-mailed







# OptumRx Transition



- **October 1, 2013**, administration of pharmacy benefit services will transition from Medco, an Express Scripts company, to OptumRx™.
  - Most existing mail service prescriptions will transfer
  - Prescriptions for certain medications, like painkillers, will not transfer. In this case, members will receive a letter from Health Plan of Nevada or Sierra Health and Life. Prescriptions that do not transfer, including expired prescriptions, will require a new prescription. OptumRx will contact members via phone or mail when it's time to process their refill order.
- **Communication Plan**
  - We'll mail a letter approximately 39 days prior to the transition, educating members on what to expect and directing them to look for their new health plan ID card
  - Members enrolled in Medco's Worry Free Fill (auto-fill) program will receive a letter in this packet, confirming the program will end upon their move to OptumRx. Information on how to enroll in the Hassle-Free Fill<sup>SM</sup> automatic refill program through OptumRx will be included.
  - Members will receive their new health plan ID card prior to their transition date.





# HEALTH PLAN OF NEVADA

A UnitedHealthcare Company

## HPN Solutions HMO 15

### Attachment A Benefit Schedule

The Calendar Year Out of Pocket Maximum is \$6,000 per Member and \$12,000 per family.

The Out Of Pocket Maximum does not include; 1) amounts charged for non-Covered Services, 2) amounts exceeding applicable Plan benefit maximums or EME payments; or, 3) penalties for not obtaining any required Prior Authorization or for the Member otherwise not complying with HPN's Managed Care Program.

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit
<p><b>Medical Office Visits and Consultations in a Medical Office Setting</b></p> <ul style="list-style-type: none"> <li>• <b>Primary Care Services</b> <ul style="list-style-type: none"> <li>Convenient Care Facility</li> <li>Physician Extender or Assistant</li> <li>Physician</li> </ul> </li> <li>• <b>Specialist Services</b></li> </ul> <p><b>Preventive Healthcare Services</b> - <i>Services include various recommended exams, immunizations, diagnostic tests and screenings. Refer to the HPN Preventive Guidelines on the HPN website (<a href="http://www.healthplanofnevada.com">www.healthplanofnevada.com</a>) located under the "Members &amp; Guests" tab or contact the Member Services Department (702-242-7300) for the complete list of covered Adult and Pediatric Preventive Services and Immunizations. These guidelines are updated in accordance with the Federal Government standards.</i></p> <p><b>Routine Lab and X-ray services provided and billed by the Physician's office.</b> <i>(Copayment/Cost-share is in addition to the Physician office visit Copayment/cost-share and applies to services rendered in a Physician's office.)</i></p> <ul style="list-style-type: none"> <li>• Lab</li> <li>• X-Ray</li> </ul>	<p>No</p> <p>Yes</p> <p>No</p> <p>Yes</p>	<p>Member pays \$5 per visit.</p> <p>Member pays \$5 per visit.</p> <p>Member pays \$15 per visit.</p> <p>Member pays \$30 per visit.</p> <p>Member pays \$0 per visit.</p> <p>Member pays \$10 per visit. Member pays \$25 per visit.</p>

## Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit
<b>Telemedicine Services</b> <i>(Only available through select Providers.)</i>	No	Member pays \$5 per visit.
<b>Laboratory Services – Outpatient</b> <i>Performed at an independent facility.</i>	Yes	Member pays \$10 per visit.
<b>Routine Radiological and Non-Radiological Diagnostic Imaging Services</b> <i>Performed at a Free-Standing Diagnostic Center.</i>	Yes	Member pays \$25 per visit.
<b>Emergency Services</b> <ul style="list-style-type: none"> <li>• Urgent Care Facility</li> <li>• Emergency Room Visit</li> <li>• Hospital Admission – Emergency Stabilization <i>Applies until patient is stabilized and safe for transfer as determined by the attending Physician.</i></li> </ul>	No No No	Member pays \$20 per visit. Member pays \$200 per visit; waived if admitted. Member pays \$500 per admission.
<b>Ambulance Services</b> <ul style="list-style-type: none"> <li>• Emergency Transport</li> <li>• Non-Emergency – HPN Arranged Transfers</li> </ul>	No Yes	Member pays \$200 per trip. Member pays \$0.
<b>Inpatient Hospital Facility Services</b> <i>Elective and Emergency Post-Stabilization Admissions</i>	Yes	Member pays \$500 per admission.
<b>Outpatient Surgery at a Hospital Facility</b>	Yes	Member pays \$250 per surgery.
<b>Ambulatory Surgical Facility Services</b>	Yes	Member pays \$100 per surgery.
<b>Anesthesia Services</b>	Yes	Member pays \$150 per surgery.
<b>Physician Surgical Services – Inpatient and Outpatient</b> <ul style="list-style-type: none"> <li>• Inpatient or Outpatient Hospital Facility</li> <li>• Ambulatory Surgical Facility</li> <li>• Physician’s Office Primary Care Physician (Includes all physician services related to the surgical procedure)</li> <li>Specialist (Includes all physician services related to the surgical procedure)</li> </ul>	Yes Yes No Yes	Member pays \$100 per surgery. Member pays \$50 per surgery. Member pays \$15 per visit. Member pays \$30 per visit.

## Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit
<p><b>Gastric Restrictive Surgery Services</b>  <i>HPN provides a lifetime benefit maximum of one (1) Medically Necessary surgery per Member.</i></p> <ul style="list-style-type: none"> <li>• Physician Surgical Services</li> <li>• Physician Office Visit</li> </ul>	Yes	<p>Member pays \$2,500 per surgery. Subject to maximum benefit.</p> <p>Member pays \$30 per visit.</p>
<p><b>Organ and Tissue Transplant Surgical Services</b></p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Facility</li> <li>• Physician Surgical Services – Inpatient Hospital Facility</li> <li>• Transportation, Lodging and Meals  <i>The maximum benefit per Member per Transplant Benefit Period for transportation, lodging and meals is \$10,000. The maximum daily limit for lodging and meals is \$200.</i></li> <li>• Procurement  <i>Benefits for procurement procedures and/or services are limited to those deemed by HPN to be Medically Necessary and appropriate for an approved Organ Transplant in a single Transplant Benefit Period.</i></li> <li>• Retransplantation Services  <i>Benefits are limited to one (1) Medically Necessary Retranplantation per Member per type of transplant.</i></li> </ul>	Yes  Yes  Yes  Yes  Yes	<p>Member pays \$500 per admission.</p> <p>Member pays \$100 per surgery.</p> <p>Member pays \$0. Subject to maximum benefit.</p> <p>Member pays \$0.</p> <p>HPN pays 50% of EME. Subject to maximum benefit.</p>
<p><b>Post-Cataract Surgical Services</b></p> <ul style="list-style-type: none"> <li>• Frames and Lenses</li> <li>• Contact Lenses</li> </ul> <p><i>Benefits are limited to one (1) Medically Necessary pair of glasses or set of contact lenses as applicable per Member per surgery.</i></p>	Yes  Yes	<p>\$10 per pair of glasses. Subject to maximum benefit.</p> <p>\$10 per set of contact lenses. Subject to maximum benefit.</p>
<p><b>Home Healthcare Services (does not include Specialty Prescription Drugs)</b>  <i>Refer to the Outpatient Prescription Drug Benefit Rider for benefits applicable to Outpatient Covered Drugs.</i></p>	Yes	Member pays \$35 per visit.

## Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit
<p><b>Hospice Care Services</b></p> <ul style="list-style-type: none"> <li>• Inpatient Hospice Facility</li> <li>• Outpatient Hospice Services</li> <li>• Inpatient and Outpatient Respite Services <i>Benefits are limited to a combined maximum benefit of five (5) Inpatient days or five (5) Outpatient visits per Member per ninety (90) days of Home Hospice Care.</i> <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Outpatient</li> </ul> </li> <li>• Bereavement Services <i>Benefits are limited to a maximum benefit of five (5) group therapy sessions. Treatment must be completed within six (6) months of the date of death of the Hospice patient.</i></li> </ul>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Member pays \$500 per admission.</p> <p>Member pays \$0 per visit.</p> <p>Member pays \$500 per admission. Subject to maximum benefit.</p> <p>Member pays \$30 per visit. Subject to maximum benefit.</p> <p>Member pays \$15 per visit. Subject to maximum benefit.</p>
<p><b>Skilled Nursing Facility</b> <i>Subject to a maximum benefit of one hundred (100) days per Member per Calendar Year.</i></p>	<p>Yes</p>	<p>Member pays \$300 per admission; waived if admitted from an acute care facility. Subject to maximum benefit.</p>
<p><b>Manual Manipulation</b> <i>Applies to Medical-Physician Services and Chiropractic office visit. Subject to a maximum benefit of twenty (20) visits per Member per Calendar Year.</i></p>	<p>Yes</p>	<p>Member pays \$15 per visit. Subject to maximum benefit.</p>
<p><b>Habilitation and Short-Term Rehabilitation Services</b></p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Facility</li> <li>• Outpatient</li> </ul>	<p>Yes</p> <p>Yes</p>	<p>Member pays \$300 per admission.</p> <p>Member pays \$15 per visit.</p>
<p><b>Durable Medical Equipment</b> <i>Monthly rental or purchase at HPN's option. Purchases are limited to a single purchase of a type of DME, including repair and replacement, every three (3) years.</i></p>	<p>Yes</p>	<p>Member pays \$0. Subject to maximum benefit.</p>
<p><b>Genetic Disease Testing Services</b></p> <ul style="list-style-type: none"> <li>• Office Visit</li> <li>• Lab <i>Includes Inpatient, Outpatient and independent Laboratory Services.</i></li> </ul>	<p>Yes</p>	<p>Member pays \$30 per visit. Member pays \$30 per test.</p>

## Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit
<b>Infertility Office Visit Evaluation</b> <i>Please refer to applicable surgical procedure</i> <i>Copayment/Cost-share herein for any surgical infertility procedures performed.</i>	Yes	Member pays \$30 per visit.
<b>Medical Supplies</b>	Yes	Member pays \$0.
<b>Other Diagnostic and Therapeutic Services</b> <i>Copayment/Cost-share is in addition to the Physician office visit Copayment/cost-share and applies to services rendered in a Physician's office or at an independent facility.</i> <ul style="list-style-type: none"> <li>• Anti-cancer drug therapy, non-cancer related intravenous injection therapy or other Medically Necessary intravenous therapeutic services.</li> <li>• Dialysis</li> <li>• Therapeutic Radiology</li>   <li>• Allergy Testing and Serum Injections</li> <li>• Otologic Evaluations</li>   <li>• Other complex diagnostic imaging services such as Positron Emission Tomography (PET) scans, CT Scan and MRI; vascular diagnostic and therapeutic services; pulmonary diagnostic services; complex neurological or psychiatric testing or therapeutic services.</li> </ul>	Yes	Member pays \$15 per day.  Member pays \$15 per day. Member pays \$15 per day.  Member pays \$15 per visit. Member pays \$15 per visit.  Member pays \$100 per test or procedure.
<b>Prosthetic Devices</b> <i>Purchases are limited to a single purchase of a type of Prosthetic Device, including repair and replacement, once every three (3) years.</i>	Yes	Member pays \$750 per device. Subject to maximum benefit.
<b>Orthotic Devices</b> <i>Purchases are limited to a single purchase of a type of Orthotic Device, including repair and replacement, once every three (3) years.</i>	Yes	Member pays \$50 per device. Subject to maximum benefit.
<b>Self-Management and Treatment of Diabetes</b> <ul style="list-style-type: none"> <li>• Education and Training</li> <li>• Supplies (except for Insulin Pump Supplies)               <ul style="list-style-type: none"> <li>Insulin Pump Supplies</li> </ul> </li> <li>• Equipment (except for Insulin Pump)               <ul style="list-style-type: none"> <li>Insulin Pump</li> </ul> </li> </ul> <p><i>Refer to the Outpatient Prescription Drug Benefit Rider for the benefits applicable to diabetic supplies and equipment obtained at a retail Plan Pharmacy.</i></p>	No  No  Yes  Yes  Yes	Member pays \$15 per visit.  Member pays \$5 per therapeutic supply.  Member pays \$10 per therapeutic supply.  Member pays \$20 per device.  Member pays \$100 per device.

## Benefit Schedule

Covered Services and Limitations	Referral or Prior Auth. Required*	Tier I HMO Plan Provider Benefit
<b>Special Food Products and Enteral Formulas</b> <i>Limited to a maximum benefit of one (1) thirty (30) day therapeutic supply per Member per Calendar Year for Special Food Products only.</i>	Yes	Member pays \$0. Subject to maximum benefit.
<b>Temporomandibular Joint Treatment</b>	Yes	HPN pays 50% of EME.
<b>Mental Health and Severe Mental Illness</b>		
• Inpatient Hospital Facility	Yes	Member pays \$500 per admission.
• Outpatient Treatment	Yes	Member pays \$15 per visit.
<b>Substance Abuse Services</b>		
• Inpatient Hospital Facility	Yes	Member pays \$500 per admission.
• Outpatient Treatment	Yes	Member pays \$15 per visit.
<b>Hearing Aids</b> <i>Purchases are limited to a single purchase of a type of Hearing Aid, including repair and replacement, once every three (3) years.</i>	Yes	Member pays \$0. Subject to maximum benefit.
<b>Applied Behavioral Analysis (ABA) for the treatment of Autism</b> <i>Limited to two hundred fifty (250) visits not to exceed seven hundred fifty (750) total hours of therapy per Member per Calendar Year.</i>	Yes	Member pays \$15 per visit. Subject to maximum benefit.

A Member's Copayment/cost-share will not be more than 50% of the allowed cost of providing any single service or supplying an item to a Member, after the deductible, if applicable, has been met. A Member may not contribute any more than the individual CYD amount toward the family CYD amount. A Member may not contribute any more than the individual Calendar Year Out of Pocket Maximum toward the family Calendar Year Out of Pocket Maximum amount.

**Please note:** For all Inpatient and Outpatient admissions, including those for Emergency or Urgent Care, in addition to specified surgical Copayment/cost-share amounts, Member is also responsible for all other applicable facility and professional Copayments/cost-share as outlined in the Attachment A Benefit Schedule.

Member is responsible for any and all amounts exceeding any stated maximum benefit amounts and/or any/all amounts exceeding the Plan's payment to Non-Plan Providers under this Plan. Further, such amounts do not accumulate to the calculation of the Calendar Year Out of Pocket Maximum.

\*Referral or Prior Auth. Required – Except as otherwise noted and, with the exception of certain Outpatient, non-emergency Mental Health, Severe Mental Illness and Substance Abuse Services, all Covered Services not provided by the Member's Primary Care Physician require a Referral or a Prior Authorization in the form of a written referral authorization from HPN. Please refer to your HPN Evidence of Coverage for additional information.



HEALTH PLAN OF NEVADA  
A UnitedHealthcare Company

**3-Tier Outpatient Prescription Drug Rider  
to the HPN Group Evidence of Coverage**

Please refer to the HPN Prescription Drug List (PDL) for the listing of Covered Drugs.

**Plan Retail Prescription Drug Benefits**

**Tier I: Member pays**

**\$7 Copayment per Designated Plan Pharmacy Therapeutic Supply**

**Tier II: Member pays**

**\$30 Copayment per Designated Plan Pharmacy Therapeutic Supply**

**Tier III: Member pays**

**\$50 Copayment per Designated Plan Pharmacy Therapeutic Supply**

**Plan Mail Order Prescription Drug Benefit**

**Member pays:**

**2.5 times the applicable Tier Copayment per Plan Mail Order Pharmacy Therapeutic Supply**

This Prescription Drug Benefit Rider is issued in consideration of: (a) Group's election of coverage under this Rider, (b) your eligibility for the benefits described in this Rider, and (c) payment of any additional premium.

This Prescription Drug Benefit Rider is a supplement to your Evidence of Coverage (EOC) and Attachment A Benefit Schedule issued by Health Plan of Nevada, Inc., and amends your coverage to include benefits for Covered Drugs. This coverage is subject to the applicable terms, conditions, limitations and exclusions contained in your HPN EOC and

herein.

**SECTION 1. Obtaining Covered Drugs**

Benefits for Covered Drugs are payable under the terms of this Rider subject to the following conditions:

- A **Designated** Plan Pharmacy must dispense the Covered Drug, except as otherwise specifically provided in Section 1.2 herein.
- A Generic Covered Drug will be dispensed when available, subject to the

Out of Pocket amounts paid for Covered Drugs accumulate to the Annual Out of Pocket Maximum as set forth in the HPN Attachment A Benefit Schedule.

## **PRESCRIPTION DRUG RIDER**

prescribing Provider's "Dispense as written" requirements.

- Benefits for Specialty Covered Drugs as defined herein are payable subject to the applicable Tier I, II or III benefit level. If you require certain Covered Drugs, including, but not limited to, Specialty Drugs, HPN may direct you to a Designated Plan Pharmacy with whom HPN have an arrangement to provide those Covered Drugs.

### **1.1 Designated Plan Pharmacy Benefit Payments**

Benefits for Covered Drugs obtained at a Designated Plan Pharmacy are payable according to the applicable benefit tiers described below, subject to the Member obtaining any required Prior Authorization or meeting any applicable Step Therapy requirement.

- (a). **Tier I** – is the low cost option for Covered Drugs.
- (b). **Tier II** – is the midrange cost option for Covered Drugs.
- (c). **Tier III** – is the high cost option for Covered Drugs.
- (d). **Mandatory Generic benefit provision applies when:**
  - a Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. The Member will pay the Covered Copayment plus the difference between the Eligible Medical Expenses ("EME") of the Generic Covered Drug and the EME of the Brand Name Covered Drug to the Designated Plan Pharmacy for each Therapeutic Supply.
- (e). When a Drug is dispensed through the Mail Order Plan Pharmacy, the applicable Tier I,

Tier II, or Tier III Mail Order Plan Pharmacy benefit tier will apply per Therapeutic Supply.

### **1.2 Emergency or Urgently Needed Services Prescription Drugs**

(a). **Dispensed by a Plan Pharmacy:** When a prescription is written by a Non-Plan Provider in connection with Emergency Services or Urgently Needed Services as defined in the HPN EOC, the Member will pay to the Plan Pharmacy at the time the Covered Drug is dispensed, the Copayment amount subject to the applicable Tier I, Tier II or Tier III benefit.

(b). **Dispensed by a Non-Plan Pharmacy:** When a prescription is written by a Non-Plan Provider in connection with Emergency Services or Urgently Needed Services as defined in the HPN EOC, the Member will pay to the Non-Plan Pharmacy at the time the Covered Drug is dispensed, the full cost of the Covered Drug subject to Section 1.3 below

### **1.3 Non-Plan Pharmacy Benefit Payments**

(a). In order that claims for Covered Drugs obtained at a Non-Plan Pharmacy be eligible for benefit payment, the Member must complete and submit a Pharmacy Reimbursement Claim Form with the prescription label and register receipt to HPN or its designee.

(b). Benefit payments are subject to the limitations and exclusions set forth in the HPN EOC and this Rider as follows:

1. When any Covered Drug is dispensed, the benefit payment will be subject to HPN's EME and the applicable Tier I, II or III Copayment amount. The Member

## ***PRESCRIPTION DRUG RIDER***

is responsible for any amounts exceeding HPN's benefit payment. .

2. The Mandatory Generic benefit provision applies when any Brand Name Covered Drug is dispensed and a Generic Covered Drug equivalent is available. The benefit payment is subject to HPN's EME of the Generic Covered Drug less the applicable tier copayment. The Member is responsible for any amounts exceeding HPN's benefit payment.
3. No benefits are payable if HPN's EME of the Covered Drug is less than the applicable Copayment.

### **1.4 Mail Order Plan Pharmacy Benefit Payments**

- (a). Benefits for Covered Drugs are available when dispensed by an HPN Mail Order Plan Pharmacy subject to the applicable Tier I, Tier II or Tier III Mail Order benefit.
- (b). Information on how to obtain Mail Order Drugs is provided in the Mail Order Brochure provided after enrollment with HPN.

### **SECTION 2. Limitations**

- 2.1 Prior Authorization or Step Therapy may be required for certain Covered Drugs.
- 2.2 A pharmacy may refuse to fill or refill a prescription order when in the professional judgment of the pharmacist the prescription should not be filled.
- 2.3 Benefits for prescriptions for Mail Order Drugs submitted following HPN's receipt of notice of individual's termination will be limited to the appropriate Therapeutic Supply from the date such notice of

termination is received to the Effective Date of termination of the individual.

- 2.4 Benefits are not payable if you are directed to a Designated Plan Pharmacy and you choose not to obtain your Covered Drug from that Designated Plan Pharmacy.
- 2.5 If HPN determines that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Plan Pharmacies may be limited. If this happens, HPN may require you to select a single Plan Pharmacy that will provide and coordinate all future pharmacy services. Benefit coverage will be paid only if you use the assigned single Plan Pharmacy. If you do not make a selection within thirty-one (31) days of the date you are notified, then HPN will select a single Plan Pharmacy for you.

### **SECTION 3. Exclusions**

No benefits are payable for the following drugs, devices and supplies as well as for any complications resulting from their use except when prescribed in connection with the treatment of Diabetes:

- 3.1 Prescription Drug furnished by the local, state or federal government. Any Prescription Drug to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
- 3.2 Prescription Drugs for any condition, Injury, Illness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.

## ***PRESCRIPTION DRUG RIDER***

- 3.3** Devices of any type, including those prescribed by a licensed Provider, except for prescription contraceptive devices.
- 3.4** Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
- 3.5** Any product dispensed for the purpose of appetite suppression or weight loss.
- 3.6** Medications used for cosmetic purposes.
- 3.7** Prescription Drug Products when prescribed to treat infertility.
- 3.8** Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.
- 3.9** Hypodermic needles, syringes, or similar devices used for any purpose other than the administration of Specialty Covered Drugs.
- 3.10** Except as otherwise specifically provided, Prescription Drugs related to medical services which are not covered under the HPN EOC.
- 3.11** Drugs for which prescriptions are written by a licensed Provider for use by the Provider or by his or her immediate family members.
- 3.12** Prescription Drugs dispensed prior to the Member's Effective Date of coverage or after Member's termination date of coverage under the Plan.
- 3.13** Prescription Drugs, including Covered Drugs dispensed by a Non-Plan Provider, except in the case of Emergency Services and Urgently Needed Services.
- 3.14** Drugs available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless HPN has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that HPN has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and HPN may decide at any time to reinstate benefits for a Prescription Drug that was previously excluded under this provision.
- 3.15** General vitamins, except the following which require a prescription order or refill: prenatal vitamins; vitamins with fluoride; and single entity vitamins.
- 3.16** Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Illness or Injury except for Prescription Drug Products that are enteral formulas prescribed for the treatment of inherited metabolic diseases as defined by state law.
- 3.17** Any Prescription Drug for which the actual charge to the Member is less than the amount due under this Rider.
- 3.18** Any refill dispensed more than one (1) year from the date of the latest prescription order or as permitted by applicable law of the jurisdiction in which the drug is dispensed.
- 3.19** Prescription Drugs as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed.
- 3.20** Medical supplies unless listed on the PDL or Prior Authorized by HPN.
- 3.21** Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
- 3.22** Coverage for Prescription Drugs for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.

## ***PRESCRIPTION DRUG RIDER***

- 3.23** Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration (FDA) and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier III).
- 3.24** Prescriptions for Covered Drugs for which Prior Authorization is required but not obtained.
- 3.25** Experimental or investigational or unproven services and medications; medication used for experimental indications and/or dosage regimens determined by the Plan to be experimental, investigational or unproven except when prescribed for the treatment of cancer or other life-threatening diseases or conditions, chronic fatigue syndrome, cardiovascular disease, surgical musculoskeletal disorder of the spine, hip and knees, and other diseases or disorders which are not life threatening or study approved by the Plan.
- 3.26** A Prescription Drug that contains an active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to a Covered Drug may be excluded as determined by the Plan.
- 3.27** Prescription Drugs dispensed outside the United States, except as required for emergency treatment.
- 3.28** Covered Drugs which are prescribed, dispensed or intended for use during an Inpatient admission.
- 3.29** Covered Drugs that are not FDA approved for a specific diagnosis.
- 3.30** Unit dose packaging of Prescription Drugs.
- 4.1** “**Brand Name Drug**” is a Prescription Drug which is marketed under or protected by:
- a registered trademark;
  - or a registered trade name;
  - or a registered patent.
- 4.2** “**Compound**” means to form or create a Medically Necessary customized composite product by combining two (2) or more different ingredients according to a Physician’s specifications to meet an individual patient’s need.
- 4.3** “**Covered Drug**” is a Brand Name or Generic Prescription Drug or diabetic supply or equipment which:
- can only be obtained with a prescription;
  - has been approved by the Food and Drug Administration (“FDA”) for general marketing, subject to 3.16 herein;
  - is dispensed by a licensed pharmacist;
  - is prescribed by a Plan Provider, except in the case of Emergency Services and Urgently Needed Services;
  - is a Prescription Drug that does not have an over-the-counter Therapeutic Equivalent available; and
  - is not specifically excluded herein.
- 4.4** “**Copayment**” means the amount the Member pays when a Covered Service is received.
- 4.5** “**Designated Plan Pharmacy**” means a pharmacy that has entered into an agreement with HPN to provide specific Covered Drugs and/or supplies to Members. The fact that a pharmacy is a Plan Pharmacy does not mean that it is a Designated Plan Pharmacy. For the purposes of the Prescription Drug Benefit Rider, please refer to the HPN PDL on the website or contact Member Services for the specific Designated Plan Pharmacy for

### **SECTION 4. Glossary**

## **PRESCRIPTION DRUG RIDER**

- your Covered Drug and/or supply/equipment.
- 4.6 **“Dispensing Period”** as established by HPN means 1) a predetermined period of time; or 2) a period of time up to a predetermined age attained by the Member that a specific Covered Drug is recommended by the FDA to be an appropriate course of treatment when prescribed in connection with a particular condition.
- 4.7 **“Eligible Medical Expense (EME)”** for purposes of this Rider, means the Plan Pharmacy’s contracted cost of the Covered Drug to HPN but not more than the actual charge to the Member.
- 4.8 **“Generic Drug”** is an FDA-approved Prescription Drug which does not meet the definition of a Brand Name Drug as defined herein.
- 4.9 **“Mail Order Plan Pharmacy”** is a duly licensed pharmacy that has an independent contractor agreement with HPN to provide certain Tier I, Tier II and Tier III Drugs to Members by mail.
- 4.10 **“Non-Plan Pharmacy”** is a duly licensed pharmacy that does not have an independent contractor agreement with HPN to provide Covered Drugs to Members.
- 4.11 **“Plan Pharmacy”** is a duly licensed pharmacy that has an independent contractor agreement with HPN to provide Covered Drugs to Members. Unless otherwise specified as Mail Order Plan Pharmacy herein, Plan Pharmacy services are retail services only and do not include Mail Order services.
- 4.12 **Prescription Drug List (PDL)”** means a list of FDA approved Generic and Brand Name Prescription Drugs established, maintained, and recommended for use by HPN.
- 4.13 **“Prescription Drug”** is any drug required by federal law or regulation to be dispensed upon written prescription including finished dosage forms and active ingredients subject to the Federal Food, Drug and Cosmetic Act.
- 4.14 **“Specialty Drugs”** are high-cost oral, injectable, infused or inhaled Covered Drugs as identified by HPN’s P&T Committee that are either self-administered or administered by a healthcare Provider and used or obtained in either an outpatient or home setting.
- 4.15 **“Step Therapy”** is a program for Members who take Prescription Drugs for an ongoing medical condition, such as arthritis, asthma or high blood pressure, which ensures the Member receives the most appropriate and cost-effective drug therapy for their condition. The Step Therapy program requires that before benefits are payable for a high cost Covered Drug that may have initially been prescribed, the Member try a lower cost first-step Covered Drug. If the prescribing Physician has documented with HPN why the Member’s condition cannot be stabilized with the first-step Covered Drug, HPN will review a request for Prior Authorization to move the Member to a second-step drug, and so on, until it is determined by HPN that the prescribed Covered Drug is Medically Necessary and eligible for benefit payment.
- 4.16 **“Therapeutic Equivalent”** means that a Covered Drug can be expected to produce essentially the same therapeutic outcome and toxicity.
- 4.17 **“Therapeutic Supply”** is the maximum quantity of a Covered Drug for which benefits are available for the applicable Drug Fee or the applicable Coinsurance amount and may be less than but shall not exceed a 30-day retail supply or 90- day mail order supply.

**Coverage Policies and Guidelines**

## ***PRESCRIPTION DRUG RIDER***

HPNs Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on HPN's behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug to a certain tier by considering a number of factors including but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug's acquisition cost including, but not limited to, available rebates and assessments of the cost effectiveness of the Prescription Drug.

Some Prescription Drugs are more cost effective for specific indications as compared to others; therefore, a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug was prescribed, or according to whether it was prescribed by a Specialist Physician.

HPN may periodically change the placement of a Prescription Drug among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: the tier status of a Prescription Drug may change periodically based on the process described above. As a result of such changes,

you may be required to pay more or less for that Prescription Drug.

Questions about HPN's PDL should be directed to the Member Services Department at (702) 242-7300 or 1-800-777-1840 or the PDL and the Pharmacy Reimbursement Claim Form is available at <http://www.uhcnevada.com/> which leads to HPN's portal [www.healthplanofnevada.com](http://www.healthplanofnevada.com).



Proposed Renewal Rates for City of Henderson  
Effective 1/1/2014 - 12/31/2014

		Current			Proposed Renewal Rates Under Current Benefits			Proposed Renewal Rates and Benefit Changes			
Subs	Mbrs	HMO G-X	HMO \$5/\$25/\$45 Rx	Total	HMO G-X	HMO \$5/\$25/\$45 Rx	Total	HPN Solutions HMO	HMO 7/30/50/n/a/2.5X	Total	
23	23	\$	292.02	\$	320.37	\$	381.61	\$	272.03	\$	330.37
11	22	\$	598.64	\$	656.76	\$	782.30	\$	557.66	\$	677.25
5	10	\$	525.64	\$	576.67	\$	686.91	\$	489.66	\$	594.67
5	18	\$	525.64	\$	576.67	\$	686.91	\$	489.66	\$	594.67
28	126	\$	832.26	\$	913.06	\$	1,087.60	\$	775.29	\$	941.55
72	199	\$		\$		\$	54,704.31	\$		\$	47,358.29
							7.00%				-7.37%

Note: Effective 1/1/2014 the group's current benefits will no longer be available. The group has been mapped to the closest matching ACA compliant benefit plan available 1/1/2014.



**Proposed Benefit Changes for City of Henderson  
Effective 1/1/2014 - 12/31/2014**

	Current Products	Mapped 2014 KA Portfolio Product
	<b>G-X</b>	<b>HPN Solutions HMO 15</b>
PCP	\$10	\$15
Spec	\$10	\$30
Lab	\$0	\$10
Rad	\$0	\$25
UC	\$15	\$20
ER	\$75	\$200
IP	\$0	\$500
OP @ ASC	\$0	\$100
OP @ Hosp	\$0	\$250
OOP Max EE	200% of Total Premium (Approx. \$5,700)	\$6,000
OOP Max FA	N/A	\$12,000
Rx	\$5/\$25/\$45	7/30/50/Inf/2.5X

**Note: Current products DO NOT INCLUDE deductibles and Rx copays in the OOP Maximums.  
2014 KA Products DO INCLUDE deductibles and Rx copays in the OOP Maximums.**



**SELF-FUNDED HEALTH INSURANCE FUND (FUND 6051)  
AS OF JULY 31, 2013**

	Estimated Year Ended 12/31/12	% of Total Rev	YTD 2012 Jan-July	% of Total Rev	Estimated YTD 2013 Jan- July	% of Total Rev	Increase/(Decrease) 2012/2013	% Change 2012/2013
<b>Working Capital Beginning of Year</b>	\$ 7,859,720		\$ 7,859,720		\$ 6,570,509		\$ (1,289,211)	-16.40%
<b>Revenue:</b>								
Premiums - HPN	\$ 538,328	4.44%	\$ 301,679	4.28%	\$ 355,402	4.65%	\$ 53,723 (1)	17.81%
Premiums - Self Funded	10,512,572	86.71%	6,164,078	87.40%	6,694,155	87.54%	530,077 (2)	8.60%
Premiums - Retirees	885,705	7.31%	479,705	6.80%	538,393	7.04%	58,688 (3)	12.23%
Interest Income	178,801	1.47%	97,936	1.39%	57,664	0.75%	(40,272)	-41.12%
Misc-Performance Guarantee	9,014	0.07%	9,014	0.13%	950	0.01%	(8,064)	-
<b>Total Revenue</b>	<b>\$ 12,124,418</b>	<b>100.0%</b>	<b>\$ 7,062,412</b>	<b>100.0%</b>	<b>\$ 7,846,664</b>	<b>100.0%</b>	<b>\$ 784,252</b>	<b>8.4%</b>
<b>Expenses:</b>								
<b>Administrative Costs</b>								
Salaries, wages & benefits	122,195	1.01%	71,302	1.01%	69,438	0.91%	(1,864)	-2.61%
Consulting	44,300	0.37%	27,400	0.39%	39,488	0.52%	12,088 (4)	44.12%
Claims Adjudication	674,214	5.56%	337,418	4.78%	306,767	4.01%	(30,651)	-9.08%
VSP Service Fee	22,767	0.19%	13,219	0.19%	14,305	0.19%	1,086 (7)	8.22%
Actuarial/Professional Costs	99,889	0.82%	55,377	0.79%	53,638	0.70%	(1,739)	-3.14%
Miscellaneous Costs	22,901	0.19%	7,213	0.10%	8,597	0.11%	1,384 (5)	19.19%
Administrative fee-GF	21,620	0.18%	11,455	0.16%	14,231	0.19%	2,776 (6)	24.23%
<b>Total Administrative Costs</b>	<b>1,007,888</b>	<b>8.31%</b>	<b>623,384</b>	<b>7.42%</b>	<b>608,484</b>	<b>6.62%</b>	<b>(19,904)</b>	<b>-3.23%</b>
<b>Fixed Premiums:</b>								
Specific Stop-Loss Premium	655,591	5.41%	380,920	5.40%	437,983	5.73%	57,063 (1)	14.98%
Life Insurance	97,959	0.81%	57,052	0.81%	57,252	0.75%	200	0.35%
AD&D	23,609	0.19%	13,784	0.20%	13,727	0.18%	(57)	-0.41%
HPN Premiums	540,370	4.46%	305,267	4.33%	349,996	4.58%	44,729 (8)	14.65%
Long Term Disability	179,227	1.48%	104,686	1.48%	104,159	1.36%	(507)	-0.48%
Dental	128,344	1.06%	55,270	0.78%	123,877	1.62%	68,607 (9)	-
<b>Total Fixed Premiums</b>	<b>1,625,160</b>	<b>13.40%</b>	<b>916,869</b>	<b>13.00%</b>	<b>1,088,994</b>	<b>14.22%</b>	<b>179,036</b>	<b>19.64%</b>
<b>Claims Paid:</b>								
Medical-Net (1)	7,465,534	61.57%	4,044,441	57.35%	5,369,340	70.22%	1,324,899 (10)	32.76%
Prescriptions	2,303,763	19.00%	1,385,731	19.65%	1,405,164	18.38%	19,433	1.40%
Dental	841,817	6.94%	524,815	7.44%	387,294	5.06%	(137,521)	-26.20%
Vision	169,529	1.40%	104,271	1.48%	101,512	1.33%	(2,759)	-2.65%
<b>Total Claims</b>	<b>10,780,643</b>	<b>88.9%</b>	<b>6,059,268</b>	<b>85.9%</b>	<b>7,263,310</b>	<b>95.0%</b>	<b>1,204,042</b>	<b>19.9%</b>
<b>Total Expenses</b>	<b>\$ 13,413,624</b>	<b>110.6%</b>	<b>\$ 7,499,801</b>	<b>106.3%</b>	<b>\$ 8,952,788</b>	<b>116.8%</b>	<b>\$ 1,452,987</b>	<b>18.1%</b>
<b>Income (Loss)</b>	<b>(1,289,211)</b>		<b>(447,189)</b>		<b>(1,210,204)</b>		<b>(763,015)</b>	<b>170.62%</b>
<b>Working Capital Before Reserve</b>	<b>6,570,509</b>		<b>7,412,531</b>		<b>5,360,305</b>		<b>(2,052,226)</b>	<b>-27.69%</b>
Less: Committee Reserve	(2,000,000)		(2,000,000)		(2,000,000)			
<b>Working Capital End of Period</b>	<b>\$4,570,509</b>		<b>\$5,412,531</b>		<b>\$3,360,305</b>		<b>(2,052,226)</b>	<b>-37.92%</b>

(1) Medical Claims-Net	7,465,534	4,044,441	5,369,340	1,324,899
Stop loss claims payments received	343,133	193,033	118,754	(76,279)
<b>Medical Claims-Gross</b>	<b>7,808,667</b>	<b>4,237,474</b>	<b>5,488,094</b>	<b>1,248,620</b>
(2) Prescription Claims-Net	2,303,763	1,385,731	1,405,164	19,433
Prescription Rebates	206,875	102,642	90,450	(12,186)
Stop loss claims payments received	8,205	8,205	-	(8,205)
<b>Prescription Claims-Gross</b>	<b>2,518,843</b>	<b>1,496,578</b>	<b>1,495,620</b>	<b>(958)</b>

**Comments:**

1. Rate and subscriber increase in 2013
2. Rate increase in 2013 and VESP agreements
3. Increase due to the number of retirees. (VESF)
4. Quarterly Consulting fee for Gallagher was being split between Consultant and Professional Costs-starting July 2013 the total base quarterly consulting fee is no longer being split and will only be charged to Consulting.
5. Dues and Membership for IFEBP increased by \$350 and \$218 fee for Web Benefit Ins Page, Postage increase of \$830, Training & Tuition increased by \$840
6. FY12 based on salaries at 04% and FY13 based on FTE's 05%
7. Rate increase in 2013
8. Combination of rate increase in 2013 and 9 employees switching to HPN
9. Delta Dental started in April '12
10. Medical claims include IBNR (2012: \$188,060 2013: \$608,309)

**SELF-FUNDED HEALTH INSURANCE FUND (FUND 6051)  
AS OF JUNE 30, 2013**

	Estimated Year Ended 12/31/12	% of Total Rev	YTD 2012 Jan-June	% of Total Rev	Estimated YTD 2013 Jan-June	% of Total Rev	Increase(Decrease) 2012/2013	% Change 2012/2013
Working Capital Beginning of Year	\$ 7,889,720		\$ 7,889,720		\$ 6,570,509		\$ (1,289,211)	-16.40%
<b>Revenue:</b>								
Premiums - HPN	\$ 538,326	4.44%	\$ 202,158	4.32%	\$ 306,178	4.62%	\$ 43,020	16.41%
Premiums - Self Funded	10,512,572	88.71%	5,298,850	87.37%	5,778,673	87.41%	477,823	9.02%
Premiums - Retirees	885,705	7.31%	405,802	6.69%	476,309	7.21%	70,707	17.43%
Interest Income	178,801	1.47%	89,400	1.47%	49,846	0.75%	(39,754)	-44.47%
Misc-Performance Guarantee	9,014	0.07%	9,014	0.15%	950	0.01%	(8,064)	-
<b>Total Revenue</b>	<b>\$ 12,124,418</b>	<b>100.0%</b>	<b>\$ 6,085,922</b>	<b>100.0%</b>	<b>\$ 6,898,764</b>	<b>100.0%</b>	<b>\$ 812,842</b>	<b>8.0%</b>
<b>Expenses:</b>								
<b>Administrative Costs:</b>								
Salaries, wages & benefits	122,195	1.01%	58,205	0.98%	57,321	0.87%	(884)	-1.52%
Consulting	44,300	0.37%	27,400	0.45%	17,550	0.27%	(9,850)	-35.95%
Claims Adjudication	874,214	5.56%	285,031	4.70%	271,948	4.11%	(13,085)	-4.59%
VSP Service Fee	22,787	0.19%	11,327	0.19%	12,285	0.19%	958	8.46%
Actuarial/Professional Costs	99,889	0.82%	52,817	0.87%	44,383	0.67%	(8,454)	-16.01%
Miscellaneous Costs	22,901	0.19%	6,683	0.11%	8,205	0.12%	1,522	22.77%
Administrative fee-GF	21,620	0.18%	9,422	0.16%	12,196	0.18%	2,774	29.44%
<b>Total Administrative Costs</b>	<b>1,997,496</b>	<b>8.31%</b>	<b>480,885</b>	<b>7.43%</b>	<b>423,866</b>	<b>6.41%</b>	<b>(22,018)</b>	<b>-5.89%</b>
<b>Fixed Premiums:</b>								
Specific Stop-Loss Premium	655,591	5.41%	326,433	5.36%	376,537	5.70%	50,104	15.35%
Life Insurance	97,959	0.81%	48,957	0.81%	49,187	0.74%	230	0.47%
AD&D	23,608	0.19%	11,837	0.20%	11,807	0.18%	(30)	-0.25%
HPN Premiums	540,370	4.48%	259,777	4.28%	298,509	4.52%	38,732	14.91%
Long Term Disability	179,227	1.48%	89,891	1.48%	89,824	1.36%	(67)	-0.30%
Dental	128,344	1.08%	41,095	0.68%	105,889	1.50%	64,794	155.28%
<b>Total Fixed Premiums</b>	<b>1,425,109</b>	<b>11.69%</b>	<b>777,990</b>	<b>12.83%</b>	<b>831,563</b>	<b>14.19%</b>	<b>183,563</b>	<b>19.74%</b>
<b>Claims Paid:</b>								
Medical-Net (1)	7,465,534	61.57%	3,335,368	54.99%	4,179,955	63.25%	844,587	25.32%
Prescriptions	2,303,763	19.00%	1,152,141	19.00%	1,179,011	17.84%	26,870	2.33%
Dental	841,817	6.94%	449,794	7.42%	312,682	4.73%	(137,112)	-30.48%
Vision	189,529	1.40%	104,271	1.72%	86,078	1.30%	(18,193)	-17.45%
<b>Total Claims</b>	<b>10,780,643</b>	<b>88.9%</b>	<b>5,041,574</b>	<b>83.1%</b>	<b>5,767,726</b>	<b>87.1%</b>	<b>716,152</b>	<b>14.2%</b>
<b>Total Expenses</b>	<b>\$ 13,413,928</b>	<b>116.8%</b>	<b>\$ 6,270,448</b>	<b>103.4%</b>	<b>\$ 7,153,148</b>	<b>107.6%</b>	<b>\$ 842,696</b>	<b>13.4%</b>
<b>Income (Loss)</b>	<b>(1,289,211)</b>		<b>(205,427)</b>		<b>(504,391)</b>		<b>(298,964)</b>	<b>145.53%</b>
<b>Working Capital Before Reserve</b>	<b>6,570,509</b>		<b>7,654,293</b>		<b>6,066,116</b>		<b>(1,588,175)</b>	<b>-20.75%</b>
Less: Committee Reserve	(2,000,000)		(2,000,000)		(2,000,000)			
<b>Working Capital End of Period</b>	<b>\$ 4,570,509</b>		<b>\$ 5,654,293</b>		<b>\$ 4,066,116</b>		<b>(1,988,175)</b>	<b>-28.96%</b>
<b>(1) Medical Claims-Net</b>	<b>7,465,534</b>		<b>3,335,368</b>		<b>4,179,955</b>		<b>844,587</b>	
Stop loss claims payments received	343,133		193,033		81,034		(111,300)	
<b>Medical Claims-Gross</b>	<b>7,808,667</b>		<b>3,528,401</b>		<b>4,261,589</b>		<b>733,187</b>	
<b>(2) Prescription Claims-Net</b>	<b>2,303,763</b>		<b>1,152,141</b>		<b>1,179,011</b>		<b>26,870</b>	
Prescription Rebates	208,875		102,642		90,456		(12,166)	
Stop loss claims payments received	8,205		8,205		-		(8,205)	
<b>Prescription Claims-Gross</b>	<b>2,519,843</b>		<b>1,262,988</b>		<b>1,269,467</b>		<b>6,479</b>	

**Comments:**

1. Rate and subscriber increase in 2013
2. Rate increase in 2013 and VESP agreements
3. Increase due to the number of retirees. (VESP)
4. 2012 includes Retiree Pricing Model of \$10,500
5. 2012 includes GASB 45 Actuarial Study
6. Dues and Membership for IFEBP increased by \$350 and \$218 fee for Web Benefit Ins Page, Postage increase of \$830, Training & Tuition increased by \$840
7. FY12 based on salaries at .04% and FY13 based on FTE's .05%
8. Rate increase in 2013
9. Combination of rate increase in 2013 and 9 employees switching to HPN
10. Delta Dental started in April '12
11. Increase in medical claims of 25.32% or 845K