MEMORANDUM

City of Sparks

To: Jen McCall, Sr. HR Analyst

From: Linda Patterson, City Clerk LP

Date: September 11, 2012

Subject: Annual Operating Plan, A-2578 - Amendment

On September 10, 2012, the Sparks City Council approved an Amendment to A-2578 to renew the agreement with CDS Group Health Third Party Administration Services for the City of Sparks.

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Copy:
A-2578
A.I. 5.8

A-2578
Amendment #1
9/10/12
A.I. 5.8

Third Party Administration Contract

THIS AGREEMENT is made by and between **City of Sparks** (the "Company"), whose principal address is 431 Prater Way, Sparks, Nevada 89431, and **CDS of Nevada dba CDS Group Health, a Dignity Health member, ("CDS"),** whose principal address is 1625 East Prater Way, Suite C-101, Sparks, Nevada 89431, effective as of **July 1, 2012,** and shall continue until terminated as herein provided.

When the Company is acting as the Plan Sponsor (as defined in the Employee Retirement Income Security Act of 1974, as amended ("ERISA") under this Agreement, it will be referred to as the "Plan Sponsor," and when it is acting as the Administrator (as defined in ERISA) under this Agreement, it will be referred to as the "Plan Administrator." As Plan Sponsor, the Company is acting in its capacity as the settlor of the Plan; and, as the Plan Administrator, it is acting in its fiduciary capacity;

WITNESSETH:

WHEREAS, the Plan Sponsor has established a self-funded Employee Welfare Benefit Plan, as defined in ERISA (the "Plan"), for the purpose of providing certain benefits to certain employees of the Plan Sponsor and for certain dependents of such employees (collectively, the "Participants"); and

WHEREAS, CDS is in the business of providing administrative services in conjunction with such plans, and the Plan Sponsor desires to engage CDS to perform the services enumerated herein below and CDS is willing to provide such services, subject to the terms and conditions hereof.

NOW, THEREFORE, in consideration of the premises and of the mutual promises and covenants contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, and intending to be legally bound hereby, the parties agree as follows:

I. PLAN

1.1. Plan Document. All services to be provided by CDS hereunder shall be performed pursuant to the provisions of the Plan Document and Summary Plan Description, as amended (collectively, the "Documents"). A copy of the Documents and any amendments thereto shall be deemed to form part of this Agreement for such purpose.

1.2. Interpretation of the Plan. The Plan Administrator shall be the final arbiter as to the interpretations of the Plan and as to the payment of benefits thereunder. CDS shall consult with the Plan Administrator in the event a determination of benefits payable with respect to a claim or any other decision is not clearly set forth in the Documents but requires the use of discretion.

II. SCOPE OF RELATIONSHIP

2.1. Agency. In performing the services hereunder, CDS is acting solely as the agent of the Plan Sponsor and the Plan Administrator, and the respective rights of the parties shall be determined in accordance with the laws of agency. In the event that the Plan Sponsor or the Plan Administrator fails to comply with any federal or state law, CDS shall not be liable in any action brought with regard to such failure.

2.2. Fiduciary. CDS is not, and shall not be deemed to be, a fiduciary of the Plan. Rather, the duties of CDS hereunder are ministerial in nature; and this Agreement does not, and shall not be deemed to, confer upon, or delegate to, CDS any discretionary authority or discretionary responsibility in the administration of the Plan. The Company is the "Administrator" and "Named Fiduciary" (as such terms are defined in ERISA) of the Plan and, as the Plan Administrator, has the sole authority to make discretionary decisions with respect to the Plan.

2.3. Communications. CDS shall be entitled to rely, without questions, upon any written or oral communication from the Plan Sponsor or the Plan Administrator.

2.4. No Third Party Beneficiaries. There shall be no third party beneficiaries to this Agreement, and no individual or entity who is not a party to this Agreement, including, but not limited to, Participants, shall have any rights under, or in connection with a breach or violation of, this Agreement.

III. DUTIES OF CDS

3.1. Claims Services. CDS agrees to perform the below-enumerated services with respect to the processing and payment of claims under the Plan:

a. Receive claims and claims documentation;

b. Correspond with the Participants and providers of services if additional information is necessary to complete the processing of claims;

c. Coordinate benefits payable under the Plan with other benefit plans, if any;

d. Calculate the amount of benefits payable under the terms of the Documents;

e. In the event the determination of benefits payable with respect to a claim is not clearly set forth in the Documents but requires the use of discretion, refer the claim, together with a suggested claim determination, to the Plan Administrator for a final determination of the benefits payable;

f. Prepare disbursement checks for the amount of benefits determined to be payable under the Plan;

g. As required by the Documents and applicable law, notify Participants or their assignees of (i) any denial of their claim and the right to file one or more appeals of the denial, as appropriate, and (ii) the decision on any such appeal(s). CDS shall review and decide any

appeals of denied claims, except those which would require the use of discretion, which shall be referred to the Plan Administrator for determination;

h. Use its best efforts in the normal course of its services hereunder to identify claims for which there is the potential for collection of amounts paid to, or on behalf of, Participants through subrogation and to notify the Plan Administrator of such claims;

i. Use its best efforts in the normal course of its services hereunder to identify claims that may be subject to reimbursement, based upon the existence of any stop loss or excess loss policy. In no event will CDS be held liable for any claims not covered by the stop loss carrier;

provided, however, that in providing the services set forth in this Section 3.2, if the use of discretion is required, CDS will refer such decision to the Plan Administrator for a determination.

3.2. **Administrative Services**. CDS agrees to:

a. Refer to the Plan Sponsor's stop loss or excess loss carrier, if any, all claims exceeding the portion of any loss or losses to be funded by the Plan Sponsor for approval, administration, and payment, whereupon CDS shall have no further obligation or liability relative to such loss or losses;

b. Provide experience reporting for coverages;

c. Issue 1099-MISC forms and correct provider tax identification numbers for all calendar years in which it processed claims.

3.3. **Practices and Procedures**. In performing such services, CDS shall employ its standard practices and procedures, whether written or otherwise; provided, however, such performance shall be subject to the provisions of this Agreement, including, but not limited to, Section 1.2.

3.4. **Recovery of Payment**. In the event payment is made to, or on behalf of, an ineligible Participant or any ineligible employee or dependent or a payment is made in excess of the amount properly payable, CDS shall make a minimum of three demands to the Participant or ineligible employee or dependent, in writing, for the return of such payment or overpayment and report the results of such efforts to the Plan Sponsor and the Plan Administrator. CDS shall have no further obligation with respect to any such payment or overpayment, except that CDS is hereby authorized to offset against any unpaid claim of such Participant unless advised otherwise by the Plan Sponsor or the Plan Administrator.

3.5 **Records and Files**. CDS shall establish and maintain a record keeping system concerning the services to be performed hereunder. All such records, including an accumulator report and member eligibility listing of such, and all hard copy files shall be the property of the Plan Sponsor and shall be delivered to the Plan Sponsor upon termination of this Agreement, subject to the right of CDS to copy and retain all or any of such records as it deems in its interest to do so. All such records shall be available for inspection by the Plan Sponsor and the Plan Administrator at any time during normal business hours at the offices of CDS in Sparks, Nevada, upon reasonable and prior notice. CDS will retain on-site twelve

(12) months of hard copy plan records and files. Plan Sponsor and the Plan Administrator will be responsible for storing records and files in excess of 12 months.

3.6. Reports. CDS shall provide the following standard reports to the Plan Sponsor, the Plan Administrator or a it's designee.

- **a.** Check register (weekly);
- **b.** Bank register (monthly);
- **c.** Lag report (monthly);
- **d.** Check adjustment report (monthly);
- **e.** Paid claims summary (monthly);
- **f.** Hospital admission report (monthly);
- **g.** Recap by service report (monthly);
- **h.** Family stop loss report over 50% of specific stop loss (monthly); and
- **i.** Eligibility report

3.7. Duty of Care. CDS shall not be liable for any loss resulting from the performance of its duties hereunder, except for losses resulting directly from:

- **a.** The negligence of CDS;
- **b.** The failure of CDS to follow the written directions of the Plan Administrator in the processing of a particular claim; or
- **c.** The fraudulent or criminal acts of the agents or employees of CDS, whether acting alone or in concert with others; except that if such act or acts shall have been performed in concert with an agent or employee of the Plan Sponsor or the Plan Administrator, the Plan Sponsor or the Plan Administrator shall share liability for the resulting loss.

The defense of any legal action brought by or on behalf of any person, including, without limitation, any Participant or fiduciary of the Plan, shall be the obligation of the Plan Sponsor and shall not be the obligation of CDS except for any legal action resulting from (a), (b), or (c) above, in which case said legal action shall be the obligation of CDS and not the Plan Sponsor.

3.8. Indemnification of Plan Sponsor. CDS agrees to indemnify and hold harmless the Plan Sponsor from and against any and all claims, losses, liabilities, damages and expenses incurred by the Plan Sponsor, including attorneys' fees and court costs, to the extent that such claims, losses, liabilities, damages and expenses arise out of, or are based upon, CDS's intentional, willful, reckless or negligent acts or omissions in the performance of its duties under this Agreement; and

IV. DUTIES OF PLAN SPONSOR

The Plan Sponsor shall:

4.1. **Establishment and Amendment of the Plan.** Have exclusive authority to establish, amend and terminate the Plan and have exclusive responsibility for Plan design;

4.2. **Documentation.** Have final authority with respect to all Documents, including the initial documentation and any amendments thereof;

4.3. **Funding.** Have the responsibility to provide funds for payment of benefit claims under the Plan. It is expressly acknowledged that CDS has no responsibility or liability for the adequacy of funds in the Plan and that claims for benefits under the Plan shall be paid only to the extent of funds made available to CDS by the Plan Sponsor and then only while so authorized by the Plan Sponsor. The Plan Sponsor shall establish, maintain and fund a trust and/or a checking account for the payment of benefits under the Plan. Both parties recognize that this specifically includes Medicare Secondary Payer claims, even though such claims may not be specifically allowed by Plan language or may be time-barred under the terms of the Documents. In the event the Plan Sponsor fails to provide funds for payment of claims within thirty (30) days of receipt of notice from CDS, CDS may notify Participants and the U.S. Department of Labor of such inability to fund processed claims;

4.4. **Notice of Changes and Amendments.** Provide CDS with at least 30 day prior notice regarding any changes in its procedures or amendments to the Documents in order to allow CDS sufficient time to make changes internally for accurate benefit administration..

4.5. **Payments to CDS.** Make full payment of CDS' invoices by the 20th of each month. More specifically, the Plan Sponsor agrees to pay the following:

a. **Service Fee**. A service fee as illustrated below based on the number of active Participants (employee, retiree, COBRA participant) covered under the Plan for any part of the month (the "Service Fee"):

The Plan Sponsor agrees to pay the Service Fee as determined above on or before the 20th of each calendar month for which services are being rendered.

SERVICES	July 1, 2012 – June 30, 2013
Medical / Dental Claims Administration	$14.35
Inpatient Pre-certification and Large Case Management	$ 3.69
Cobra Administration	$ 1.00
Flexible Spending Administration	$ 5.00
Premium Billing	$ 100/month
Plan Document Services	$100/hour
EDI Eligibility transmission – up to 2 vendors (i.e. PBM & VSP)	$ 75/month
Technical Support/Data Interface & Management	$ 75/hour
All printing Costs	At Cost
Audit and Recovery - (i.e. Dependent Eligibility, Coordination of Benefits, Pharmacy and Hospital Bill Audit. Recovery fee does not apply to any overpayments recovered as the result of a CDS error.	25% of any savings/recovery
Plan Savings Resulting from Re-directing Services (i.e. physicians office versus hospital setting)	25% of savings
Out of Network Case Negotiations	25% of savings

b. **Change of Service Fee**. In the event the Plan Sponsor requests CDS to perform services other than those listed in Article III of this Agreement, both parties maintain the right to negotiate the compensation for services.

c. **Audit Fees**. CDS recognizes that from time to time during the term of this Agreement the Plan Sponsor may wish to perform (or have performed) an audit for financial statement purposes, performance standard related, claims payment or other purposes.

d. **Other Expenses.** For any other expenses incurred by CDS in connection with administration of the Plan, CDS will bill Plan Sponsor and supply records supporting the expenses.

e. **Reprocessing Fee.** In the event a retroactive amendment or the Plan Sponsor's failure to fund claims in a timely manner results in the need to reprocess claims, the Plan Sponsor agrees to pay CDS's $20.00 per claim in performing that service.

f. **Increased Postal Fees.** Notwithstanding the fees in effect under this Agreement, should the United States postal service institute a postal rate increase during the term of this Agreement, then CDS shall increase the fees then in effect.

g. **Changes in Law Resulting in Increased Costs.** Notwithstanding the fees in effect under this Agreement, should there be a change in any law or regulation that results in increased costs to CDS, CDS shall increase its fees to cover such increased costs.

h. **Consultants' Fees.** The Plan Sponsor hereby authorizes CDS to obtain professional reviews, independent medical evaluations, and audits of hospital or other health care provider costs, expenses and credit balances in accordance with group health industry standards and practices in order to determine whether hospital and physician charges are accurate, appropriate and necessary. The Plan Sponsor shall be responsible for all fees or expenses, if any, of third parties in connection with such audits, which will be passed on to the Plan, at CDS's cost. Further, the Plan Sponsor shall be responsible for all fees

of medical, vocational, and dental consultants and any consulting attorneys who may be consulted to assist in a determination of whether benefits are payable under the Plan, and any such consultants' fees will be passed on to the Plan, at CDS's costs;

i. **Taxes and Other Assessments**. Within a reasonable time after assessment, any tax or charge assessed against CDS which may be incurred by reason of (a) a ruling or other determination by an Insurance Department or other governmental authority to the effect that any fees or charges payable under Section 4.6 or the amount of claim payments made in accordance with the Plan is an insurance premium and subject to the premium tax provisions of the applicable statutes, including any retroactive assessment; or (b) a change in any charges imposed on CDS by any public body, exclusive of federal or state income taxes, which affect this Agreement. The Plan Sponsor will promptly pay to CDS all state and local taxes which may be imposed on the Plan Sponsor or CDS as a result of this Agreement. CDS agrees to remit these to the proper authorities in a timely fashion. It is agreed that nothing in this Agreement will be deemed to confer on CDS any responsibility for any federal, state or local tax liability which may be imposed upon CDS, the Plan Sponsor, Plan Administrator, any trust associated with the Plan, a fiduciary of the Plan or any Participant of the Plan.

j. **Printing Costs**. Printing costs such as Plan Document, Summary Plan Descriptions, identification cards, communication materials and printing materials for checks and EOBs will be the responsibility of the Plan Sponsor or Plan Administrator.

4.6. Census. Plan Sponsor or Plan Administrator is responsible for supplying adequate eligibility and other information on a timely basis to enable CDS to effectively carry out its duties. Plan Sponsor or Plan Administrator manages the Plan's eligibility by entering eligibility data through CDS' web portal. CDS shall be entitled to fully rely on the adequacy and accuracy of such data. In no event will more than three (3) months of adjustments to an individual's Service Fee (Section 4.5) be taken for clerical errors in the census.

4.7. Indemnification of CDS. The Plan Sponsor agrees to defend, indemnify and hold harmless CDS from and against any and all claims, losses, liabilities, damages and expenses incurred by CDS, including attorneys' fees and court costs, concerning the Plan or this Agreement, including, but not limited to, (a) any claim for benefits under the Plan, (b) any breach of this Agreement by the Company; (c) any actions of, or services provided by, the Providers or the Broker, including any services of third parties or stop loss insurance coverage which are recommended or obtained by the Broker; (d) any actions taken by the Plan Administrator, its employees or representatives, in accessing the Plan's records or files, or the results of such access; or (e) any claim relating to a delay in funding by the Plan Sponsor that causes any discounts to be lost or rescinded.

V. DUTIES OF PLAN ADMINISTRATOR

The Plan Administrator shall:

5.1. Eligibility Verification. Assist CDS in verification of Participants' eligibility under the Plan. Eligibility verification is deemed to be confirmation that the employee on whom a claim is based (or that employee's dependent) was or was not within an eligible employee (or dependent) class at the time services were rendered, such that whatever benefits, if any, are due and payable under the terms of the Documents can be adjudicated accordingly;

5.2. COBRA/HIPAA Compliance. Ensure compliance with COBRA and with the portability requirements of HIPAA;

5.3. Enrollment Forms and Changes. Furnish to CDS all completed enrollment forms and all additions, changes and terminations of persons under the Plan; and

5.4. Final Authority. Have final authority with respect to all claims determinations and operations of the Plan.

VI. OTHER PROVIDERS; BROKER; DISCLOSURE OF OTHER COMPENSATION

The Plan Sponsor and the Plan Administrator have elected to utilize the services of certain other providers (the "Providers") in connection with the administration of the Plan and authorizes CDS to enter into agreements on its behalf with the Providers. The Plan Sponsor authorizes CDS to prepare periodic billing statements for payment by the Plan Sponsor of the Provider fees listed below. The Plan Sponsor further authorizes CDS to collect and remit such fees on its behalf to the Providers designated herein. CDS shall collect such fees from the Plan Sponsor, either directly or as a part of the Plan Sponsor's funding of claims where the Provider fee is based upon a percentage discount, deposit them into an account maintained for this purpose and pay the appropriate Provider therefrom. The Plan Sponsor acknowledges and agrees to the payment terms of any Provider utilized by the Plan.

The Plan Sponsor has used the services of **L/P Insurance Services** (the "Broker") in connection with the Plan.

The Plan Sponsor acknowledges that CDS has no ownership or affiliation with the Providers or the Broker, except as set forth below, other than the right to access their networks or services. The Plan Sponsor further acknowledges that CDS may receive compensation from certain Vendors for providing administrative support to them in connection with the Claims Cost Containment services they provide to the Plan, as set forth below:

Claims Cost Containment Services

Provider Name	Provider Fee	CDS Administrative Interface Fee Received from Provider
The Phia Group or any other Third Party Recovery provider.	35%	5%
TC3 or any other Network Negotiator or Fraud and Abuse provider.	30%	8%
Hospital recovery audits	40%	10%

The above fees and Providers may change from time to time.

VII. CDS INSURANCE

CDS shall maintain, at its own expense, errors and omissions coverage and a fidelity bond in the form of employee dishonesty coverage, which shall meet the requirements of ERISA and any applicable state laws and regulations.

VIII. ADDITIONAL PAYMENTS TO CLAIMANTS

The Plan Administrator may, by written notice to CDS signed by an executive officer of the Plan Administrator, instruct CDS to pay claims, which in CDS's opinion, are not payable under the Plan, upon the condition that such instruction is hereby deemed to release CDS from any liability in connection therewith. The Plan Sponsor and the Plan Administrator hereby acknowledge that such payments will not qualify for credit toward excess loss insurance coverage, if any, and, as such, are considered "outside" the Plan. The Plan Sponsor and the Plan Administrator assume all legal requirements for such payment.

IX. OWNERSHIP OF BOOKS AND RECORDS; ACCESS BY PLAN ADMINISTRATOR

CDS acknowledges that all records and files maintained by it with regard to the Plan are the property of the Plan Sponsor. In the event the Plan Administrator or its employees accesses the Plan's records or files, whether to update eligibility information, process claims or perform some other function, the Plan Administrator acknowledges and agrees that CDS shall have no responsibility or liability in connection with any actions taken by it or its employees or the results thereof.

X. GENERAL PROVISIONS

10.1. Entire Contract. This Agreement, together with any exhibits, attachments and amendments appended hereto, constitutes the entire agreement between the parties. No representations, understandings or agreements which are not expressly contained herein, shall be binding or enforceable.

No modification of the terms or provisions of this Agreement shall be effective unless evidenced by written amendment hereto, signed by an authorized officer of both the Company and of CDS.

10.2. Applicable Law; Dispute Resolution. Any dispute which may arise between the parties as to the proper interpretation or application of this Agreement shall be governed by the laws of the State of Nevada, without regard to its conflicts of laws provisions. In the event any legal action or other proceeding shall be instituted with respect to a breach of any of the provisions of this Agreement and such breach shall be held to have occurred, then the prevailing party shall be entitled to recover all expenses incurred in connection with such action or proceeding, including reasonable attorneys' fees, through any appeal.

10.3. Binding Effect; Assignment; Survival. This Agreement shall be binding upon the parties hereto and their successors and assigns; provided, however, that neither party may assign its rights or obligations hereunder without the prior written consent of the other. The provisions of Sections 4.7 and 4.8 shall survive the termination of this Agreement.

10.4. Notices. All notices hereunder shall be in writing and delivered by hand, by certified mail, return receipt requested or by overnight delivery, to the addresses set forth above, or to such other addresses as the parties may from time to time designate in writing.

XI. TERM OF AGREEMENT

11.1. Term. This Agreement shall commence on **July 1, 2012** and shall continue in effect until **June 30, 2013,** unless otherwise terminated under the terms of this Agreement. This Agreement has mutually agreeable options to extend for a period not exceeding five (5) years.

11.2. Termination.

11.2.1. By Notice. Either party may terminate this Agreement for any reason at any time by providing written notice to the other party. The notice shall specify an effective date of termination, which shall be not less than ninety (90) days nor more than one-hundred twenty days (120) days after the date of receipt of the notice by the other party. If the notice does not specify a date of termination, the effective date of termination shall be ninety (90) days after receipt of the notice by the other party.

11.2.2. By Default. Should either party default in the performance of any of the terms or conditions of this Agreement, the other party shall deliver to the defaulting party written notice thereof specifying the matters in default. The defaulting party shall have ten (10) calendar days after its receipt of the written notice to cure such default. If the defaulting party fails to cure the default within such ten-day period, this Agreement shall terminate at 11:59 p.m. on the tenth day after the receipt of the notice by the defaulting party.

11.2.3. By Law. If any state or federal law or regulation is enacted or promulgated which prohibits the performance of any of the duties hereunder, or if any law is interpreted to prohibit such performance, this Agreement shall automatically terminate as of the effective date of such prohibition.

11.3. Effect of Termination. As of the effective date of termination of this Agreement, CDS shall have no further duties under this Agreement. The period between notice of termination and the effective date of termination shall be used to effect an orderly transfer of records and funds, if any, from CDS to the Plan Sponsor or to such person as the Plan Sponsor may designate in writing. Any record transfer shall be completed within thirty (30) calendar days of the termination date.

11.4. Run-out Claims. CDS will provide, at the Plan Sponsor's request, claims administration for claims incurred during the term of this Agreement for one-hundred twenty (120) days after date of termination of this Agreement for an additional four (4) months' Service Fees, based on the number of Participants during the last month of the term of this Agreement. CDS will provide claims administration after four (4) months at a rate of $20.00 per claim. Claim is defined as either a EOB or check per claim number.

CDS of Nevada, Inc. dba
CDS Group Health

By: Rayne Niehaus

Print Name: Rayne Niehaus

Title: Vice President

Dated: 9/13/2012

City of Sparks

By: Geno R. Martini

Print Name: Geno R. Martini

Title: Mayor

Dated: 09/11/12

ATTEST:

Linda Patterson, City Clerk

City of Sparks

APPROVED AS TO FORM

City Attorney

APPENDIX A
MEDICAL MANAGEMENT SERVICES

The Medical Management program and related policies and procedures are consistent with State, Federal and NCQA standards, regulations and guidelines, and are updated periodically.

Utilization Management:

Pre-service Review (Prior Authorization) provides a "before the fact" opportunity to evaluate medical appropriateness, cost-effectiveness and quality of care being recommended based on Plan Sponsor's Plan Document dated July 1, 2012.

- Inpatient-Acute, Rehabilitation, Psychiatric, Sub-acute, and Skilled Nursing Facilities
- Transplants
- Nevada Clinical Trials

The basic elements of pre-service review (prior authorization) include medical necessity review. Pre-service review (prior authorization) is performed by licensed professional nurses (RNs) under the direction of a medical director in accordance with the management Policies and Procedures, accepted national medical criteria. Each decision takes into account the individual needs of the patient and the availability of services in the local delivery system.

Care that is needed on an urgent or emergency basis is not subject to pre-service or prior authorization, regardless of the time of day, day of the week or place of service. "Emergency medical condition" or "emergency" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual or in the case of a pregnant woman, the health of the woman or her unborn child, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

Post-service (retrospective) emergency services claim review will include review of presenting symptoms and not base coverage solely on discharge diagnosis.

Concurrent Review

Concurrent review is performed for all known admissions to health care facilities including but not limited to, acute, rehab, SNF and all out of network home care services. Concurrent review is an assessment of ongoing medical and behavioral health services to determine continued medical necessity and appropriateness of care. Concurrent review is performed by licensed professional nurses (RNs), under the direction of a medical director. Appropriateness is determined by level of care, intensity of service and severity of symptoms using nationally recognized medical review criteria such as Interqual, as a guide. Case managers issue concurrent authorization in accordance with accepted medical criteria, taking into

account the needs of the individual patient and the local delivery system such as availability of skilled nursing facilities, sub acute facilities or home care in the service area to support the patient after hospital discharge. All cases that do not meet screening criteria for the member's condition or setting of care are referred to the medical director for review, recommendation and determination.

Discharge Planning

Telephonic review is performed for all facility services needing review. All staff identifies themselves by name, title and organization and follows all facility protocols for on-site review. Discharge planning is the process used to meet the member's needs beyond the inpatient setting. Discharge planning is performed by RN case managers, who work under the direct supervision of the medical director. The case managers work with the member, the member's family and physicians to assist in facilitating a discharge plan that is the most appropriate and least restrictive, while affording quality health care. During the initial chart review and or patient interview the member's potential discharge needs are assessed. Case managers are not the primary discharge planner in most cases but work closely with the hospital case managers to assist and augment in a discharge plan that meets the member's needs. The case managers assist with coordinating transfers and other needed services such as DME etc, to facilitate a plan prior to the member's discharge or transfer from a health care facility. When a member is out-of-area/out-of-network the case manager works closely, via telephone, with the facility case manager to meet the member's needs beyond the inpatient setting, utilizing some or all of the methods listed above.

Case Management

Case management is a collaborative process which assess, plans, implements, coordinates, monitors and evaluates the options and services to meet an individual's health needs, using communication and available resources to promote quality, cost effective outcomes. It also involves the proactive management of anticipated medical situations. The case management process encompasses care coordination in all settings including ambulatory and institutional care settings. Case management is limited to utilization management activities such as referral management, ensuring appropriate use of resources, timely care, delivery of high quality services and assisting in identifying patients for complex case management. A case manager works with the member, family and other interested parties in collaboration with the member's physician and other allied health care providers to assist in facilitating the delivery of quality health care services in the most appropriate and least restrictive manner. Case Management is voluntary and not mandated by the Plan Sponsor.

Post-service Review (Retrospective)

Clinical staff conducts post-service review (retrospective) based on the same established review guidelines described above. The review process includes reviewing medical care after the service has been provided, level of care, medical necessity, practitioner notification, emergency admission status, etc.

Medical Claims Review

Claims processors may request a medical review of claims and codes that have been submitted for payment. The process includes reviewing medical care after the service has been provided, components of eligibility and coverage determination, medical necessity, level of care, appropriateness, and presenting symptoms. However, if a case must be sent out for a third party specialized review, the cost is the responsibility of the Plan Sponsor.

Authorizations and Decisions

When making a determination of coverage based on medical necessity, authorization decisions are supported by relevant clinical information appropriate to each case include but are not limited to: medical records, consultation with the treating practitioner, diagnostic testing results, photos, operative reports, etc. The medical director or designated physician advisor reviews and make the final denial determination regardless of the reason for the denial. Decisions are made in a timely manner to accommodate the clinical urgency of the situation. Timeliness standards are developed in accordance with The Department of Labor, NCQA or other state or federal guidelines as appropriate. Timeliness is monitored through periodic (prior authorization) reports and periodic audits and denial turnaround time reports. Medical management decision-making is based only on appropriateness of care and service. Bonuses or other incentives are not provided for denial of medically necessary services or to encourage inappropriate under-utilization.

Denials and Appeals

All medical management denials regardless of the reason require review and determination by the medical director or practitioner designee. Denial decisions are communicated via telephone or fax to the requesting practitioner/provider and in writing to the member and requesting practitioner/provider. The denial letters contain the reason for the denial, in easily understood language, and information on the member and practitioner/provider appeal process. The requesting practitioner/provider is given the opportunity to discuss any denial decision with the medical director/physician advisor. Appeals must be made in accordance with the appropriate appeal requirements in effect in the Plan Document. Medical management review criteria is objective and evidence based, in order to make impartial, fair and consistent decisions, using the most current guidelines and criteria sets in making medical management decisions. Use of the criteria guidelines should not preempt sound clinical judgment. Criteria includes, but is not limited to:

- Milliman Care Guidelines
- Interqual Criteria
- ACOEM Guidelines
- Medicare DME Guidelines
- Aetna Clinical Policy Bulletins
- Behavioral Health Criteria (e.g. ASAM, Diagnostic and Statistical Manual of Mental Disorders, Clinical Guidelines)

When applying the criteria, the medical management staff will consider the following factors: age, comorbidities, and complications, progress of treatment, individual needs, psychosocial situation, and home environment, as applicable. The guidelines are intended to be used as screening tools to determine medical necessity, and appropriate care for requested treatment. In addition, decision makers will consider characteristics of the local delivery system available to the patient including: coverage of benefits for and availability of skilled nursing facilities, subacute care facilities, or home care when needed in the service area to support the patient after discharge, and local hospitals' ability to provide all recommended services within the estimated length of stay. Medical management staff collaborates with the medical director when needed to explore alternative coverage or services when medical management guidelines are not appropriate.

Access

The medical management department hours of operation are Monday through Friday: 8:00am to 5:00pm Pacific Time. Twenty-four (24) hours, seven- (7) day a week confidential voice mail and incoming faxing is available for inbound communication regarding medical management issues after normal business hours.

APPENDIX B
COBRA AND HIPAA ADMINISTRATION

I. DUTIES OF CDS

1.1 Election Notice. CDS will provide participants who are eligible for COBRA with notice of their COBRA continuation rights within fourteen (14) days from receipt of the COBRA Action Form from Employer.

1.2 Plan Records. CDS will maintain records of all qualified events reported by Employer. CDS will also maintain records of all notices, acceptances or rejections of election of COBRA continuation, applicable COBRA contributions, length of COBRA coverage, and any subsequent qualifying events.

1.3 Receipts of COBRA Contribution. CDS shall receive COBRA contributions from Plan participants who have elected COBRA continuation. COBRA contributions received by CDS will be forwarded to Employer.

1.4 COBRA Termination Notice. CDS will give notice of termination of COBRA continuation to Plan participants who are no longer entitled to receive COBRA continuation.

1.5 Plan Reports. CDS will separately account for Plan participants who have elected COBRA continuation in Plan reports provided under the Third Party Administrative Agreement. Upon termination of the services provided under this Addendum, CDS will make available to Employer all COBRA administration records and files. Upon request and at the expense of the Employer CDS will arrange for the delivery of the COBRA administration records and files to the employer or authorized agent.

II. DUTIES OF THE EMPLOYER

2.1 Notification of Qualifying Event.

(a) Employer will notify CDS with-in thirty (30) days of an employee's termination, reduction of hours, death or other qualifying event as required in the Consolidated Omnibus Budget Reconciliation Act.

(b) Employer will notify CDS within seven (7) days of receiving notice of Plan participants divorce or legal separation, a Plan participant's dependent ceasing to satisfy the definition of dependent child under the Plan, or other qualifying event as required in the Consolidated Omnibus Budget Reconciliation Act.

2.2 COBRA Contribution Amount. Employer will provide CDS with the COBRA contribution rates to be charged.

2.3 Certificate of Coverage. CDS will issue Certificate of Coverage to plan participants who lost coverage.

APPENDIX C

BUSINESS ASSOCIATE AGREEMENT

WHEREAS, City of Sparks, the Covered Entity, will make available and/or transfer to Business Associate certain Protected Health Information, in conjunction with goods or services to be provided by Business Associate to Covered Entity, that is confidential and subject to privacy protections afforded by federal law; and,

WHEREAS, CDS of Nevada dba, CDS Group Health, the Business Associate, will have access to and/or receive from Covered Entity certain Protected Health Information that shall be used or disclosed only in accordance with this Addendum, and applicable federal privacy regulations.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Covered Entity and Business Associate agree as follows:

I. Definitions

Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in 45 CFR 160.103 and 164.501.

(a) Business Associate. "Business Associate" shall mean CDS of Nevada, Inc. dba CDS Group Helath.

(b) Covered Entity. "Covered Entity" shall mean City of Sparks.

(c) Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

(d) Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

(e) Protected Health Information. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

(f) Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR 164.501.

(g) Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

II. Obligations and Activities of Business Associate

(a) Business Associate agrees to not use or further disclose Protected Health Information other than as permitted or required by the Agreement or as Required by Law.

(b) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this Addendum.

(c) Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Addendum.

(d) Business Associate agrees to report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Addendum of which it becomes aware.

(e) Business Associate agrees to ensure that any agent, including a subcontractor, to whom it provides Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity agrees to the same restrictions and conditions that apply through this Addendum to Business Associate with respect to such information.

(f) Business Associate agrees to provide access, at the request of Covered Entity, and in the time and manner designated by Covered Entity, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR 164.524.

(g) Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.

(h) Business Associate agrees to make internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

(i) Business Associate agrees to document such disclosures of Protected Health Information and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

(j) Business Associate agrees to provide to Covered Entity or an Individual, in time and manner designated by Covered Entity, information collected in accordance with Section II. (i) of this Addendum, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528.

III. Permitted Uses and Disclosures by Business Associate

(a) Except as otherwise limited in this Addendum, Business Associate may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

(b) Except as otherwise limited in this Addendum, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

(c) Except as otherwise limited in this Addendum, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(d) Except as otherwise limited in this Addendum, Business Associate may use Protected Health Information to provide Data Aggregation Services to Covered Entity as permitted by 45 CFR 164.504(e)(2)(i)(B).

(e) Business Associate may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502(j).

(f) For purposes of administration and management of the Agreement, Business Associate may disclose Protected Health Information to other Business Associates contracted with Covered Entity including but not limited to brokers and payors of record and any pharmacy/vision/dental plans in connection with the administration of the Benefits Agreement.

IV. Obligations of Covered Entity

(a) Covered Entity shall notify Business Associate of any limitation(s) in its Notice of Privacy Practices of Covered Entity in accordance with 45 CFR 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

(b) Covered Entity shall notify Business Associate with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

(c) Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

V. Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

VI. Term and Termination

(a) Term. The Term of this Addendum shall be effective as of the date of the Agreement, and shall terminate when all of the Protected Health Information provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is destroyed or returned to Covered Entity, or, if it is not feasible to return or destroy Protected Health Information, protections are extended to such information, in accordance with the termination provisions in this Section.

(b) Termination for Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall either: (1) Provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Addendum, and the Agreement if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; or, (2) Immediately terminate this Addendum, and the Agreement if Business Associate has breached a material term of this Addendum and cure is not possible; or, (3) If neither termination nor cure are feasible, Covered Entity shall report the violation to the Secretary.

(c) Effect of Termination.

(1) Except as provided in paragraph (2) of this section, upon termination of this Addendum, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

(2) In the event that Business Associate determines that returning or destroying the Protected Health Information is not feasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction not feasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is not feasible, Business Associate shall extend the protections of this Addendum to such Protected Health Information and limit further uses

and disclosures of such Protected Health Information to those purposes that make the return or destruction not feasible, for so long as Business Associate maintains such Protected Health Information.

VII. Miscellaneous

(a) Regulatory References. A reference in this Addendum to a section in the Privacy Rule means the section as in effect or as amended, and for which compliance is required.

(b) Amendment. The Parties agree to take such action as is necessary to amend this Addendum from time to time as is necessary for Covered Entity to comply with the requirements of the Privacy Rule and the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191.

(c) Survival. The respective rights and obligations of Business Associate under Section VI. (c) of this Addendum shall survive the termination of this Addendum.

(d) Interpretation. Any ambiguity in this Addendum shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy Rule.

(e) All Other Terms Of Agreement. Except as modified by the terms of this Addendum, all other terms of the Agreement shall remain in full force and effect.

(f) Conflict. In the event of a conflict between the terms of this Addendum and the Agreement, the provisions of this Addendum shall be deemed controlling.

Initials of:

Business Associate: RN

Covered Entity: gm