REGIONAL FLOOD CONTROL DISTRICT

NOTICE OF PUBLIC MEETING

CLARK COUNTY REGIONAL FLOOD CONTROL DISTRICT
BOARD OF DIRECTORS

NOVEMBER 14, 2024
8:30 A.M.

CLARK COUNTY COMMISSION CHAMBERS
500 SOUTH GRAND CENTRAL PARKWAY
LAS VEGAS, NV 89155

This agenda, including the supporting materials, is available at the Regional Flood Control District's website, ***https://www.regionalflood.org***; or by contacting:

DEANNA M. HUGHES, BOARD SECRETARY
600 SOUTH GRAND CENTRAL PARKWAY, SUITE 300
LAS VEGAS, NEVADA 89106
(702) 685-0000
Email: DHughes@regionalflood.org

TT/TDD: Relay Nevada toll free (800) 326-6868

This meeting will be open to the public and will also be broadcast live in the Las Vegas area on Clark County Television, which can be found on Channel 4 or 1004 on Cox Cable or CenturyLink, and in Laughlin it can be found on Channel 14 on Suddenlink. Live streaming of this meeting is available at: https://www.YouTube.com/user/ClarkCountyNV.

The Regional Flood Control District encourages citizen participation at its public meetings. If you wish to speak to the Regional Flood Control District Board of Directors, please step up to the speaker's podium, clearly state your name and address and please spell your last name for the record. Comments will be limited to three minutes. If any member of the Regional Flood Control District Board of Directors wishes to extend the length of a presentation, this will be done by the Chair, or the Regional Flood Control District Board of Directors by majority vote.

The first citizen's participation period is dedicated to those wishing to speak on an item appearing on the agenda. If you wish to speak to the Regional Flood Control District Board of Directors about items within its jurisdiction but not appearing on this agenda, you must wait until the last "Comments By the General Public" period listed at the end of this agenda. Comments will be limited to three minutes for both citizen's participation comment periods. If any member of the Regional Flood Control District Board of Directors wishes to extend the length of a presentation, this will be done by the Chair, or the Regional Flood Control District Board of Directors by majority vote.

All comments should be relevant to the Regional Flood Control District's Board of Directors action and jurisdiction.

Pursuant to NRS 241.020(4), this meeting has been properly noticed and posted at the following locations:

The Notice has been posted on the State of Nevada Public Notice Website at https://notice.nv.gov/	The Notice, Agenda, and Agenda Full-Backup have been posted on the Clark County Regional Flood Control District's Website at www.regionalflood.org

Clark County Regional Flood Control District
600 South Grand Central Parkway
Las Vegas, Nevada 89106

By: Regina Morales

1. **Comments By the General Public**

This is a period devoted to comments by the general public about items on **this** agenda. If you wish to speak to the Regional Flood Control District Board of Directors, please step up to the speaker's podium, clearly state your name and address and please spell your last name for the record. Comments will be limited to three minutes. If any member of the Regional Flood Control District Board of Directors wishes to extend the length of a presentation, this will be done by the Chair, or the Regional Flood Control District Board of Directors by majority vote.

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All comments should be relevant to the Regional Flood Control District Board of Directors action and jurisdiction.

CLARK COUNTY REGIONAL FLOOD CONTROL DISTRICT
BOARD OF DIRECTORS
NOVEMBER 14, 2024
8:30 A.M.

- Items on the agenda may be taken out of order.
- The Regional Flood Control District Board of Directors may combine two or more agenda items for consideration.
- The Regional Flood Control District Board of Directors may remove an item from the agenda or delay discussion relating to an item on the agenda at any time.

I. Call to Order

1. **Comments By the General Public**
   This is a period devoted to comments by the general public about items on **this** agenda. If you wish to speak to the Regional Flood Control District Board of Directors, please step up to the speaker's podium, clearly state your name and address and please spell your last name for the record. Comments will be limited to three minutes. If any member of the Regional Flood Control District Board of Directors wishes to extend the length of a presentation, this will be done by the Chair, or the Regional Flood Control District Board of Directors by majority vote.

   The first citizen's participation period is dedicated to those wishing to speak on an item appearing on the agenda. If you wish to speak to the Regional Flood Control District's Board of Directors about items within its jurisdiction, but not appearing on this agenda, you must wait until the last "Comments by the General Public" period listed at the end of the agenda.

   All comments should be relevant to the Regional Flood Control District Board of Directors action and jurisdiction.

2. Action to approve the agenda with deletion of any items ***(For possible action)***

3. Action to approve the minutes of the October 10, 2024 meeting ***(For possible action)***

4. Discuss the General Manager's Monthly Report

II. ******Consent Agenda – Items #05 through #17 are considered by the Regional Flood Control District to be routine and may be acted upon in one motion. However, the Board of Directors may discuss any consent item individually if requested by a Board member or a citizen when the consent agenda is considered for approval. Items considered for approval include the staff recommendation.***

Administration

5. Action to accept the financial reports ***(For possible action)***

6. Action to adopt amendments to the Ten-Year Construction Program ***(For possible action)***

7. Action to accept the final accounting reports and closeout the Fiscal Year 2023-24 Maintenance Work Program Interlocal Contracts with each entity ***(For possible action)***

8. Action to accept the final accounting reports and close out the interlocal contracts for the following projects ***(For possible action)***:

   - Duck Creek – Jones Boulevard Storm Drain (construction) – CLA38E20
   - Goodsprings – Phase 1 (design) – GSP01B10

9. Action to adopt amendments to the Regional Flood Control District Policies and Procedures Manual – 2024 Annual review/update ***(For possible action)***

10. Action to approve and authorize the General Manager to sign the fourth amendment to the agreement for professional services between Arcadis US, Inc. and the District to extend the completion date to fund the development of site-specific criteria for selenium in the Las Vegas Wash ***(For possible action)***

11. Action to approve and authorize the General Manager to sign the web services sales agreement with Revize for website design and implementation ***(For possible action)***

12. Action to approve the first optional one-year extension to the contract to provide municipal advisor services with Hobbs Ong & Associates and PFM Financial Advisors, LLC for the period covering January 1, 2025 through December 31, 2025 and authorize the General Manager to sign the extension letter ***(For possible action)***

13. Action to approve and authorize the Chair to sign an amendment to the Self-Funded Group Medical and Dental Benefits Exclusive Provider Organization (EPO) Plan among Clark County, Clark County Water Reclamation District, University Medical Center of Southern Nevada, Las Vegas Convention and Visitors Authority, Las Vegas Valley Water District, Clark County Regional Flood Control District, Regional Transportation Commission of Southern Nevada, Southern Nevada Health District, Henderson District Public Libraries, Mount Charleston Fire Protection District, Las Vegas Metropolitan Police Department, Moapa Valley Fire Protection District and Eighth Judicial District Court adopting an amended Self-Funded Group Medical and Dental Benefits EPO Plan, effective, January 1, 2025 ***(For possible action)***

14. Action to approve and authorize the Chair to sign an amendment to the Self-Funded Group Medical and Dental Benefits Preferred Provider Organization (PPO) Plan among Clark County, Clark County Water Reclamation District, University Medical Center of Southern Nevada, Las Vegas Convention and Visitors Authority, Las Vegas Valley Water District, Clark County Regional Flood Control District, Regional Transportation Commission of Southern Nevada, Southern Nevada Health District, Henderson District Public Libraries, Mount Charleston Fire Protection District, Las Vegas Metropolitan Police Department, Moapa Valley Fire Protection District and Eighth Judicial District Court adopting an amended Self-Funded Group Medical and Dental Benefits PPO Plan, effective, January 1, 2025 ***(For Possible Action)***

15. Action to approve and authorize the Chair to sign the first amendment to the professional services agreement with Joshua Tree Productions, Inc., to provide additional services for "Open" and "Closed" captioning for recording and editing of up to six Flood Channel television shows ***(For Possible action)***

Design and Construction

16. Action to approve and authorize the Chair to sign the second supplemental interlocal contract for design to increase funding of the Cadiz Storm Drain – Racetrack to Pueblo – City of Henderson ***(For possible action)***

17. Action to approve and authorize the Chair to sign the fourth supplemental interlocal contract for design to increase funding and extend the project completion date for Flamingo Wash, UPRR to Hotel Rio Drive – Clark County ***(For possible action)***:

******End of Consent Agenda***

III. Discussion Items

Administration

18. Action to accept the Financial Statements, accompanying information and report of independent auditors for the Regional Flood Control District as prepared by Crowe LLP for the Fiscal Year that ended June 30, 2024 ***(For possible action)***

19. Action to adopt the Fiscal Year 2023-2024 Annual Report and authorize the General Manager to provide it to the public at no cost ***(For possible action)***

20. Discussion and possible action to appoint a committee to evaluate the performance of the General Manager – 2024 review ***(For possible action)***

21. Regional Flood Control District – General Manager/Chief Engineer Position ***(For possible action)***

    a. Action to accept the resignation of the General Manager/Chief Engineer and the termination of the contract effective at the close of business on April 1, 2025
    b. Action to accept the General Manager/Chief Engineer Job Description and direct staff regarding recruitment of the General Manager/Chief Engineer or take action as deemed appropriate

22. **Comments By the General Public**

    This is a period devoted to comments by the general public about matters relevant to the Regional Flood Control District's Board of Directors jurisdiction. No vote may be taken on a matter not listed on the posted agenda. If you wish to speak to the Regional Flood Control District's Board of Directors, please step up to the speaker's podium, clearly state your name and address and please spell your last name for the record. Comments will be limited to three minutes. If any member of the Regional Flood Control District's Board of Directors wishes to extend the length of a presentation, this will be done by the Chair or the Regional Flood Control District Board of Directors by majority vote.

    All comments should be relevant to the Regional Flood Control District Board of Directors action and jurisdiction.

REGIONAL FLOOD CONTROL DISTRICT

MEMORANDUM

NOVEMBER 14, 2024

TO: **BOARD OF DIRECTORS**

FROM: **STEVEN C. PARRISH, P.E.**
GENERAL MANAGER/CHIEF ENGINEER

DATE: **November 4, 2024**

I. Call to Order

1. Comments By the General Public

2. Action to approve the agenda with deletion of any items *(For possible action)*
The agenda is in order for approval.

3. Action to approve the minutes of the October 10, 2024, meeting *(For possible action)*
The minutes are in order for approval.

4. Discuss the General Manager's Monthly Report
Receive the General Manager's Monthly Report.

II. ***Consent Agenda – Items #05 through #17 are considered by the Regional Flood Control District to be routine and may be acted upon in one motion. However, the Board of Directors may discuss any consent item individually if requested by a Board member or a citizen when the consent agenda is considered for approval. Items considered for approval include the staff recommendation.***

Administration

5. Action to accept the financial reports *(For possible action)*
The financial reports are in order for acceptance.

6. Action to adopt amendments to the Ten-Year Construction Program *(For possible action)*
In accordance with Policies and Procedures Section II.B.9, general amendments can be processed to address scheduling changes and/or the

need for additional funding. This agenda item addresses requested changes in funding, positive and negative, associated with this agenda as they impact the Ten-Year Construction Program (TYCP). Staff, TAC and CAC recommend approval.

7. **Action to accept the final accounting reports and closeout the Fiscal Year 2023-24 Maintenance Work Program Interlocal Contracts with each entity *(For possible action)***
Final accounting reports have been prepared for the fiscal year 2023-24 Maintenance Work Program ending June 30, 2024. The attached reports represent an accurate accounting of the charges and the remaining balances. Any maintenance work that was not completed during fiscal year 2023-24 has been reprogrammed within each entity's fiscal year 2024-25 program. Staff, TAC and CAC recommend accepting the final accounting reports and closing out the Interlocal Contracts.

8. **Action to accept the final accounting reports and close out the interlocal contracts for the following projects *(For possible action)*:**

   - **Duck Creek – Jones Boulevard Storm Drain (construction) – CLA38E20**
   - **Goodsprings – Phase 1 (design) – GSP01B10**

   Final accounting reports are routinely prepared for District-funded projects that have been completed. These reports represent an accurate accounting of the charges and the remaining balance for each project. Upon approval, no additional funds can be expended for the projects.

   Staff, TAC and CAC recommend accepting the final accounting reports and closing out the interlocal contracts.

9. **Action to adopt amendments to the Regional Flood Control District Policies and Procedures Manual – 2024 Annual review/update *(For possible action)***
The District Policies and Procedures Manual – Section XIII, states that the Advisory Committees will review the policies and procedures in August of each year; thereafter the amended manual will be presented to the Board for adoption. Staff has proposed changes to the following sections:

SECTION II – PROJECT DEVELOPMENT

- **Section II.B.1.a – Project Evaluation (page 16)** – Adds a Hydrographic Basin "Eldorado Valley" to the City of Henderson's planning area.
- **Section II.B.4 – Project Evaluation (page 19)** – Adds verbiage regarding compliance with Section II.C.7 to request construction funding.
- **Section II.C.1.d – Implementation of the Master Plan (pages 20-21)** – Adds a Hydrographic Basin "Eldorado Valley" to the City of Henderson's planning area.
- **Section II.C.7 – Implementation of the Master Plan (pages 24-25)** – Adds a paragraph "7 - Project Loan Program Eligibility" to clarify eligibility for this program.
- **Section II.D.3.a – Project Funding (page 25)** – Adds verbiage regarding compliance with Section II.C.7.
- **Section II.D.5.b – Project Funding (pages 26-27)** – Adds a paragraph "b" regarding annual reimbursement payments and prioritization on the Estimated Funding Schedule (EFS).

EXHIBITS J and K

EXHIBIT J – Project Specific Loan Agenda Item and Interlocal Contract
EXHIBIT K – Reimbursement Resolution Agenda Item and Reimbursement Resolution

Staff, TAC and CAC recommend adopting amendments to the RFCD Policies and Procedures Manual – 2024 annual review/update.

10. **Action to approve and authorize the General Manager to sign the Fourth Amendment to the Agreement for professional services between Arcadis US, Inc., and the District to extend the completion date to fund the development of site-specific criteria for selenium in the Las Vegas Wash *(For possible action)***
In May of 2019, the NDEP published a notice of intent to revise various water quality standards for the Las Vegas Wash. The proposed standards included establishing statewide criteria for selenium based on guidance from the U.S Environmental Protection Agency (EPA). Under current conditions, portions of the Las Vegas Wash would be in non-compliance with the proposed statewide selenium criteria. The Original Agreement

for Arcadis US, Inc. was approved on April 21, 2020, for services related to the development of a selenium site-specific surface water criteria for the Las Vegas Wash to cover project management activities. After discussion with various stakeholders in Southern Nevada, NDEP agreed to delay the establishment of a selenium standard for the Las Vegas Wash until December 31, 2022, or until site-specific criteria for the Las Vegas Wash can be developed.

On May 14, 2020, the Board approved an agreement between the District and the Southern Nevada Water Authority (SNWA) for the transfer of $100,000 to the District to fund the first phase of the effort to establish site-specific criteria for selenium for the Las Vegas Wash. On June 11, 2020, the Board ratified a grant agreement between the District and NDEP for $50,000 for the development of site-specific criteria for the Las Vegas Wash. On November 12, 2020, the Board ratified a grant agreement with NDEP for an additional $15,000 to support the development of site-specific criteria for the Las Vegas Wash. On February 11, 2021, the Board approved the First Amendment to the Agreement with Arcadis US, Inc. for additional project management activities for the establishment of Selenium Site-Specific Criteria. On August 12, 2021, the Board approved the First Amendment to the Agreement with SNWA to increase funding in the amount of $114,000 to reimburse the District for Arcadis US, Inc. expenditures. On September 8, 2022, the Board approved the Second Amendment to the Agreement with Arcadis US, Inc. which increased funding and extended the completion date to allow for additional studies or analysis that may be required by NDEP and/or EPA. On October 12, 2023, the Board approved the Third Amendment to the Agreement with Arcadis US, Inc., which extended the completion date.

The District is requesting that the Board approve the Fourth Amendment to the Agreement with Arcadis US, Inc. to extend the completion date from December 31, 2024, to June 30, 2025, and authorize the General Manager to sign the Agreement. The RFCD Attorney has reviewed the Fourth Amendment to the Agreement. Staff, TAC and CAC recommend approval.

11. Action to approve and authorize the General Manager to sign the web services sales agreement with Revize for website design and implementation *(For possible action)*

Due to the rapidly changing nature of digital communications, the District's current website requires redesign. The District would like to

provide the viewing audience with a citizen focused government website compatible with modern mobile devices, which would include information relevant to the District, include items of flood control interest for all audiences, promote self-service and make the citizen journey through the website seem effortless.

The District would like to enter into an Agreement with Revize to provide their expertise in the creation of a new website design. Revize would provide their services on the new website design and implementation, ongoing software support and cyber security, unlimited technical support, customized applications, and training to District staff.

The website design and implementation one-time fee to the District to begin the process is $18,814.00. The maintenance, hosting, and license fee for the first year is included in this cost. Subsequent years maintenance, hosting and licensing fees shall be budgeted in the District's annual budget request for consideration and approval by the District's Board of Directors. This agreement shall commence on November 14, 2024, and shall automatically terminate on November 14, 2029, unless otherwise terminated earlier as provided in Section 5.2 of the Agreement.

The District Attorney has reviewed the Agreement. There is sufficient funding in the FY 2024-25 budget to support this Agreement with Revize. Staff recommends approval.

12. **Action to approve the first optional one-year extension to the contract to provide municipal advisor services with Hobbs Ong & Associates and PFM Financial Advisors, LLC for the period covering January 1, 2025, through December 31, 2025, and authorize the General Manager to sign the extension letter *(For possible action)***

On February 10, 2022, the District's Board of Directors approved a Municipal Advisor Services Contract (MASC), as a joint venture, with Hobbs Ong & Associates and PFM Financial Advisors, LLC to provide advisory services. Pursuant to Section I – Term of Contract, states in part, an option to renew for two (2), one-year periods, subject to the provision of Section II within the MASC.

At this time, the District is requesting approval from the District Board to exercise the first optional one-year extension and authorize the General Manager to sign and provide the Consultant with a written letter

exercising the first optional one-year extension for the period covered January 1, 2025, through December 31, 2025. The terms and conditions will continue to be those set forth in the originally approved MASC.

The RFCD Attorney has reviewed the Extension Letter. Staff recommends that the Board approve the first optional one-year extension for Municipal Advisor Services.

13. **Action to approve and authorize the Chair to sign an amendment to the Self-Funded Group Medical and Dental Benefits Exclusive Provider Organization (EPO) Plan among Clark County, Clark County Water Reclamation District, University Medical Center of Southern Nevada, Las Vegas Convention and Visitors Authority, Las Vegas Valley Water District, Clark County Regional Flood Control District, Regional Transportation Commission of Southern Nevada, Southern Nevada Health District, Henderson District Public Libraries, Mount Charleston Fire Protection District, Las Vegas Metropolitan Police Department, Moapa Valley Fire Protection District and Eighth Judicial District Court adopting an amended Self-Funded Group Medical and Dental Benefits EPO Plan, effective, January 1, 2025** ***(For Possible Action)***

Clark County established a Self-Funded Group Medical and Dental Benefits program in 1984 to provide group medical and dental benefits to the employees of Clark County and affiliated entities. The program consists of a Preferred Provider Organization (PPO) plan and an Exclusive Provider Organization (EPO) plan. Annually, the Plan is put before the Regional Flood Control District's Board for approval.

Following are the proposed modifications for the upcoming Plan Year, effective January 1, 2025:

- The addition of a $30 specialist copay for University Medical Center of Southern Nevada outpatient clinics.
- The removal of a fourth-tier pharmacy benefit for GLP-1-FSA approved weight loss medication(s).
- The clarification of a benefit rule pertaining to the child of a surviving spouse.
- The change of the effective date of employee coverage from 60 days to 45 days.
- Broadening the coverage for speech therapy to include other types of communication disorders.

- The replacement of UMR CARE with Care Management.
- The addition of Alternative/Complementary Treatment to the Glossary of Terms.

The amended Plan has been discussed with represented members, as required by governing bargaining agreements. The Clark County Board of County Commissioners approved this item at their October 15, 2024, Board meeting. Staff recommends approval.

14. Action to approve and authorize the Chair to sign an amendment to the Self-Funded Group Medical and Dental Benefits Preferred Provider Organization (PPO) Plan among Clark County, Clark County Water Reclamation District, University Medical Center of Southern Nevada, Las Vegas Convention and Visitors Authority, Las Vegas Valley Water District, Clark County Regional Flood Control District, Regional Transportation Commission of Southern Nevada, Southern Nevada Health District, Henderson District Public Libraries, Mount Charleston Fire Protection District, Las Vegas Metropolitan Police Department, Moapa Valley Fire Protection District and Eighth Judicial District Court adopting an amended Self-Funded Group Medical and Dental Benefits PPO Plan, effective, January 1, 2025 ***(For Possible Action)***

Clark County established a Self-Funded Group Medical and Dental Benefits program in 1984 to provide group medical and dental benefits to the employees of Clark County and affiliated entities. The program consists of a Preferred Provider Organization (PPO) plan and an Exclusive Provider Organization (EPO) plan. Annually, the Plan is put before the Regional Flood Control District Board for approval.

Following are the proposed Plan modifications for the upcoming plan year, effective January 1, 2025:

- The clarification of a benefit rule pertaining to the child of a surviving spouse.
- Changing the employee timeframe to provide documents from 90 days to 45 days. This is in alignment with the eligibility timeframe.
- The addition of a $30 specialist copay for University Medical Center of Southern Nevada outpatient clinics.
- The addition of copays for walk-in retail health clinics.
- The addition of copays for hospice care services.
- The removal of the 60-day benefit limitation for inpatient rehabilitation care.

- The removal of a pharmacy benefit for GLP-1-FSA approved weight loss medications(s).
- The addition of genetic testing to the Care Management program (prior authorization process).
- The addition of maximum benefit amounts for Center of Excellence facilities.
- The removal of "no benefit" for residential treatment facilities.
- The addition of a $35 insulin cost to the Employer Group Waiver Plan, which covers Medicare retirees.
- The change from 20 days to 30 days for the Plan Administrator to respond to second level appeals. This is in alignment with the timeframe for first level appeals.

The amended Plan has been discussed with represented members, as required by the governing bargaining agreements. The Clark County Board of County Commissioners approved this item at their October 15, 2024, Board meeting. Staff recommends approval.

15. **Action to approve and authorize the Chair to sign the first amendment to the professional services agreement with Joshua Tree Productions, Inc., to provide additional services for "Open" and "Closed" captioning for recording and editing of up to six Flood Channel television shows *(For Possible action)***

On August 8, 2024, the District Board of Directors approved a Professional Services Agreement with Joshua Tree Productions, Inc., to provide recording and editing of The Flood Channel television program that airs on government access cable stations. The agreement will include up to five shows focusing on the construction of flood control projects, flood safety, and stormwater quality. The remaining show will combine segments from the previous year as a "Best Of" episode. This agreement is from August 8, 2024, through June 30, 2025.

The First Amendment to the Professional Services Agreement will provide additional services which contain "Open" and "Closed" captioning.

Joshua Tree Productions, Inc. will perform the following services for the District:

- record and edit up to six television shows;
- as producer, will produce, write, and direct, The Flood Channel episodes;

- store the District's digital library;
- coordinate with the District for show content, production, and direction, scheduling videographer and editing equipment; and
- provide supplemental services which may include recording of storms and/or special events;
- provide "Open" captioning;
- provide "Closed" captioning.

The above outline is an example of the services that will be performed as part of the television show recording and editing in coordination with the District.

The FY 2024-2025 budget identifies sufficient funding for this First Amendment to the Professional Services Agreement. The First Amendment to the Agreement has been reviewed by the RFCD Attorney and is included in the backup. Staff recommends approval.

Design and Construction

16. Action to approve the Second Supplemental Interlocal Contract for design to increase funding of the Cadiz Storm Drain – Racetrack to Pueblo – City of Henderson *(For possible action)*

An interlocal contract was entered into between the District and the City of Henderson on September 14, 2023, to provide funding for design and environmental. Right-of-way, Conditional Letter of Map Revision/Letter of Map Revision (CLOMR/LOMR) and entity design labor for the subject project. A First Supplemental Interlocal Contract was approved February 8, 2024, which provided additional funding necessary to complete the project design, obtain right-of-way and process the CLOMR/LOMR. This Second Supplemental Interlocal Contract will increase funding for additional design and analyses to extend the proposed storm drain lateral on Racetrack Road to Essex Avenue, an approximate 1,400 linear feet, the addition of drop inlets at the intersections of Racetrack Rd./Essex Ave., and Racetrack Rd./Dublin Ave., to collect the 100-year storm event flows.

The RFCD Attorney has reviewed the contract. Staff, TAC and CAC recommend approval subject to approval of the Ten-Year Construction Program Amendment item on this agenda.

17. Action to approve the Fourth Supplemental Interlocal Contract for design to increase funding and extend the project completion date for Flamingo Wash, UPRR to Hotel Rio Drive – Clark County *(For possible action)*

On April 8, 2010, the Regional Flood Control District entered into an interlocal contract with Clark County to provide funding for design, environmental, and right-of-way for the subject project. Supplemental No. 1 dated June 11, 2015, provided additional funding for design, environmental, and right-of-way and extended the term of the contract. Supplemental No. 2 dated June 11, 2020, changed the name of the project and extended the term of the contract. Supplemental No. 3 dated July 8, 2021, increased funding for design and right-of-way and added line items for entity design labor and Conditional Letter of Map Revision/Letter of Map Revision (CLOMR/LOMR).

This fourth supplemental interlocal contract will increase design funds to cover consultant design services for the additional hydrologic analysis that were preformed to evaluate flows along Flamingo Road between the Flamingo Wash and Valley View Boulevard, alternative alignment evaluations for regional facilities to minimize both present and future cost to the master plan, and additional design to be able reduce/eliminate the acquisition cost to the project associated with the Union Pacific Rail Road. This fourth supplemental interlocal contract will also extend the project completion date from June 30, 2025, to December 30, 2026, to complete design and provide support through construction.

The RFCD Attorney has reviewed the contract. Staff, TAC and CAC recommend approval subject to approval of the Ten-Year Construction Program Amendment item on this agenda.

******End of Consent Agenda***

III. Discussion Items

Administration

18. Action to accept the Financial Statements, accompanying information and report of independent auditors for the Regional Flood Control District as prepared by Crowe LLP for the Fiscal Year that ended June 30, 2024 *(For possible action)*

An annual financial audit for the fiscal year that ended June 30, 2024, was performed by independent auditors, Crowe LLP, for the Regional

Flood Control District. A copy of the Auditor's Required Communication to the Board of Directors, along with the Component Unit Financial Statements, which include the *Independent Auditor's Report*, *Management's Discussion and Analysis*, *Financial Statements*, and accompanying information are included in the backup.

It was the opinion of the independent auditors that "the financial statements referred to above present fairly, in all material respects, the respective financial position of the governmental activities and each major fund of the Clark County Regional Flood Control District as of June 30, 2024, and the respective changes in financial position for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Staff recommends accepting the Financial Statements for the Fiscal Year that ended June 30, 2024.

19. Action to adopt the Fiscal Year 2023-2024 Annual Report and authorize the General Manager to provide it to the public at no cost *(For possible action)*

In accordance with Nevada Revised Statutes (NRS) 543.5955, the District publishes an annual report summarizing the District's accomplishments and highlighting the flood control improvements completed in that year. The report also provides information about District finances, programs, partnerships, and outreach efforts, among other things. The District produced the report electronically, which helps promote sustainability of our natural resources.

I would like to acknowledge the dedicated support of the District's staff in accomplishing the wide variety of tasks highlighted in this annual report. Without their commitment, the District could not achieve its goals, complete the magnitude of construction projects included in this year's annual report, nor address the dynamic needs of the community we serve.

It is recommended that the Board authorize the General Manager to provide the annual report to the public at no cost.

20. Discussion and possible action to appoint a committee to evaluate the performance of the General Manager – 2024 review *(For possible action)*

It is the policy of the Board to evaluate the performance of the General Manager. In keeping with the Board's past practice, it is recommended that the Board consider appointing a committee of its members to review the General Manager's performance for 2024 and to recommend goals and objectives for 2025. The committee's recommendations will be presented to the Board for consideration.

21. Regional Flood Control District – General Manager/Chief Engineer Position *(For possible action)*

a. Action to accept the resignation of the General Manager/Chief Engineer and the termination of the contract effective at the close of business on April 1, 2025

Steven C. Parrish joined the staff of the Clark County Regional Flood Control District (District) on June 10, 2000, as a Senior Civil Engineer after his start with Clark County on March 2, 1992. During his years at the District, he also held the positions of Principal Civil Engineer, RFCD Engineering Director, and Assistant General Manager. On March 12, 2015, he was appointed to the position of General Manager/Chief Engineer by the Board of Directors. Included in your backup is Mr. Parrish's announcement of his intention to resign at the close of business on Tuesday, April 1, 2025.

Staff recommends the Board accept the resignation of the General Manager/Chief Engineer and terminate the contract effective at the close of business on April 1, 2025.

b. Action to accept the General Manager/Chief Engineer job description and direct staff regarding recruitment of the General Manager/Chief Engineer or take action as deemed appropriate.

With the pending resignation of the current General Manager/Chief Engineer it is recommended that the District's Board of Directors (Board) accept the job description for the position and provide direction on the Board's desires to select or appoint a candidate to fill the position of General Manager/Chief Engineer in accordance with Nevada Revised Statue 543.

It is expressly understood Mr. Parrish's role in this recruitment will be to aid in the process and will not be reviewing applicants; nor making a recommendation to shape the outcome to the Board.

Staff recommends the Board accept the General Manager/Chief Engineer job description and direct staff regarding recruitment of the General Manager/Chief Engineer.

22. Comments By the General Public

Respectfully submitted,

Steven C. Parrish, P.E.
General Manager/Chief Engineer

MINUTES
CLARK COUNTY REGIONAL FLOOD CONTROL DISTRICT
BOARD OF DIRECTORS
OCTOBER 10, 2024
8:30 A.M.

These minutes are prepared in compliance with NRS 241.035. Text is in summarized rather than verbatim format. For complete contents, please refer to meeting recordings on file at the Regional Flood Control District.

MEETING NOTICES: Public Notices of this meeting were properly posted by Angela Hamilton of the Regional Flood Control District in the following locations: Clark County Regional Flood Control District Building, Clark County Government Center, the Clark County Regional Flood Control District Website (www.regionalflood.org), and the State of Nevada Public Notice Website (https://notice.nv.gov/).

MEMBERS PRESENT:
Justin Jones, Chair, Clark County
Isaac Barron, Vice-Chair, City of North Las Vegas *
Carolyn Goodman, City of Las Vegas
Paul Wanlass, City of Mesquite
Brian Knudsen, City of Las Vegas
Dan Shaw, City of Henderson

MEMBERS ABSENT:
Joe Hardy, City of Boulder City
Tick Segerblom, Clark County

INTERESTED PARTIES:

STAFF:
Steven Parrish, General Manager/Chief Engineer
Lisa Logsdon, Clark County District Attorney
Jessica Honour, Administrative Services Director
John Tennert, Environmental Mitigation Manager
Michelle French, Public Information Manager
Jacob Sanders, Public Information Coordinator
Carol Trujillo, Fiscal Servvices Administrator
Patti Metz, Office Services Manager
Paulina Velez, Senior Financial Office Specialist
Brittney Duncan, Assistant Engineer
Angela Hamilton, Senior Office Specialist

I. Call to Order

Commissioner Jones, Chair, called the meeting to order at 8:35 a.m. in the Clark County Board of County Commissioners Chambers, 500 South Grand Central Parkway, Las Vegas, Nevada.

1. **Comments By the General Public**

   There was no response to the call for Comments by the General Public.

2. Action to approve the agenda with deletion of any items ***(For possible action)***

   Upon a motion by Mayor Goodman, the agenda was approved.

   VOTE: 5 AYES – 0 NAYS

3. Action to approve the minutes of the September 12, 2024, meeting ***(For possible action)***

   Upon a motion by Mayor Goodman, the minutes of the September 12, 2024, meeting were approved.

   VOTE: 5 AYES – 0 NAYS

*Vice-Chair Isaac Barron arrived at the meeting at 8:37 a.m.

4. Discuss the General Manager's Monthly Report

   Mr. Parrish informed the Board construction of the Alexander Storm Drain between Simmons and Decatur in North Las Vegas near the North Las Vegas airport is complete. This is part of a multi-phase facility that will eventually extend to Craig Road and US95. Mr. Parrish also informed the Board the District has a new episode of the Flood Channel currently airing regarding this project and it explains the outlying challenges that occurred during construction.

   Vice-Chair Barron commented he was able to see the finished project during a tour and was impressed to see it in action.

5. Action to accept the Government Finance Officers Association Distinguished Budget Presentation Award – Fiscal Year 2024-2025 ***(For possible action)***

Mr. Parrish announced the District's finance team had once more been awarded top honors regarding the Government Finance Officers Association Distinguished Budget Presentation Award Fiscal Year 2024-2025. The District has attained this recognition for the 31st year in a row. Mr. Parrish noted that this achievement was evidence of a commitment to meet the highest principals of government budgeting by the District's staff. He recognized and congratulated the District's finance team, which included Jessica Honour, Deanna Hughes, Carol Trujillo, and Paulina Velez.

Ms. Honour thanked Mr. Parrish and the Board of Directors for allowing the District's finance professionals to participate in the program over the years. She stated attaining the award entailed a considerable amount of work and was a team effort.

When asked, Mr. Parrish informed Mayor Goodman the District has received this award under his leadership for 24 of the 31 years of recognition.

No action was taken on this item.

II. ***Consent Agenda – Items #06 through #18 are considered by the Regional Flood Control District to be routine and may be acted upon in one motion. However, the Board of Directors may discuss any consent item individually if requested by a Board member or a citizen when the consent agenda is considered for approval. Items considered for approval include the staff recommendation.

Administration

6. Action to accept the financial reports ***(For possible action)***

7. Action to adopt amendments to the Ten-Year Construction Program ***(For possible action)***

8. Action to accept the final accounting reports and close out the interlocal contract for the following project ***(For possible action)***:

   - Whitney Ranch Channel Replacement Project (design) – HEN07F18

9. Action to accept the quarterly status reports, reporting period: May 2024 through July 2024 ***(For possible action)***

10. Action to approve and authorize the Chair to sign the third amendment to the revised Section 214 Memorandum of Agreement for expedited reviews of Section 408 permits from US Army Corps of Engineers ***(For possible action)***

11. Action to approve and authorize the Chair to sign an amendment to the interlocal agreement among Clark County, Clark County Water Reclamation District, University Medical Center of Southern Nevada, Las Vegas Convention and Visitors Authority, Las Vegas Valley Water District, Clark County Regional Flood Control District, Regional Transportation Commission of Southern Nevada, Southern Nevada Health District, Henderson District Public Libraries, Mount Charleston Fire Protection District, Las Vegas Metropolitan Police Department, Moapa Valley Fire Protection District and Eighth Judicial District Court establishing the rates for the Self-Funded Group Medical and Dental Benefits Plan, effective January 1, 2025 ***(For possible action)***

12. Action to approve and authorize the Chair to sign the first amendment to the consultant agreement with Brown and Caldwell to extend the term of the agreement for the National Pollutant Discharge Elimination System Permit Compliance for the Las Vegas Valley ***(For possible action)***

Design and Construction

13. Action to approve the request to reallocate funding in the interlocal contract for construction for Harry Reid Airport Peaking Basin – East Outfall – Clark County ***(For possible action)***:

14. Action to approve and authorize the Chair to sign the supplemental interlocal contracts for design to increase funding for the following projects. ***(For possible action)***

    a. First Supplemental: Sloan Channel East Branch, Las Vegas Boulevard to Valmark Drive – Clark County
    b. Third Supplemental: Flamingo, Cimarron Branch – Russell Road to Patrick Lane – Clark County
    c. Third Supplemental: Las Vegas Wash – Branch 02 – Monson Channel – Jimmy Durante to Boulder Highway – Clark County

15. Meadows – Charleston Storm Drain, Essex to Lindell – City of Las Vegas

    a. Action to approve and authorize the Chair to sign the first supplemental

interlocal contract for construction to increase funding ***(For possible action)***

b. Receive a report on the award of bid for construction

16. Fairgrounds Detention Basin and Outfall – Clark County ***(For possible action)***

a. Action to approve and authorize the Chair to sign the second supplemental interlocal contract for construction to increase funding
b. Action to approve construction change order no. 3

17. Action to approve and authorize the Chair to sign the first supplemental interlocal contract for construction to revise the project scope and change the name of the project from Flamingo Wash, Maryland Parkway to Palos Verdes Street to Flamingo Wash, Maryland Parkway to Cambridge Street – Clark County ***(For possible action)***

18. Receive a report on the rejection of bids for Flamingo Wash, Maryland Parkway to Palos Verdes Street – Clark County

****End of Consent Agenda***

Upon a motion by Vice-Chair Barron, the Consent Agenda was approved.

VOTE: 6 AYES – 0 NAYS

III. Discussion Items

Administration

19. Action to approve a Proclamation that October 2024 be proclaimed "Stormwater Pollution Awareness Month" and all residents and visitors be urged to make themselves aware that pet waste, yard debris, household chemicals, household cleaners, paint, and vehicle fluids are examples of materials that can cause stormwater pollution if not property stored or cleaned up when spilled outdoors. ***(For possible action)***

Mr. Parrish communicated the ongoing Public Information efforts being made to heighten awareness to the public of the potential for stormwater pollution. Mr. Parrish wanted to remind residents and visitors to take care of their waste, household cleaners and paint when it rains as those pollutants are picked up and go to Lake Mead untreated, which is our primary source of drinking water.

Staff recommends approval

Vice-Chair Barron made a motion to approve a Proclamation that October 2024 be proclaimed "Stormwater Pollution Awareness Month".

VOTE: 6 AYES – 0 NAYS

20. **Comments By the General Public**

Mayor Goodman commented she was proud of Southern Nevada's Fire and Rescue training program. This training afforded us the ability to help with the flooding in Florida caused by the recent hurricanes.

There was no further response to the call for Comments by the General Public.

ADJOURNMENT

The meeting was adjourned at 8:44 a.m.

Respectfully submitted,

Steven C. Parrish, P.E.
General Manager/Chief Engineer

Justin Jones, Chair
Clark County

Attest_____, 2024.

Deanna Hughes
Board Secretary

/alh

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

GENERAL MANAGER'S MONTHLY REPORT

RECOMMENDATION SUMMARY

STAFF:	Receive the report.
TECHNICAL ADVISORY:	The Technical Advisory Committee did not hear this item.
CITIZENS ADVISORY:	The Citizens Advisory Committee did not hear this item.

RFCD AGENDA
ITEM #04
DATE: 11/14/2024

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT: GENERAL MANAGER'S MONTHLY REPORT
PETITIONER: STEVEN C. PARRISH, P.E., GENERAL MANAGER/CHIEF ENGINEER
RECOMMENDATION OF PETITIONER: DISCUSS GENERAL MANAGER'S MONTHLY REPORT

FISCAL IMPACT:

None.

BACKGROUND:

In the General Manager's report, the District will report on prior months accomplishments relating to District activities.

Respectfully submitted,

RFCD AGENDA
ITEM #04
Date: 11/14/2024

Steven C. Parrish, P.E.
General Manager/Chief Engineer

111424 GM Report-item

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

FINANCIAL REPORTS – SEPTEMBER 2024

RECOMMENDATION SUMMARY

STAFF:	Accept the reports.
TECHNICAL ADVISORY:	Accept the reports.
CITIZENS ADVISORY:	Accept the reports.

RFCD AGENDA
ITEM #05
DATE: 11/14/2024

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT
AGENDA ITEM

SUBJECT: FINANCIAL REPORTS – SEPTEMBER 2024
PETITIONER: STEVEN C. PARRISH, P.E., GENERAL MANAGER/CHIEF ENGINEER
RECOMMENDATION OF PETITIONER: ACCEPT THE REPORTS (FOR POSSIBLE ACTION)

FISCAL IMPACT: None

BACKGROUND: The financial reports for September 2024, are submitted for your review:

TAC AGENDA ITEM #04 DATE: 10/31/2024	RFCD AGENDA ITEM # 05 DATE: 11/14/2024
CAC AGENDA ITEM #04 DATE: 11/04/2024	

Respectfully submitted,

TAC AGENDA ITEM #04 DATE: 10/31/2024	RFCD AGENDA ITEM # 05 DATE: 11/14/204
CAC AGENDA ITEM #04 DATE: 11/04/2024	

Jessica Honour
Administrative Services Director

REGIONAL FLOOD CONTROL DISTRICT
FUND 2860 - OPERATING FUND
FUND BALANCE REPORT
SEPTEMBER 2024

BEGINNING CASH BALANCE:		$ 12,774,047.77	
Accruals/Adjustments		(340.46)	
	TOTAL BEGINNING BALANCE		$ 12,773,707.31
REVENUES:			
Sales Tax Revenue (June)		12,617,697.39	
Interest Earnings		-	
Fund 4430 - Transfer In Interest Earnings		-	
Sale of Materials		-	
Miscellaneous Other Revenue		-	
Petty Cash Reimbursements		-	
Miscellaneous Accruals/Adjustments		3,867.19	
	TOTAL REVENUES		$ 12,621,564.58
EXPENDITURES:			
Salaries & Benefits		(358,834.64)	
Services & Supplies		(34,173.01)	
Professional Services		(228,043.22)	
Capital Expenditures		-	
Fund 2870 - Transfer Out Maintenance Work Program		(1,600,000.00)	
Fund 3300 - Transfer Out Debt Service		(3,990,406.28)	
Fund 4430 - Transfer Out Budgeted Transfers		(9,000,000.00)	
Accruals/Adjustments		-	
Accounts Payable		-	
Miscellaneous Accruals/Adjustments		15,517.73	
	TOTAL EXPENSES		$ (15,195,939.42)
ENDING CASH BALANCE:			$ 10,199,332.47

REGIONAL FLOOD CONTROL DISTRICT
FUND 2860 - OPERATING FUND
APPROPRIATION BALANCE REPORT
FISCAL YEAR 2023-24

REVENUES/FINANCING SOURCES

	BUDGET	ACTUAL	ENCUMBRANCE/ ILC	UNREALIZED	% UNREALIZED
Revenues	$ 159,062,147.00	$ 160,726,915.52	N/A	$ (1,664,768.52)	-1.05%
Other Sources	350,000.00	350,000.00	N/A	-	0.00%
TOTAL	**$ 159,412,147.00**	**$ 161,076,915.52**	**N/A**	**$ (1,664,768.52)**	**-1.04%**

EXPENDITURES/TRANSFERS

	BUDGET (2)	ACTUAL	ENCUMBRANCE/ ILC	AVAILABLE	% AVAILABLE
Expenditures	$ 12,034,768.00	$ 8,683,591.92	$ 613,117.14	$ 2,738,058.94	22.75%
Transfers Out					
Debt Service	47,870,386.00	47,870,384.84	-	1.16	0.00%
MWP	17,000,000.00	17,000,000.00	-	-	0.00%
CIP (1)	97,000,000.00	97,000,000.00	-	-	0.00%
TOTAL	**$ 173,905,154.00**	**$ 170,553,976.76**	**$ 613,117.14**	**$ 2,738,060.10**	**1.57%**

Notes:
(1) Includes Local Drainage program.

REGIONAL FLOOD CONTROL DISTRICT
FUND 2860 - OPERATING FUND
APPROPRIATION BALANCE REPORT
FISCAL YEAR 2024-25

REVENUES/FINANCING SOURCES

	BUDGET	ACTUAL	ENCUMBRANCE/ ILC	UNREALIZED	% UNREALIZED
Revenues	$ 167,450,000.00	$ 12,997,337.38	N/A	$ 154,452,662.62	92%
Other Sources	1,250,000.00	-	N/A	1,250,000.00	100%
TOTAL	**$ 168,700,000.00**	**$ 12,997,337.38**	**N/A**	**$ 155,702,662.62**	**92%**

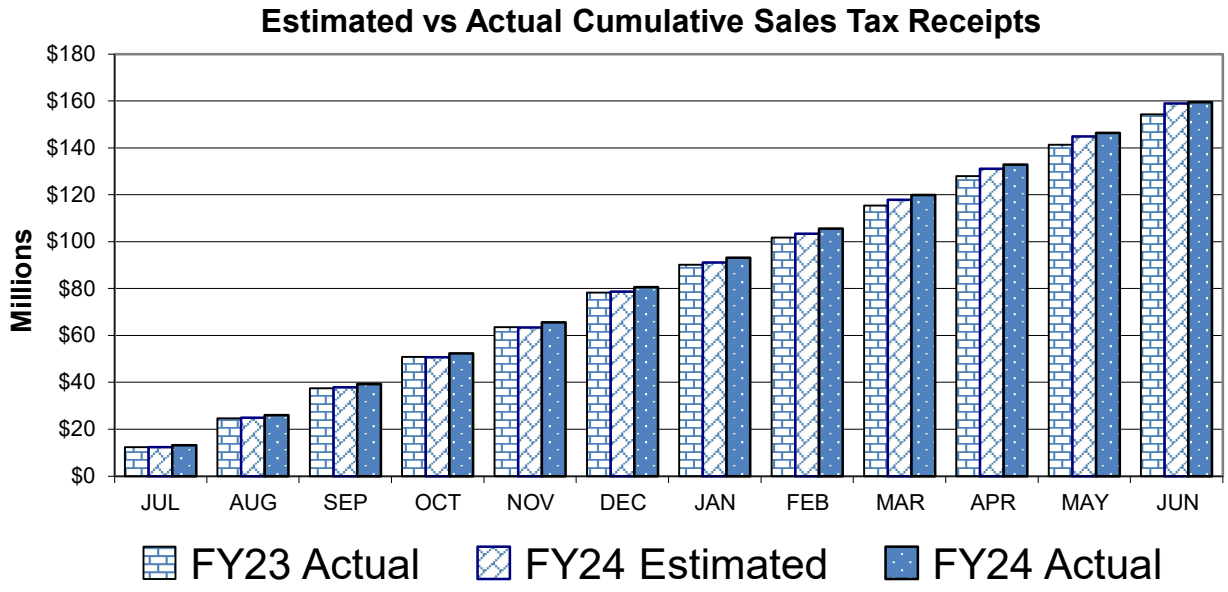
EXPENDITURES/TRANSFERS

	BUDGET (2)	ACTUAL	ENCUMBRANCE/ ILC	AVAILABLE	% AVAILABLE
Expenditures	$ 12,620,787.00	$ 1,670,377.58	$ 3,295,437.64	$ 7,654,971.78	61%
Transfers Out					
Debt Service	47,849,028.00	15,961,625.12	-	31,887,402.88	67%
MWP	17,000,000.00	1,600,000.00	-	15,400,000.00	91%
CIP (1)	98,000,000.00	9,000,000.00	-	89,000,000.00	91%
TOTAL	**$ 175,469,815.00**	**$ 28,232,002.70**	**$ 3,295,437.64**	**$ 143,942,374.66**	**82%**

Notes:
(1) Includes Local Drainage program.

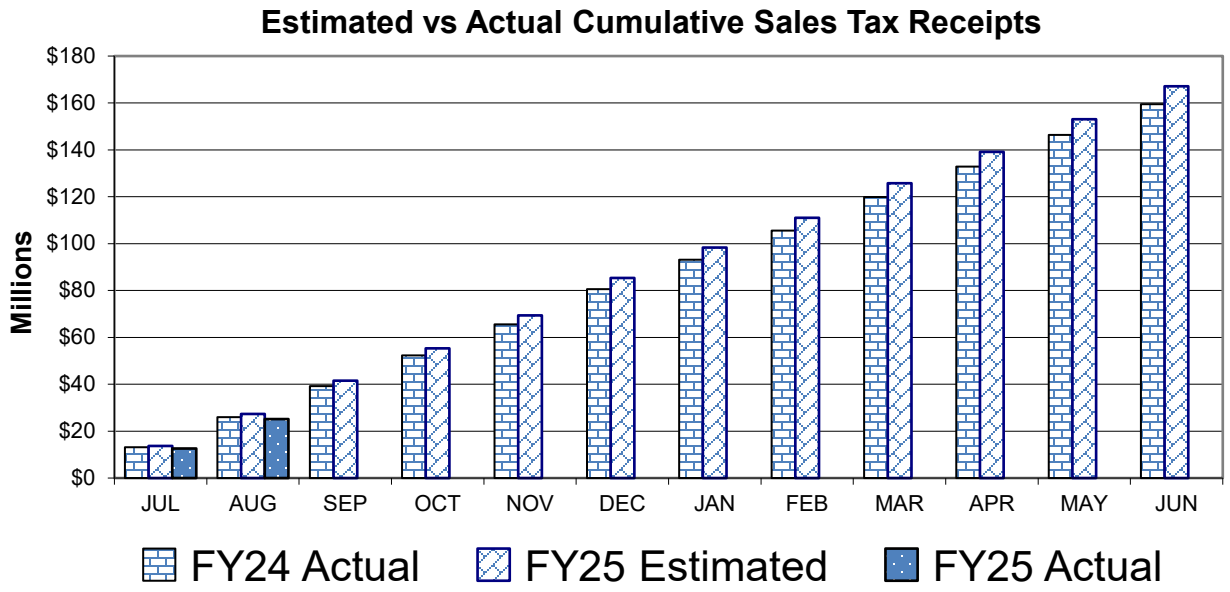
SALES TAX REVENUE REPORT
REGIONAL FLOOD CONTROL DISTRICT
FISCAL YEAR 2023-24
MODIFIED ACCRUAL BASIS

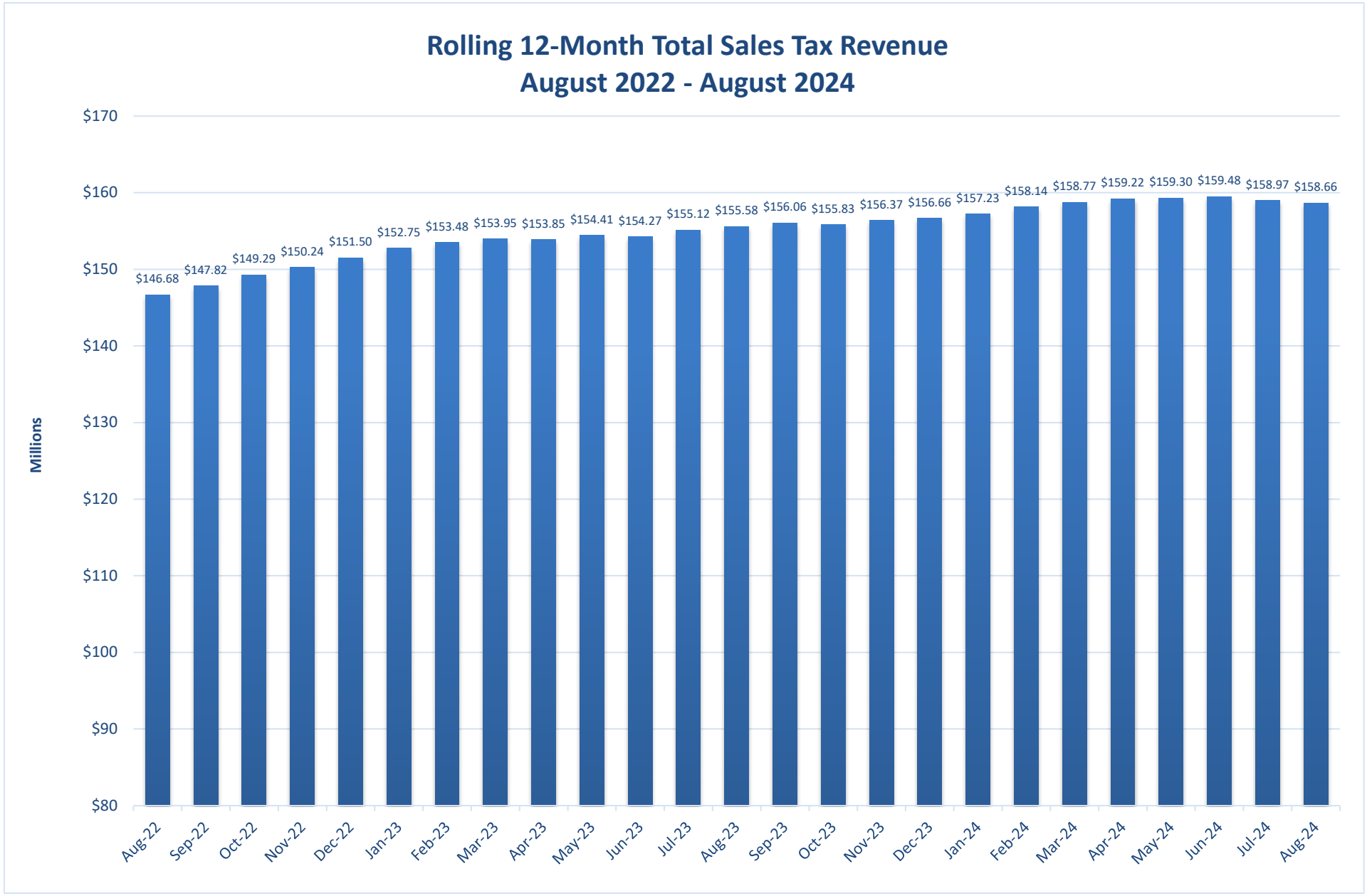
MONTH SALES TAX COLLECTED BY MERCHANT	1/4 CENT SALES TAX ESTIMATE (as approved April 13, 2023)	ACTUAL SALES TAX REVENUES	DIFFERENCE OVER/(UNDER) ESTIMATE	PERCENT +/- FROM ESTIMATE
JULY	$ 12,366,611.52	$ 13,129,362.87	$ 762,751.35	6.17%
AUGUST	12,453,177.80	12,860,576.51	407,398.71	3.27%
SEPTEMBER	12,963,758.09	13,288,214.59	324,456.50	2.50%
OCTOBER	12,834,120.51	13,043,703.96	209,583.45	1.63%
NOVEMBER	12,808,452.27	13,280,546.78	472,094.51	3.69%
DECEMBER	15,267,675.10	14,976,257.79	(291,417.31)	-1.91%
JANUARY	12,366,816.83	12,528,097.79	161,280.96	1.30%
FEBRUARY	12,243,148.66	12,437,643.15	194,494.49	1.59%
MARCH	14,569,346.91	14,325,362.93	(243,983.98)	-1.67%
APRIL	13,258,105.69	12,963,300.77	(294,804.92)	-2.22%
MAY	13,669,106.96	13,523,392.62	(145,714.34)	-1.07%
JUNE	14,099,679.66	13,127,402.10	(972,277.56)	-6.90%
TOTAL:	$ 158,900,000.00	$ 159,483,861.86	$ 583,861.86	0.37%



SALES TAX REVENUE REPORT
REGIONAL FLOOD CONTROL DISTRICT
FISCAL YEAR 2024-25
MODIFIED ACCRUAL BASIS

MONTH SALES TAX COLLECTED BY MERCHANT	1/4 CENT SALES TAX ESTIMATE (as approved April 11, 2024)	ACTUAL SALES TAX REVENUES	DIFFERENCE OVER/(UNDER) ESTIMATE	PERCENT +/- FROM ESTIMATE
JULY	$ 13,650,638.42	$ 12,617,697.39	$ (1,032,941.03)	-7.57%
AUGUST	13,718,891.61	12,551,905.70	(1,166,985.91)	-8.51%
SEPTEMBER	14,130,458.36	-		
OCTOBER	13,861,979.65	-		
NOVEMBER	14,028,323.41	-		
DECEMBER	15,922,147.07	-		
JANUARY	12,960,627.71	-		
FEBRUARY	12,779,178.93	-		
MARCH	14,759,951.66	-		
APRIL	13,357,756.25	-		
MAY	13,851,993.23	-		
JUNE	14,078,053.70	-		
TOTAL:	$ 167,100,000.00	$ 25,169,603.09	$ (2,199,926.94)	-8.04%




Rolling 12-Month Total Sales Tax Revenue
August 2022 - August 2024
Millions
$170
$160
$150
$140
$130
$120
$110
$100
$90
$80
$146.68
$147.82
$149.29
$150.24
$151.50
$152.75
$153.48
$153.95
$153.85
$154.41
$154.27
$155.12
$155.58
$156.06
$155.83
$156.37
$156.66
$157.23
$158.14
$158.77
$159.22
$159.30
$159.48
$158.97
$158.66
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24

Schedule of Monthly Expenditures - Summary
Fund 2860 - Operating Fund
9/1/2024 to 9/30/2024

Fiscal Year	Account #	Account Name		Amount
2023	61*/62*	Salaries and Benefits		0.00
	640340	R & M-Vehicles		20.00
			Fiscal Year Total	**$20.00**

Fiscal Year	Account #	Account Name		Amount
2025	61*/62*	Salaries and Benefits		358,834.64
	630000	Other Professional Services		214,519.22
	635000	Pro Svcs-Legal		13,524.00
	640310	R & M-Facilities		10,070.29
	640340	R & M-Vehicles		2,146.53
	641000	Other Rental Expense		1,151.79
	644610	Information System Services		1,669.69
	645000	Other Insurance		260.30
	646100	Telephone-Local		514.70
	646110	Telephone-Long Distance		7.22
	646120	Cell Phones/Beepers		813.03
	648100	Printing/Reproduction		3,468.26
	649100	Airfare		239.96
	649200	Lodging		681.48
	649300	Auto		80.00
	649400	Meals		295.50
	649500	Registration/Training		585.00
	649510	Travel/Training		225.00
	663000	Operating Supplies		1,318.52
	663200	Food		220.80
	663400	Office Supplies		357.50
	663500	Wearing Apparel		23.16
	663610	Computers & Supplies		1,882.79
	670100	Electricity		5,546.89
	670500	Disposal		122.38
	679220	Software Licenses		1,806.80
	679300	Dues		665.42
			Fiscal Year Total	**$621,030.87**
			Grand Total	**$621,050.87**

REGIONAL FLOOD CONTROL DISTRICT
FUND 2870 - FACILITIES MAINTENANCE FUND
FUND BALANCE REPORT
SEPTEMBER 2024

BEGINNING CASH BALANCE:	$ 10,062,252.65	
Accruals/Adjustments		
TOTAL BEGINNING CASH BALANCE:		$ 10,062,252.65
REVENUES:		
Interest Income		
Fund 2860 - Transfer In Maintenance Work Program	1,600,000.00	
Miscellaneous Other Revenue/Adjustments	-	
TOTAL MONTHLY REVENUES		$ 1,600,000.00
EXPENDITURES:		
Services & Supplies	(308,288.09)	
Maintenance Work Program Expenditures	-	
Accruals/Adjustments	-	
Miscellaneous Accruals/Adjustments	-	
Contract Retention Payable	-	
Contract Retention Interest Payable	-	
Accounts Payable	-	
TOTAL MONTHLY EXPENSES		$ (308,288.09)
ENDING CASH BALANCE:		$ 11,353,964.56

Regional Flood Control District
Monthly Expenditures
Maintenance Work Program
9/1/2024 to 9/30/2024

Fiscal Year - 2025

Vendor	Facility	Invoice No.	Inv. Date	P.O. Number	Date Paid	Amount
CITY OF LAS VEGAS	RF.LV51	386423	08/22/2024	4500392918	09/24/2024	$1,163.40
CITY OF LAS VEGAS	RF.LV51	386809	09/23/2024	4500392918	09/25/2024	$2,219.58
CITY OF LAS VEGAS	RF.LV52	386423	08/22/2024	4500392918	09/24/2024	$47.77
CITY OF LAS VEGAS	RF.LV52	386809	09/23/2024	4500392918	09/25/2024	$12,688.34
CITY OF LAS VEGAS	RF.LV53	386423	08/22/2024	4500392918	09/24/2024	$930.72
CITY OF LAS VEGAS	RF.LV53	386809	09/23/2024	4500392918	09/25/2024	$2,102.76
CITY OF LAS VEGAS	RF.LV54	386423	08/22/2024	4500392918	09/24/2024	$1,279.74
CITY OF LAS VEGAS	RF.LV54	386809	09/23/2024	4500392918	09/25/2024	$2,219.58
PUBLIC WORKS/CC TREAS	RF.CC01	4025000017	09/30/2024	none	09/30/2024	$9,919.00
PUBLIC WORKS/CC TREAS	RF.CC01	4025000018	09/30/2024	none	09/30/2024	$9,147.13
PUBLIC WORKS/CC TREAS	RF.CC01	4025000032	09/30/2024	none	09/30/2024	$87,041.50
PUBLIC WORKS/CC TREAS	RF.CC02	4025000019	09/30/2024	none	09/30/2024	$2,639.00
PUBLIC WORKS/CC TREAS	RF.CC02	4025000033	09/30/2024	none	09/30/2024	$18,928.00
PUBLIC WORKS/CC TREAS	RF.CC03	4025000020	09/30/2024	none	09/30/2024	$7,826.00
PUBLIC WORKS/CC TREAS	RF.CC03	4025000021	09/30/2024	none	09/30/2024	$3,430.17
PUBLIC WORKS/CC TREAS	RF.CC03	4025000034	09/30/2024	none	09/30/2024	$25,844.00
PUBLIC WORKS/CC TREAS	RF.CC05	4025000022	09/30/2024	none	09/30/2024	$7,280.00
PUBLIC WORKS/CC TREAS	RF.CC05	4025000023	09/30/2024	none	09/30/2024	$2,286.78
PUBLIC WORKS/CC TREAS	RF.CC05	4025000035	09/30/2024	none	09/30/2024	$15,583.75
PUBLIC WORKS/CC TREAS	RF.CC06	4025000024	09/30/2024	none	09/30/2024	$6,643.00
PUBLIC WORKS/CC TREAS	RF.CC06	4025000025	09/30/2024	none	09/30/2024	$3,430.17
PUBLIC WORKS/CC TREAS	RF.CC06	4025000036	09/30/2024	none	09/30/2024	$38,652.25
PUBLIC WORKS/CC TREAS	RF.CC07	4025000037	09/30/2024	none	09/30/2024	$5,664.75
PUBLIC WORKS/CC TREAS	RF.CC08	4025000038	09/30/2024	none	09/30/2024	$4,982.25
PUBLIC WORKS/CC TREAS	RF.CC09	4025000026	09/30/2024	none	09/30/2024	$1,001.00
PUBLIC WORKS/CC TREAS	RF.CC10	4025000039	09/30/2024	none	09/30/2024	$23,136.75
PUBLIC WORKS/CC TREAS	RF.CC11	4025000027	09/30/2024	none	09/30/2024	$1,143.39
PUBLIC WORKS/CC TREAS	RF.CC11	4025000040	09/30/2024	none	09/30/2024	$4,436.25
PUBLIC WORKS/CC TREAS	RF.CC14	4025000028	09/30/2024	none	09/30/2024	$1,143.39
PUBLIC WORKS/CC TREAS	RF.CC16	4025000029	09/30/2024	none	09/30/2024	$1,143.39
PUBLIC WORKS/CC TREAS	RF.CC16	4025000041	09/30/2024	none	09/30/2024	$2,047.50
PUBLIC WORKS/CC TREAS	RF.CC18	4025000030	09/30/2024	none	09/30/2024	$1,143.39
PUBLIC WORKS/CC TREAS	RF.CC20	4025000031	09/30/2024	none	09/30/2024	$1,143.39
			Total Expenditures			**$308,288.09**
			Grand Total			**$308,288.09**

Regional Flood Control District
Maintenance Work Program Status Report - Fiscal Year 2024

Boulder City

Facility	Facility Name	Budget	Amount Spent	Amount Remaining
RF.BC01	Hemenway Watershed	$273,200.00	$107,789.13	$165,410.87
RF.BC02	Georgia/Buchanan Watershed	$276,350.00	$109,967.90	$166,382.10
RF.BC03	North Railroad Watershed	$93,500.00	$38,132.53	$55,367.47
RF.BC04	West Airport Watershed	$275,500.00	$23,642.37	$251,857.63
		$918,550.00	**$279,531.93**	**$639,018.07**

Clark County

Facility	Facility Name	Budget	Amount Spent	Amount Remaining
RF.CC01	Flamingo Wash	$1,910,000.00	$1,797,591.39	$112,408.61
RF.CC02	Las Vegas Wash	$581,000.00	$561,064.32	$19,935.68
RF.CC03	Duck Creek	$691,500.00	$441,636.16	$249,863.84
RF.CC05	Las Vegas Range Wash	$624,500.00	$508,458.70	$116,041.30
RF.CC06	Tropicana Wash	$625,000.00	$594,440.39	$30,559.61
RF.CC07	Airport Channel	$125,000.00	$86,992.88	$38,007.12
RF.CC08	Monson Channel	$113,000.00	$44,542.82	$68,457.18
RF.CC09	Rawhide Channel	$93,500.00	$27,271.79	$66,228.21
RF.CC10	Van Buskirk Channel	$318,000.00	$220,046.70	$97,953.30
RF.CC11	Flamingo Wash North Fork	$89,500.00	$58,951.15	$30,548.85
RF.CC14	Laughlin Washes	$100,000.00	$70,369.14	$29,630.86
RF.CC15	Moapa Valley	$43,000.00	$9,261.28	$33,738.72
RF.CC16	Blue Diamond Wash	$150,000.00	$30,281.72	$119,718.28
RF.CC17	Searchlight	$5,000.00	$0.00	$5,000.00
RF.CC18	Bunkerville	$24,500.00	$12,959.23	$11,540.77
RF.CC19	Pittman Wash	$44,000.00	$10,929.57	$33,070.43
RF.CC20	Indian/Good Spngs, Jean, Mt Charleston	$15,500.00	$12,459.23	$3,040.77
RF.CC21	Northern Beltway Channels	$24,500.00	$8,913.82	$15,586.18
		$5,577,500.00	**$4,496,170.29**	**$1,081,329.71**

Henderson

Facility	Facility Name	Budget	Amount Spent	Amount Remaining
RF.HN65	C1 North	$855,000.00	$258,063.38	$596,936.62
RF.HN66	C1 South	$226,000.00	$181,530.26	$44,469.74
RF.HN67	Pittman Central NE	$211,000.00	$72,281.64	$138,718.36
RF.HN68	Pittman Central SE	$266,000.00	$67,560.32	$198,439.68
RF.HN69	Pittman Central NW	$1,230,500.00	$1,031,897.22	$198,602.78
RF.HN70	Pittman Central SW	$401,500.00	$253,837.53	$147,662.47
RF.HN71	Pittman Anthem Inspirada	$268,000.00	$21,542.38	$246,457.62
RF.HN72	Pittman Seven Hills	$2,199,500.00	$1,415,012.62	$784,487.38
RF.HN73	Pittman West Henderson	$42,500.00	$16,995.48	$25,504.52
		$5,700,000.00	**$3,318,720.83**	**$2,381,279.17**

Las Vegas

Facility	Facility Name	Budget	Amount Spent	Amount Remaining
RF.LV51	Cedar Ave Channel/Nellis System	$17,236.77	$17,236.77	$0.00
RF.LV52	Gowan/Angel Pk/Lone Mtn System	$2,961,262.21	$2,961,262.21	$0.00
RF.LV53	Lake Mead/Smoke Ranch/Washington Sys	$15,477.27	$15,477.27	$0.00

Regional Flood Control District
Maintenance Work Program Status Report - Fiscal Year 2024

Facility	Facility Name	Budget	Amount Spent	Amount Remaining
RF.LV54	Las Vegas Wash System	$1,031,489.72	$1,031,489.72	$0.00
RF.LV55	Meadows/Oakey System	$419,018.32	$419,018.32	$0.00
RF.LV56	Washington Ave/LV Creek System	$18,054.07	$18,054.07	$0.00
RF.LV57	US95/Outer Beltway/Ann Road System	$37,461.64	$37,461.64	$0.00
		$4,500,000.00	**$4,500,000.00**	**$0.00**

Las Vegas Valley

Facility	Facility Name	Budget	Amount Spent	Amount Remaining
RF.WW01	Las Vegas Valley WAC-SNWA	$614,616.00	$614,616.00	$0.00
		$614,616.00	**$614,616.00**	**$0.00**

Mesquite

Facility	Facility Name	Budget	Amount Spent	Amount Remaining
RF.ME01	Mesquite Town Wash	$13,771.84	$13,772.16	($0.32)
RF.ME02	Abbott Wash Channel	$12,615.98	$12,615.54	$0.44
RF.ME04	Town Wash Detention Basin	$338,344.45	$338,344.45	$0.00
RF.ME07	Pulsipher Wash	$32,229.01	$32,228.63	$0.38
RF.ME08	Abbott Wash Detention Basin	$2,186.00	$2,186.25	($0.25)
RF.ME09	Pulsipher Wash Detention Basin	$21,117.72	$21,117.97	($0.25)
		$420,265.00	**$420,265.00**	**$0.00**

North Las Vegas

Facility	Facility Name	Budget	Amount Spent	Amount Remaining
RF.NL01	LV Wash "N" Channel	$228,641.94	$5,316.03	$223,325.91
RF.NL02	Las Vegas Wash-Middle	$413,000.00	$316,234.88	$96,765.12
RF.NL03	LV Wash-King Charles Channel	$76,000.00	$5,086.33	$70,913.67
RF.NL04	Vandenberg Detention Basin	$129,411.56	$63,045.63	$66,365.93
RF.NL05	North Las Vegas Detention Basin	$110,184.50	$1,411.92	$108,772.58
RF.NL06	Upper LVW DB & Moccasin Levee	$132,604.57	$14,556.06	$118,048.51
RF.NL07	Carey/Lake Mead Detention Basin	$208,706.12	$172,517.54	$36,188.58
RF.NL08	Gowan Outfall Channel	$173,411.66	$131,352.22	$42,059.44
RF.NL09	Speedway, APEX, KAPEX	$60,000.00	$1,953.07	$58,046.93
RF.NL10	Upper Las Vegas Wash	$131,000.00	$88,467.93	$42,532.07
RF.NL11	Clayton Street Channel	$57,000.00	$36,253.39	$20,746.61
RF.NL12	Lower Las Vegas Detention Basin	$117,395.43	$82,022.63	$35,372.80
RF.NL13	West Trib-Ranch House to Lower LV DB	$114,641.61	$86,083.40	$28,558.21
RF.NL14	Trib to Western Trib @ Craig Rd	$77,500.00	$7,979.29	$69,520.71
RF.NL15	Las Vegas Wash-Smoke Ranch	$54,000.00	$3,496.79	$50,503.21
RF.NL16	Upper Las Vegas Wash Channel	$86,067.16	$61,207.65	$24,859.51
RF.NL17	Range Wash-LVW Diversion & Levee	$20,391.57	$383.77	$20,007.80
RF.NL18	Cheyenne Peaking Basin	$94,000.00	$39,849.53	$54,150.47
RF.NL19	LVW-Middle Cheyenne Ave to Owens Ave	$698,843.88	$686,978.45	$11,865.43
		$2,982,800.00	**$1,804,196.51**	**$1,178,603.49**
	Program Total	**$20,713,731.00**	**$15,433,500.56**	**$5,280,230.44**

Regional Flood Control District
Maintenance Work Program Status Report - Fiscal Year 2025

Boulder City

Facility	Facility Name	Budget	Amount Spent	Amount Remaining
RF.BC01	Hemenway Watershed	$245,200.00	$0.00	$245,200.00
RF.BC02	Georgia/Buchanan Watershed	$543,850.00	$0.00	$543,850.00
RF.BC03	North Railroad Watershed	$93,500.00	$0.00	$93,500.00
RF.BC04	West Airport Watershed	$36,000.00	$0.00	$36,000.00
		$918,550.00	**$0.00**	**$918,550.00**

Clark County

Facility	Facility Name	Budget	Amount Spent	Amount Remaining
RF.CC01	Flamingo Wash	$1,999,400.00	$135,955.63	$1,863,444.37
RF.CC02	Las Vegas Wash	$674,600.00	$30,576.00	$644,024.00
RF.CC03	Duck Creek	$637,400.00	$55,664.17	$581,735.83
RF.CC05	Las Vegas Range Wash	$525,900.00	$31,975.53	$493,924.47
RF.CC06	Tropicana Wash	$1,380,637.00	$59,827.42	$1,320,809.58
RF.CC07	Airport Channel	$147,600.00	$6,301.75	$141,298.25
RF.CC08	Monson Channel	$113,000.00	$4,982.25	$108,017.75
RF.CC09	Rawhide Channel	$53,500.00	$3,367.00	$50,133.00
RF.CC10	Van Buskirk Channel	$308,000.00	$23,136.75	$284,863.25
RF.CC11	Flamingo Wash North Fork	$309,400.00	$5,579.64	$303,820.36
RF.CC14	Laughlin Washes	$407,000.00	$1,343.39	$405,656.61
RF.CC15	Moapa Valley	$38,000.00	$0.00	$38,000.00
RF.CC16	Blue Diamond Wash	$150,000.00	$3,190.89	$146,809.11
RF.CC17	Searchlight	$7,000.00	$0.00	$7,000.00
RF.CC18	Bunkerville	$24,500.00	$1,143.39	$23,356.61
RF.CC19	Pittman Wash	$44,000.00	$0.00	$44,000.00
RF.CC20	Indian/Good Spngs, Jean, Mt Charleston	$10,000.00	$1,143.39	$8,856.61
RF.CC21	Northern Beltway Channels	$30,000.00	$0.00	$30,000.00
		$6,859,937.00	**$364,187.20**	**$6,495,749.80**

Henderson

Facility	Facility Name	Budget	Amount Spent	Amount Remaining
RF.HN65	C1 North	$642,000.00	$0.00	$642,000.00
RF.HN66	C1 South	$240,000.00	$0.00	$240,000.00
RF.HN67	Pittman Central NE	$624,000.00	$0.00	$624,000.00
RF.HN68	Pittman Central SE	$166,000.00	$0.00	$166,000.00
RF.HN69	Pittman Central NW	$1,015,000.00	$0.00	$1,015,000.00
RF.HN70	Pittman Central SW	$491,000.00	$0.00	$491,000.00
RF.HN71	Pittman Anthem Inspirada	$610,000.00	$0.00	$610,000.00
RF.HN72	Pittman Seven Hills	$113,000.00	$277,965.40	($164,965.40)
RF.HN73	Pittman West Henderson	$47,000.00	$0.00	$47,000.00
		$3,948,000.00	**$277,965.40**	**$3,670,034.60**

Las Vegas

Facility	Facility Name	Budget	Amount Spent	Amount Remaining
RF.LV51	Cedar Ave Channel/Nellis System	$100,000.00	$3,382.98	$96,617.02
RF.LV52	Gowan/Angel Pk/Lone Mtn System	$900,000.00	$12,736.11	$887,263.89
RF.LV53	Lake Mead/Smoke Ranch/Washington Sys	$100,000.00	$3,033.48	$96,966.52

Regional Flood Control District
Maintenance Work Program Status Report - Fiscal Year 2025

Facility	Facility Name	Budget	Amount Spent	Amount Remaining
RF.LV54	Las Vegas Wash System	$600,000.00	$3,499.32	$596,500.68
RF.LV55	Meadows/Oakey System	$400,000.00	$0.00	$400,000.00
RF.LV56	Washington Ave/LV Creek System	$300,000.00	$0.00	$300,000.00
RF.LV57	US95/Outer Beltway/Ann Road System	$1,100,000.00	$0.00	$1,100,000.00
		$3,500,000.00	**$22,651.89**	**$3,477,348.11**

Las Vegas Valley

Facility	Facility Name	Budget	Amount Spent	Amount Remaining
RF.WW01	Las Vegas Valley WAC-SNWA	$605,988.00	$605,988.00	$0.00
		$605,988.00	**$605,988.00**	**$0.00**

Mesquite

Facility	Facility Name	Budget	Amount Spent	Amount Remaining
RF.ME01	Mesquite Town Wash	$19,155.00	$0.00	$19,155.00
RF.ME02	Abbott Wash Channel	$14,455.00	$0.00	$14,455.00
RF.ME04	Town Wash Detention Basin	$467,400.00	$0.00	$467,400.00
RF.ME07	Pulsipher Wash	$29,555.00	$0.00	$29,555.00
RF.ME08	Abbott Wash Detention Basin	$60,000.00	$0.00	$60,000.00
RF.ME09	Pulsipher Wash Detention Basin	$29,700.00	$0.00	$29,700.00
		$620,265.00	**$0.00**	**$620,265.00**

North Las Vegas

Facility	Facility Name	Budget	Amount Spent	Amount Remaining
RF.NL01	LV Wash "N" Channel	$86,500.00	$0.00	$86,500.00
RF.NL02	Las Vegas Wash-Middle	$320,500.00	$0.00	$320,500.00
RF.NL03	LV Wash-King Charles Channel	$77,500.00	$0.00	$77,500.00
RF.NL04	Vandenberg Detention Basin	$876,000.00	$0.00	$876,000.00
RF.NL05	North Las Vegas Detention Basin	$180,500.00	$0.00	$180,500.00
RF.NL06	Upper LVW DB & Moccasin Levee	$172,000.00	$0.00	$172,000.00
RF.NL07	Carey/Lake Mead Detention Basin	$124,500.00	$0.00	$124,500.00
RF.NL08	Gowan Outfall Channel	$75,500.00	$0.00	$75,500.00
RF.NL09	Speedway, APEX, KAPEX	$115,000.00	$0.00	$115,000.00
RF.NL10	Upper Las Vegas Wash	$58,500.00	$0.00	$58,500.00
RF.NL11	Clayton Street Channel	$57,500.00	$0.00	$57,500.00
RF.NL12	Lower Las Vegas Detention Basin	$117,500.00	$0.00	$117,500.00
RF.NL13	West Trib-Ranch House to Lower LV DB	$72,500.00	$0.00	$72,500.00
RF.NL14	Trib to Western Trib @ Craig Rd	$80,000.00	$0.00	$80,000.00
RF.NL15	Las Vegas Wash-Smoke Ranch	$44,000.00	$0.00	$44,000.00
RF.NL16	Upper Las Vegas Wash Channel	$105,500.00	$0.00	$105,500.00
RF.NL17	Range Wash-LVW Diversion & Levee	$165,500.00	$0.00	$165,500.00
RF.NL18	Cheyenne Peaking Basin	$94,000.00	$0.00	$94,000.00
RF.NL19	LVW-Middle Cheyenne Ave to Owens Ave	$183,500.00	$0.00	$183,500.00
		$3,006,500.00	**$0.00**	**$3,006,500.00**
	Program Total	**$19,459,240.00**	**$1,270,792.49**	**$18,188,447.51**

REGIONAL FLOOD CONTROL DISTRICT
FUND 3300 - BOND DEBT SERVICE FUND
FUND BALANCE REPORT
SEPTEMBER 2024

BEGINNING CASH BALANCE	$ 33,831,813.07	
Accruals/Adjustments	-	
TOTAL BEGINNING CASH BALANCE		$ 33,831,813.07
REVENUES:		
Interest Income		
Fund 2860 - Transfer In Debt Service	3,990,406.28	
Bonds Issued	-	
Premium on Bonds Issued	-	
Miscellaneous Other Revenue	-	
Accruals/Adjustments	-	
Miscellaneous Accruals/Adjustments	-	
TOTAL MONTHLY REVENUES		$ 3,990,406.28
EXPENDITURES:		
Professional Services	-	
Debt Service Payments*	-	
Payments to Escrow Agent	-	
Transfers Out to Other Funds	-	
Accruals/Adjustments	-	
Miscellaneous Accruals/Adjustments	-	
TOTAL MONTHLY EXPENSES		$ -
ENDING CASH BALANCE:		$ 37,822,219.35

*Principal payments paid annually (November); Interest payments paid semi-annually (May and November)

REGIONAL FLOOD CONTROL DISTRICT
FUND 4430 - CONSTRUCTION FUND
FUND BALANCE REPORT
SEPTEMBER 2024

BEGINNING CASH BALANCE:		
Cash in Custody of Treasurer	312,977,500.51	
Custodial Account Cash Balance	45,827,677.38	
Accruals/Adjustments		
TOTAL BEGINNING CASH BALANCE		$ 358,805,177.89
REVENUES:		
Fund 2860 - Transfer In Budgeted Transfer	9,000,000.00	
Fund 3300 - Transfer In Bond Proceeds	-	
Custodial Account - Transfer In to Treasurer	-	
Interest Earnings	-	
Custodial Account Interest Earnings	-	
Proceeds from Bonds and Loans	-	
Miscellaneous Other Revenue	5,617.30	
Accruals/Adjustments	-	
Miscellaneous Accruals/Adjustments	-	
TOTAL MONTHLY REVENUES		$ 9,005,617.30
EXPENDITURES:		
Capital Improvement Program	(4,760,488.78)	
Professional Services	-	
Project Reimbursements	-	
Fund 2860 - Transfer Out Interest Earnings	-	
Fund 2860 - Transfer Out ILA Closeout/Reductions	-	
Custodial Account - Transfer Out to Treasurer/ Adjustments	-	
Accruals/Adjustments		
Contracts Retention Payable	-	
Contracts Retention Interest Payable	-	
Accounts Payable	26,770.10	
Miscellaneous Accruals/Adjustments	-	
TOTAL MONTHLY EXPENDITURES		$ (4,733,718.68)
ENDING CASH BALANCE:		
Cash in Custody of Treasurer	317,249,399.13	
Custodial Account Cash Balance	45,827,677.38	
ENDING CASH BALANCE:		$ 363,077,076.51

Regional Flood Control District
Monthly Expenditures
Capital Improvement Program
9/1/2024 to 9/30/2024

Fund 4430

Fiscal Year 2024

Vendor	Project	Invoice No.	Inv. Date	P.O. Number	Date Paid	Amount
REGIONAL FLOOD CONTROL	RF.CLA01F21	1124001409	06/30/2024	none	09/04/2024	$8,642.70
REGIONAL FLOOD CONTROL	RF.CLA01F21	1124001409	06/30/2024	none	09/04/2024	$1,448.28
REGIONAL FLOOD CONTROL	RF.CLA01F21	1124001410	06/30/2024	none	09/05/2024	$1,743.75
REGIONAL FLOOD CONTROL	RF.CLA01F21	1124001410	06/30/2024	none	09/05/2024	$2,578.59
REGIONAL FLOOD CONTROL	RF.CLA10F10	1124001409	06/30/2024	none	09/04/2024	$15,848.98
REGIONAL FLOOD CONTROL	RF.CLA10K22	1024078424	06/30/2024	none	09/04/2024	$26,770.10
REGIONAL FLOOD CONTROL	RF.CLA14X21	1124001409	06/30/2024	none	09/04/2024	$91,836.27
REGIONAL FLOOD CONTROL	RF.CLA14X21	1124001409	06/30/2024	none	09/04/2024	$40,214.05
REGIONAL FLOOD CONTROL	RF.CLA14X21	1124001410	06/30/2024	none	09/05/2024	$1,444.52
REGIONAL FLOOD CONTROL	RF.CLA21A00	1124001409	06/30/2024	none	09/04/2024	$781.29
REGIONAL FLOOD CONTROL	RF.CLA21A00	1124001409	06/30/2024	none	09/04/2024	$2,380.00
REGIONAL FLOOD CONTROL	RF.CLA36B23	1124001410	06/30/2024	none	09/05/2024	$28,227.92
REGIONAL FLOOD CONTROL	RF.CLA38G20	1124001409	06/30/2024	none	09/04/2024	$3,939.94
REGIONAL FLOOD CONTROL	RF.CLA38G20	1124001409	06/30/2024	none	09/04/2024	$1,889.40
REGIONAL FLOOD CONTROL	RF.CLA39A19	1124001410	06/30/2024	none	09/05/2024	$11,366.75
REGIONAL FLOOD CONTROL	RF.CLA39A19	1124001410	06/30/2024	none	09/05/2024	$33,177.94
REGIONAL FLOOD CONTROL	RF.LAS04F22	1124001410	06/30/2024	none	09/05/2024	$17,176.22
REGIONAL FLOOD CONTROL	RF.LAS05N22	1124001410	06/30/2024	none	09/05/2024	$112.13
REGIONAL FLOOD CONTROL	RF.LAS23J21	1124001410	06/30/2024	none	09/05/2024	$2,311.44
REGIONAL FLOOD CONTROL	RF.LAS23L23	1124001410	06/30/2024	none	09/05/2024	$55,485.41
REGIONAL FLOOD CONTROL	RF.LAS25C20	1124001410	06/30/2024	none	09/05/2024	$53,604.84
REGIONAL FLOOD CONTROL	RF.LAS29D17	1124001410	06/30/2024	none	09/05/2024	$77,040.01
REGIONAL FLOOD CONTROL	RF.LAS29F20	1124001410	06/30/2024	none	09/05/2024	$33,728.00
REGIONAL FLOOD CONTROL	RF.LAS30A13	1124001410	06/30/2024	none	09/05/2024	$24,497.86
REGIONAL FLOOD CONTROL	RF.LAS33A22	1124001410	06/30/2024	none	09/05/2024	$20,224.13
REGIONAL FLOOD CONTROL	RF.LAU04A08	1124001409	06/30/2024	none	09/04/2024	$4,924.17
REGIONAL FLOOD CONTROL	RF.LAU04A08	1124001409	06/30/2024	none	09/04/2024	$24,619.82
REGIONAL FLOOD CONTROL	RF.MOA03B21	1124001410	06/30/2024	none	09/05/2024	$9,153.23
REGIONAL FLOOD CONTROL	RF.MOA03B21	1124001416	06/30/2024	none	09/09/2024	$567,493.29
REGIONAL FLOOD CONTROL	RF.MOA03B21	1124001446	06/30/2024	none	09/19/2024	$881,265.96
REGIONAL FLOOD CONTROL	RF.MES01F24	1124001409	06/30/2024	none	09/04/2024	$12,514.63
REGIONAL FLOOD CONTROL	RF.LAS24N21	1124001410	06/30/2024	none	09/05/2024	$27,569.00
		Fiscal Year Total				**$2,084,010.62**

Fiscal Year 2025

Vendor	Project	Invoice No.	Inv. Date	P.O. Number	Date Paid	Amount

Regional Flood Control District
Monthly Expenditures
Capital Improvement Program
9/1/2024 to 9/30/2024

CITY OF LAS VEGAS	RF.LAS04F22	386391	08/21/2024	4800010880 00040	09/04/2024	$886.29
CITY OF LAS VEGAS	RF.LAS04F22	386530	06/30/2024	4800010880 00010	09/05/2024	$17,176.22
CITY OF LAS VEGAS	RF.LAS04F22	386802	09/23/2024	4800010880 00010	09/25/2024	$21,978.84
CITY OF LAS VEGAS	RF.LAS04F22	386802	09/23/2024	4800010880 00040	09/25/2024	$1,096.86
CITY OF LAS VEGAS	RF.LAS05N22	386531	06/30/2024	4800011144 00030	09/05/2024	$112.13
CITY OF LAS VEGAS	RF.LAS05N22	386801	09/23/2024	4800011144 00030	09/25/2024	$399.45
CITY OF LAS VEGAS	RF.LAS22U19	386808	09/23/2024	4800009466 00010	09/25/2024	$217.18
CITY OF LAS VEGAS	RF.LAS23J21	386395	08/21/2024	4800010471 00040	09/04/2024	$1,444.14
CITY OF LAS VEGAS	RF.LAS23J21	386525	06/30/2024	4800010471 00010	09/05/2024	$2,311.44
CITY OF LAS VEGAS	RF.LAS23J21	386806	09/23/2024	4800010471 00040	09/25/2024	$1,826.56
CITY OF LAS VEGAS	RF.LAS23L23	386396	08/21/2024	4800012101 00020	09/04/2024	$232.68
CITY OF LAS VEGAS	RF.LAS23L23	386524	06/30/2024	4800012101 00010	09/05/2024	$55,485.41
CITY OF LAS VEGAS	RF.LAS23L23	386807	09/23/2024	4800012101 00010	09/25/2024	$55,842.46
CITY OF LAS VEGAS	RF.LAS23L23	386807	09/23/2024	4800012101 00020	09/25/2024	$3,111.02
CITY OF LAS VEGAS	RF.LAS25C20	386389	08/21/2024	4800010086 00040	09/04/2024	$116.34
CITY OF LAS VEGAS	RF.LAS25C20	386533	06/30/2024	4800010086 00010	09/05/2024	$53,604.84
CITY OF LAS VEGAS	RF.LAS25C20	386799	09/23/2024	4800010086 00040	09/25/2024	$467.33
CITY OF LAS VEGAS	RF.LAS29D17	386394	08/21/2024	4800008455 00040	09/04/2024	$1,666.54
CITY OF LAS VEGAS	RF.LAS29D17	386526	06/30/2024	4800008455 00010	09/05/2024	$77,040.01
CITY OF LAS VEGAS	RF.LAS29D17	386805	09/23/2024	4800008455 00040	09/25/2024	$4,391.15
CITY OF LAS VEGAS	RF.LAS29F20	386393	08/21/2024	4800009931 00030	09/04/2024	$13,244.28
CITY OF LAS VEGAS	RF.LAS29F20	386527	06/30/2024	4800009931 00020	09/05/2024	$33,728.00
CITY OF LAS VEGAS	RF.LAS29F20	386804	09/23/2024	4800009931 00020	09/26/2024	$66,366.71
CITY OF LAS VEGAS	RF.LAS29F20	386804	09/23/2024	4800009931 00030	09/26/2024	$16,942.29
CITY OF LAS VEGAS	RF.LAS30A13	386529	06/30/2024	4800005744 00020	09/05/2024	$24,497.86
CITY OF LAS VEGAS	RF.LAS32A21	386392	08/21/2024	4800010470 00040	09/04/2024	$116.34
CITY OF LAS VEGAS	RF.LAS33A22	386390	08/21/2024	4800011143 00040	09/04/2024	$116.34
CITY OF LAS VEGAS	RF.LAS33A22	386532	06/30/2024	4800011143 00010	09/05/2024	$20,224.13
CITY OF LAS VEGAS	RF.LAS33A22	386800	09/23/2024	4800011143 00040	09/25/2024	$175.27
CITY OF LAS VEGAS	RF.LAS24N21	386528	06/30/2024	4800010709 00010	09/05/2024	$27,569.00
CITY OF LAS VEGAS	RF.LAS24N21	386803	09/23/2024	4800010709 00030	09/25/2024	$130.92
CITY OF NORTH LAS VEGAS	RF.NLV01K22	13875	08/31/2024	4800011178 00010	09/16/2024	$47,641.25
CITY OF NORTH LAS VEGAS	RF.NLV01K22	13875	08/31/2024	4800011178 00030	09/16/2024	$1,951.86
CITY OF NORTH LAS VEGAS	RF.NLV04K17	13873	08/31/2024	4800008195 00010	09/20/2024	$3,382.50
CITY OF NORTH LAS VEGAS	RF.NLV09L24	13871	08/31/2024	4800012119 00010	09/16/2024	$8,565.50
CITY OF NORTH LAS VEGAS	RF.NLV09L24	13871	08/31/2024	4800012119 00020	09/16/2024	$413.09
CITY OF NORTH LAS VEGAS	RF.NLV09L24	13871	08/31/2024	4800012119 00030	09/16/2024	$2,889.99
CITY OF NORTH LAS VEGAS	RF.NLV10M21	13872	08/31/2024	4800010302 00020	09/16/2024	$757.98

Regional Flood Control District
Monthly Expenditures
Capital Improvement Program
9/1/2024 to 9/30/2024

CITY OF NORTH LAS VEGAS	RF.NLV10M21	13872	08/31/2024	4800010302 00030	09/16/2024	$2,174.78
CITY OF NORTH LAS VEGAS	RF.NLV19A19	13876	08/31/2024	4500311504 00020	09/16/2024	$265.40
CITY OF NORTH LAS VEGAS	RF.NLV04L21	13874	08/31/2024	4800010493 00010	09/16/2024	$689,303.03
CITY OF NORTH LAS VEGAS	RF.NLV04L21	13874	08/31/2024	4800010493 00020	09/16/2024	$62,407.25
CITY OF NORTH LAS VEGAS	RF.NLV04L21	13874	08/31/2024	4800010493 00030	09/16/2024	$11,901.64
PUBLIC WORKS/CC TREAS	RF.CLA10F10	1525050354	09/10/2024	none	09/10/2024	$5,201.80
PUBLIC WORKS/CC TREAS	RF.CLA10K22	1525062370	09/25/2024	none	09/25/2024	$2,691.00
PUBLIC WORKS/CC TREAS	RF.CLA14X21	1525058156	09/19/2024	none	09/19/2024	$1,083.39
PUBLIC WORKS/CC TREAS	RF.CLA16O19	1525058167	09/19/2024	none	09/19/2024	$3,062.98
PUBLIC WORKS/CC TREAS	RF.CLA16O19	1525058168	09/19/2024	none	09/19/2024	$330.48
PUBLIC WORKS/CC TREAS	RF.CLA21A00	1525050366	09/10/2024	none	09/10/2024	$5,009.76
PUBLIC WORKS/CC TREAS	RF.CLA21A00	1525051706	09/11/2024	none	09/11/2024	$416,193.00
PUBLIC WORKS/CC TREAS	RF.CLA21A00	1525051707	09/11/2024	none	09/11/2024	$654,782.00
PUBLIC WORKS/CC TREAS	RF.CLA21A00	1525054278	09/16/2024	none	09/16/2024	$1,494.00
PUBLIC WORKS/CC TREAS	RF.CLA21A00	1525054280	09/16/2024	none	09/16/2024	$1,851.61
PUBLIC WORKS/CC TREAS	RF.CLA35B23	1525050382	09/10/2024	none	09/10/2024	$7,341.31
PUBLIC WORKS/CC TREAS	RF.CLA35B23	1525050382	09/10/2024	none	09/10/2024	$8,277.15
PUBLIC WORKS/CC TREAS	RF.CLA35B23	1525050382	09/10/2024	none	09/10/2024	$28,875.00
PUBLIC WORKS/CC TREAS	RF.CLA36A18	1525044469	09/03/2024	none	09/03/2024	$236,731.04
PUBLIC WORKS/CC TREAS	RF.CLA36B23	1525052742	09/12/2024	none	09/12/2024	$127,398.00
PUBLIC WORKS/CC TREAS	RF.CLA36B23	1525056853	09/18/2024	none	09/18/2024	$430,240.00
PUBLIC WORKS/CC TREAS	RF.CLA36B23	1525060223	09/23/2024	none	09/23/2024	$7,428.40
PUBLIC WORKS/CC TREAS	RF.LAU04A08	1525058155	09/19/2024	none	09/19/2024	$5,121.15
PUBLIC WORKS/CC TREAS	RF.MOA03B21	1525044401	09/03/2024	none	09/03/2024	$567,493.29
PUBLIC WORKS/CC TREAS	RF.MOA03B21	1525052780	09/12/2024	none	09/12/2024	$881,265.96
PUBLIC WORKS/CC TREAS	RF.MOA03B21	1525060222	09/23/2024	none	09/23/2024	$7,675.06
REGIONAL FLOOD CONTROL	RF.CLA01F21	1125000287	09/04/2024	none	09/04/2024	($8,642.70)
REGIONAL FLOOD CONTROL	RF.CLA01F21	1125000287	09/04/2024	none	09/04/2024	($1,448.28)
REGIONAL FLOOD CONTROL	RF.CLA01F21	1125000294	09/05/2024	none	09/05/2024	($1,743.75)
REGIONAL FLOOD CONTROL	RF.CLA01F21	1125000294	09/05/2024	none	09/05/2024	($2,578.59)
REGIONAL FLOOD CONTROL	RF.CLA10F10	1125000287	09/04/2024	none	09/04/2024	($15,848.98)
REGIONAL FLOOD CONTROL	RF.CLA14X21	1125000287	09/04/2024	none	09/04/2024	($40,214.05)
REGIONAL FLOOD CONTROL	RF.CLA14X21	1125000287	09/04/2024	none	09/04/2024	($91,836.27)
REGIONAL FLOOD CONTROL	RF.CLA14X21	1125000294	09/05/2024	none	09/05/2024	($1,444.52)
REGIONAL FLOOD CONTROL	RF.CLA21A00	1125000287	09/04/2024	none	09/04/2024	($781.29)
REGIONAL FLOOD CONTROL	RF.CLA21A00	1125000287	09/04/2024	none	09/04/2024	($2,380.00)
REGIONAL FLOOD CONTROL	RF.CLA36B23	1125000294	09/05/2024	none	09/05/2024	($28,227.92)
REGIONAL FLOOD CONTROL	RF.CLA38G20	1125000287	09/04/2024	none	09/04/2024	($1,889.40)

Regional Flood Control District
Monthly Expenditures
Capital Improvement Program
9/1/2024 to 9/30/2024

REGIONAL FLOOD CONTROL	RF.CLA38G20	1125000287	09/04/2024	none	09/04/2024	($3,939.94)
REGIONAL FLOOD CONTROL	RF.CLA39A19	1125000294	09/05/2024	none	09/05/2024	($11,366.75)
REGIONAL FLOOD CONTROL	RF.CLA39A19	1125000294	09/05/2024	none	09/05/2024	($33,177.94)
REGIONAL FLOOD CONTROL	RF.LAS04F22	1125000294	09/05/2024	none	09/05/2024	($17,176.22)
REGIONAL FLOOD CONTROL	RF.LAS05N22	1125000294	09/05/2024	none	09/05/2024	($112.13)
REGIONAL FLOOD CONTROL	RF.LAS23J21	1125000294	09/05/2024	none	09/05/2024	($2,311.44)
REGIONAL FLOOD CONTROL	RF.LAS23L23	1125000294	09/05/2024	none	09/05/2024	($55,485.41)
REGIONAL FLOOD CONTROL	RF.LAS25C20	1125000294	09/05/2024	none	09/05/2024	($53,604.84)
REGIONAL FLOOD CONTROL	RF.LAS29D17	1125000294	09/05/2024	none	09/05/2024	($77,040.01)
REGIONAL FLOOD CONTROL	RF.LAS29F20	1125000294	09/05/2024	none	09/05/2024	($33,728.00)
REGIONAL FLOOD CONTROL	RF.LAS30A13	1125000294	09/05/2024	none	09/05/2024	($24,497.86)
REGIONAL FLOOD CONTROL	RF.LAS33A22	1125000294	09/05/2024	none	09/05/2024	($20,224.13)
REGIONAL FLOOD CONTROL	RF.LAU04A08	1125000287	09/04/2024	none	09/04/2024	($24,619.82)
REGIONAL FLOOD CONTROL	RF.LAU04A08	1125000287	09/04/2024	none	09/04/2024	($4,924.17)
REGIONAL FLOOD CONTROL	RF.MOA03B21	1125000294	09/05/2024	none	09/05/2024	($9,153.23)
REGIONAL FLOOD CONTROL	RF.MOA03B21	1125000312	09/09/2024	none	09/09/2024	($567,493.29)
REGIONAL FLOOD CONTROL	RF.MOA03B21	1125000412	09/19/2024	none	09/19/2024	($881,265.96)
REGIONAL FLOOD CONTROL	RF.MES01F24	1125000287	09/04/2024	none	09/04/2024	($12,514.63)
REGIONAL FLOOD CONTROL	RF.LAS24N21	1125000294	09/05/2024	none	09/05/2024	($27,569.00)
			Fiscal Year Total			**$2,676,478.16**
			Fund Total			**$4,760,488.78**

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

ENTITY: Boulder City

BOU01C10
Hemenway System, Phase II Improvements **Original Funding Date 02/11/2010**
Interlocal Amount $935,500.00 **Expiration Date 01/14/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$783,632.00	$767,346.41	$16,285.59
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$15,000.00	$7,726.67	$7,273.33
Entity Costs	$15,003.00	$2,208.84	$12,794.16
Other	$121,865.00	$120,295.96	$1,569.04
Total	$935,500.00	$897,577.88	$37,922.12

BOU01D17
Hemenway System, Phase IIA Improvements **Original Funding Date 02/09/2017**
Interlocal Amount $2,495,000.00 **Expiration Date 02/09/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$2,200,000.00	$2,097,672.44	$102,327.56
Const Engineering	$295,000.00	$289,453.97	$5,546.03
Environmental	$0.00	$0.00	$0.00
Entity Costs	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$2,495,000.00	$2,387,126.41	$107,873.59

BOU02B22
Avenue I Storm Drain Improvements **Original Funding Date 07/14/2022**
Interlocal Amount $863,498.10 **Expiration Date 06/30/2027**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$838,498.10	$425,672.50	$412,825.60
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$25,000.00	$4,388.95	$20,611.05
Other	$0.00	$0.00	$0.00
Total	$863,498.10	$430,061.45	$433,436.65

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

BOU05N22
Wells Drive Levee Lining **Original Funding Date 07/14/2022**
Interlocal Amount $156,345.90 **Expiration Date 06/30/2027**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$149,345.90	$58,343.96	$91,001.94
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$7,000.00	$2,171.36	$4,828.64
Other	$0.00	$0.00	$0.00
Total	$156,345.90	$60,515.32	$95,830.58

ENTITY: Clark County

CLA01F21
Flamingo, Cimarron Branch-Russell Rd to Patrick Lane **Original Funding Date 08/12/2021**
Interlocal Amount $620,000.00 **Expiration Date 06/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$4,500.00	$4,400.00	$100.00
Pre-Design	$0.00	$0.00	$0.00
Design	$502,500.00	$434,443.49	$68,056.51
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$43,000.00	$42,939.27	$60.73
Entity Costs	$60,000.00	$53,288.26	$6,711.74
Other	$10,000.00	$1,035.15	$8,964.85
Total	$620,000.00	$536,106.17	$83,893.83

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

CLA03I23
Van Buskirk – Paradise Detention Basin **Original Funding Date 05/18/2023**
Interlocal Amount $4,061,885.00 **Expiration Date 06/30/2028**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$4,061,885.00	$0.00	$4,061,885.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$4,061,885.00	$0.00	$4,061,885.00

CLA04Y19
Flamingo Wash, Maryland Pkwy to Palos Verdes Street **Original Funding Date 04/11/2019**
Interlocal Amount $680,000.00 **Expiration Date 06/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$560,000.00	$463,744.41	$96,255.59
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$40,000.00	$22,520.41	$17,479.59
Entity Costs	$50,000.00	$40,384.36	$9,615.64
Other	$30,000.00	$0.00	$30,000.00
Total	$680,000.00	$526,649.18	$153,350.82

CLA04Z23
Flamingo Wash, Maryland Pkwy to Cambridge Street **Original Funding Date 05/18/2023**
Interlocal Amount $15,114,000.00 **Expiration Date 06/30/2028**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$13,711,000.00	$0.00	$13,711,000.00
Const Engineering	$1,125,180.00	$0.00	$1,125,180.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$277,820.00	$0.00	$277,820.00
Other	$0.00	$0.00	$0.00
Total	$15,114,000.00	$0.00	$15,114,000.00

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

CLA08S13
Silverado Ranch Detention Basin and Outfall Facilities **Original Funding Date 09/12/2013**
Interlocal Amount $1,593,400.00 **Expiration Date 12/31/2024**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$28,000.00	$26,742.17	$1,257.83
Pre-Design	$0.00	$0.00	$0.00
Design	$1,414,000.00	$1,412,972.81	$1,027.19
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$41,000.00	$39,858.06	$1,141.94
Entity Costs	$50,000.00	$17,923.44	$32,076.56
Other	$60,400.00	$17,923.44	$42,476.56
Total	$1,593,400.00	$1,515,419.92	$77,980.08

CLA10F10
Flamingo Wash, UPRR to Hotel Rio Drive **Original Funding Date 04/08/2010**
Interlocal Amount $506,000.00 **Expiration Date 06/30/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$60,500.00	$6,574.40	$53,925.60
Pre-Design	$0.00	$0.00	$0.00
Design	$342,000.00	$292,153.63	$49,846.37
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$3,500.00	$2,618.17	$881.83
Entity Costs	$40,000.00	$11,190.26	$28,809.74
Other	$60,000.00	$0.00	$60,000.00
Total	$506,000.00	$312,536.46	$193,463.54

CLA10H13
Airport Channel - Naples **Original Funding Date 09/12/2013**
Interlocal Amount $2,060,000.00 **Expiration Date 06/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$2,000.00	$1,388.00	$612.00
Pre-Design	$0.00	$0.00	$0.00
Design	$1,989,640.00	$1,838,282.03	$151,357.97
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$37,000.00	$27,782.00	$9,218.00
Entity Costs	$31,360.00	$29,298.64	$2,061.36
Other	$0.00	$0.00	$0.00
Total	$2,060,000.00	$1,896,750.67	$163,249.33

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

CLA10I19
Wagon Trail Chnl, Sunset Rd to Teco Avenue **Original Funding Date 04/11/2019**
Interlocal Amount $368,800.00 **Expiration Date 06/30/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$50,000.00	$8,581.30	$41,418.70
Pre-Design	$0.00	$0.00	$0.00
Design	$253,800.00	$248,941.58	$4,858.42
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$15,000.00	$8,689.41	$6,310.59
Entity Costs	$50,000.00	$37,547.15	$12,452.85
Other	$0.00	$0.00	$0.00
Total	$368,800.00	$303,759.44	$65,040.56

CLA10J21
Wagon Trail Chnl-Sunset Rd to Teco Ave **Original Funding Date 06/10/2021**
Interlocal Amount $2,950,008.00 **Expiration Date 06/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$2,650,008.00	$2,357,964.82	$292,043.18
Const Engineering	$250,000.00	$17,636.25	$232,363.75
Environmental	$0.00	$0.00	$0.00
Entity Costs	$50,000.00	$0.00	$50,000.00
Other	$0.00	$0.00	$0.00
Total	$2,950,008.00	$2,375,601.07	$574,406.93

CLA10K22
Harry Reid Airport Peaking Basin - East Outfall **Original Funding Date 08/11/2022**
Interlocal Amount $7,989,465.00 **Expiration Date 06/30/2027**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$7,031,075.00	$7,026,075.26	$4,999.74
Const Engineering	$888,390.00	$709,557.28	$178,832.72
Environmental	$0.00	$0.00	$0.00
Entity Costs	$70,000.00	$57,478.74	$12,521.26
Other	$0.00	$0.00	$0.00
Total	$7,989,465.00	$7,793,111.28	$196,353.72

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

CLA14X21
Sunset Park-Duck Creek Wash to Eastern Avenue **Original Funding Date 08/12/2021**
Interlocal Amount $2,130,000.00 **Expiration Date 06/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$2,040,000.00	$539,729.55	$1,500,270.45
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$90,000.00	$34,932.89	$55,067.11
Other	$0.00	$0.00	$0.00
Total	$2,130,000.00	$574,662.44	$1,555,337.56

CLA16O19
Blue Diamond Wash, Arville Street to I-15 **Original Funding Date 04/11/2019**
Interlocal Amount $650,000.00 **Expiration Date 06/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$35,000.00	$13,454.25	$21,545.75
Pre-Design	$0.00	$0.00	$0.00
Design	$537,300.00	$512,756.61	$24,543.39
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$27,700.00	$20,907.65	$6,792.35
Entity Costs	$30,000.00	$28,335.64	$1,664.36
Other	$20,000.00	$0.00	$20,000.00
Total	$650,000.00	$575,454.15	$74,545.85

CLA16P21
Blue Diamond Channel, Amigo to Haven **Original Funding Date 04/08/2021**
Interlocal Amount $1,881,254.00 **Expiration Date 06/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$1,075,010.00	$0.00	$1,075,010.00
Pre-Design	$0.00	$0.00	$0.00
Design	$726,244.00	$0.00	$726,244.00
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$40,000.00	$1,634.49	$38,365.51
Other	$40,000.00	$0.00	$40,000.00
Total	$1,881,254.00	$1,634.49	$1,879,619.51

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

CLA16Q21
Blue Diamond Wash, Arville Street to I-15 **Original Funding Date 11/18/2021**
Interlocal Amount $8,171,346.00 **Expiration Date 06/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$7,405,769.00	$6,682,569.80	$723,199.20
Const Engineering	$715,577.00	$66,020.00	$649,557.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$50,000.00	$0.00	$50,000.00
Other	$0.00	$0.00	$0.00
Total	$8,171,346.00	$6,748,589.80	$1,422,756.20

CLA21A00
Orchard Detention Basin **Original Funding Date 07/13/2000**
Interlocal Amount $5,049,700.00 **Expiration Date 06/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$3,320,200.00	$1,546,913.71	$1,773,286.29
Pre-Design	$0.00	$0.00	$0.00
Design	$1,300,800.00	$1,201,248.96	$99,551.04
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$301,900.00	$204,945.09	$96,954.91
Entity Costs	$100,000.00	$0.00	$100,000.00
Other	$26,800.00	$20,081.83	$6,718.17
Total	$5,049,700.00	$2,973,189.59	$2,076,510.41

CLA35B23
Tropicana Avenue Conveyance - LV Wash to Andover Drive **Original Funding Date 08/10/2023**
Interlocal Amount $1,670,000.00 **Expiration Date 06/30/2028**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$116,000.00	$45,248.42	$70,751.58
Pre-Design	$0.00	$0.00	$0.00
Design	$1,209,000.00	$158,515.05	$1,050,484.95
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$100,000.00	$60,500.00	$39,500.00
Entity Costs	$145,000.00	$0.00	$145,000.00
Other	$100,000.00	$0.00	$100,000.00
Total	$1,670,000.00	$264,263.47	$1,405,736.53

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

CLA36A18
Jim McGaughey DB, Collection Basin and Outfall **Original Funding Date 06/14/2018**
Interlocal Amount $4,432,870.00 **Expiration Date 06/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$2,500,000.00	$712,882.69	$1,787,117.31
Pre-Design	$0.00	$0.00	$0.00
Design	$1,882,870.00	$1,675,563.80	$207,306.20
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$50,000.00	$36,451.31	$13,548.69
Other	$0.00	$0.00	$0.00
Total	$4,432,870.00	$2,424,897.80	$2,007,972.20

CLA36B23
Jim McGaughey DB, Collection and Outfall **Original Funding Date 07/13/2023**
Interlocal Amount $26,154,327.00 **Expiration Date 06/30/2028**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$23,701,380.00	$474,810.40	$23,226,569.60
Const Engineering	$2,093,124.00	$170,123.50	$1,923,000.50
Environmental	$0.00	$0.00	$0.00
Entity Costs	$359,823.00	$0.00	$359,823.00
Other	$0.00	$0.00	$0.00
Total	$26,154,327.00	$644,933.90	$25,509,393.10

CLA38E20
Duck Creek - Jones Boulevard Storm Drain **Original Funding Date 05/21/2020**
Interlocal Amount $3,650,769.00 **Expiration Date 06/30/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$3,328,864.00	$3,114,515.49	$214,348.51
Const Engineering	$271,905.00	$12,562.20	$259,342.80
Environmental	$0.00	$0.00	$0.00
Entity Costs	$50,000.00	$45,836.01	$4,163.99
Other	$0.00	$0.00	$0.00
Total	$3,650,769.00	$3,172,913.70	$477,855.30

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

CLA38F20
Blue Diamond Channel 02, Decatur-Le Baron to Richmar Phase 1 — **Original Funding Date 08/13/2020**
Interlocal Amount $2,004,641.00 — **Expiration Date 06/30/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$1,780,000.00	$1,727,109.71	$52,890.29
Const Engineering	$184,641.00	$180,399.43	$4,241.57
Environmental	$0.00	$0.00	$0.00
Entity Costs	$40,000.00	$0.00	$40,000.00
Other	$0.00	$0.00	$0.00
Total	$2,004,641.00	$1,907,509.14	$97,131.86

CLA38G20
Blue Diamond Railroad Channel — **Original Funding Date 10/08/2020**
Interlocal Amount $1,637,520.00 — **Expiration Date 06/30/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$701,120.00	$32,380.00	$668,740.00
Pre-Design	$0.00	$0.00	$0.00
Design	$876,400.00	$509,896.34	$366,503.66
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$30,000.00	$0.00	$30,000.00
Entity Costs	$30,000.00	$24,267.88	$5,732.12
Other	$0.00	$0.00	$0.00
Total	$1,637,520.00	$566,544.22	$1,070,975.78

CLA39A19
Duck Creek/Blue Diamond, Bermuda Rd to LV Blvd — **Original Funding Date 04/11/2019**
Interlocal Amount $1,753,000.00 — **Expiration Date 06/30/2027**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$18,000.00	$4,602.48	$13,397.52
Pre-Design	$0.00	$0.00	$0.00
Design	$1,628,000.00	$640,636.91	$987,363.09
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$31,000.00	$19,166.58	$11,833.42
Entity Costs	$30,000.00	$27,333.19	$2,666.81
Other	$46,000.00	$1,491.94	$44,508.06
Total	$1,753,000.00	$693,231.10	$1,059,768.90

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

CLA40A21
LVW-Branch 02-Monson Chnl-Jimmy Durante to Boulder Highway **Original Funding Date 04/08/2021**
Interlocal Amount $1,150,000.00 **Expiration Date 06/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$5,000.00	$0.00	$5,000.00
Pre-Design	$0.00	$0.00	$0.00
Design	$1,036,000.00	$702,909.24	$333,090.76
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$49,000.00	$22,576.67	$26,423.33
Entity Costs	$60,000.00	$36,609.61	$23,390.39
Other	$0.00	$0.00	$0.00
Total	$1,150,000.00	$762,095.52	$387,904.48

CLA41A24
Sloan Chnl E Branch, LV Blvd to Valmark Drive **Original Funding Date 05/23/2024**
Interlocal Amount $412,000.00 **Expiration Date 06/30/2028**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$365,000.00	$0.00	$365,000.00
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$27,000.00	$0.00	$27,000.00
Entity Costs	$20,000.00	$0.00	$20,000.00
Other	$0.00	$0.00	$0.00
Total	$412,000.00	$0.00	$412,000.00

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

ENTITY: Clark County Outlying

BUN01D11
Windmill Wash DB Exp & Jess Waite Levee Facilities **Original Funding Date 02/10/2011**
Interlocal Amount $1,430,000.00 **Expiration Date 06/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$41,000.00	$40,023.59	$976.41
Pre-Design	$0.00	$0.00	$0.00
Design	$1,156,000.00	$878,099.06	$277,900.94
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$179,000.00	$176,298.63	$2,701.37
Entity Costs	$50,000.00	$38,295.29	$11,704.71
Other	$4,000.00	$0.00	$4,000.00
Total	$1,430,000.00	$1,132,716.57	$297,283.43

GSP01B10
Goodsprings - Phase I **Original Funding Date 03/11/2010**
Interlocal Amount $133,400.00 **Expiration Date 06/30/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$57,500.00	$50,866.23	$6,633.77
Pre-Design	$0.00	$0.00	$0.00
Design	$75,400.00	$70,240.51	$5,159.49
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$500.00	$0.00	$500.00
Entity Costs	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$133,400.00	$121,106.74	$12,293.26

LAU04A08
SR 163 at Casino Drive **Original Funding Date 10/09/2008**
Interlocal Amount $898,500.00 **Expiration Date 06/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$3,926.29	$3,926.29	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$769,073.71	$731,098.51	$37,975.20
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$125,500.00	$125,459.24	$40.76
Entity Costs	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$898,500.00	$860,484.04	$38,015.96

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

LAU04C24
SR 163 Phase 2 - Sediment Basin - Original **Original Funding Date 08/08/2024**
Interlocal Amount $1,860,670.00 **Expiration Date 06/30/2029**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$1,715,670.00	$0.00	$1,715,670.00
Const Engineering	$105,000.00	$0.00	$105,000.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$40,000.00	$0.00	$40,000.00
Other	$0.00	$0.00	$0.00
Total	$1,860,670.00	$0.00	$1,860,670.00

LAU05A23
Thomas Edison Detention Basin, Collection and Outfall **Original Funding Date 11/09/2023**
Interlocal Amount $963,205.00 **Expiration Date 06/30/2028**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$50,000.00	$0.00	$50,000.00
Pre-Design	$0.00	$0.00	$0.00
Design	$863,205.00	$0.00	$863,205.00
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$50,000.00	$0.00	$50,000.00
Other	$0.00	$0.00	$0.00
Total	$963,205.00	$0.00	$963,205.00

MOA03A11
Fairgrounds Detention Basin and Outfall **Original Funding Date 02/10/2011**
Interlocal Amount $1,231,500.00 **Expiration Date 06/30/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$95,000.00	$64,978.05	$30,021.95
Pre-Design	$0.00	$0.00	$0.00
Design	$847,000.00	$778,896.40	$68,103.60
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$172,500.00	$156,487.46	$16,012.54
Entity Costs	$100,000.00	$90,626.70	$9,373.30
Other	$17,000.00	$11,929.36	$5,070.64
Total	$1,231,500.00	$1,102,917.97	$128,582.03

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

MOA03B21
Fairgrounds DB and Outfall **Original Funding Date 06/10/2021**
Interlocal Amount $27,072,873.00 **Expiration Date 06/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$24,729,550.00	$19,453,461.90	$5,276,088.10
Const Engineering	$2,093,323.00	$2,050,584.41	$42,738.59
Environmental	$0.00	$0.00	$0.00
Entity Costs	$250,000.00	$0.00	$250,000.00
Other	$0.00	$0.00	$0.00
Total	$27,072,873.00	$21,504,046.31	$5,568,826.69

SEA02B19
Searchlight West - State Highway 164 **Original Funding Date 10/10/2019**
Interlocal Amount $990,500.00 **Expiration Date 06/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$18,000.00	$700.00	$17,300.00
Pre-Design	$0.00	$0.00	$0.00
Design	$972,500.00	$692,546.73	$279,953.27
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$990,500.00	$693,246.73	$297,253.27

ENTITY: Henderson

HEN04R23
Cadiz Storm Drain - Racetrack to Pueblo **Original Funding Date 09/14/2023**
Interlocal Amount $625,000.00 **Expiration Date 12/31/2027**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$41,380.00	$39,923.20	$1,456.80
Pre-Design	$0.00	$0.00	$0.00
Design	$482,880.00	$135,761.28	$347,118.72
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$30,000.00	$0.00	$30,000.00
Entity Costs	$35,000.00	$18,445.04	$16,554.96
Other	$35,740.00	$0.00	$35,740.00
Total	$625,000.00	$194,129.52	$430,870.48

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

HEN07F18
Whitney Ranch Channel Replacement Project **Original Funding Date 08/09/2018**
Interlocal Amount $931,138.61 **Expiration Date 12/31/2024**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$48,232.75	$48,232.75	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$672,500.07	$672,500.07	$0.00
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$114,163.50	$114,163.50	$0.00
Entity Costs	$0.00	$0.00	$0.00
Other	$96,242.29	$96,242.29	$0.00
Total	$931,138.61	$931,138.61	$0.00

HEN12K19
Pittman - Sunset, Galleria to Foster **Original Funding Date 12/12/2019**
Interlocal Amount $909,973.00 **Expiration Date 12/31/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$18,424.00	$3,070.73	$15,353.27
Pre-Design	$0.00	$0.00	$0.00
Design	$704,028.00	$673,445.63	$30,582.37
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$58,210.00	$53,796.82	$4,413.18
Entity Costs	$113,659.00	$77,714.34	$35,944.66
Other	$15,652.00	$0.00	$15,652.00
Total	$909,973.00	$808,027.52	$101,945.48

HEN12M24
Pittman Sunset-Burns to Foster, Ph 2 - Boulder Highway Crossing **Original Funding Date 04/11/2024**
Interlocal Amount $8,534,521.00 **Expiration Date 12/31/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$7,795,341.00	$0.00	$7,795,341.00
Const Engineering	$665,262.00	$5,490.32	$659,771.68
Environmental	$0.00	$0.00	$0.00
Entity Costs	$73,918.00	$0.00	$73,918.00
Other	$0.00	$0.00	$0.00
Total	$8,534,521.00	$5,490.32	$8,529,030.68

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

HEN25C23
Pittman Pabco Boulder Highway, Water St to Lake Mead Pkwy — **Original Funding Date 07/13/2023**
Interlocal Amount $266,623.00 — **Expiration Date 06/30/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$236,623.00	$195,653.83	$40,969.17
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$30,000.00	$6,103.40	$23,896.60
Other	$0.00	$0.00	$0.00
Total	$266,623.00	$201,757.23	$64,865.77

HEN25D24
Pittman-Pabco, Water St to Lake Mead Pkwy — **Original Funding Date 04/11/2024**
Interlocal Amount $8,751,898.00 — **Expiration Date 12/31/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$7,993,890.00	$0.00	$7,993,890.00
Const Engineering	$682,207.00	$5,490.32	$676,716.68
Environmental	$0.00	$0.00	$0.00
Entity Costs	$75,801.00	$0.00	$75,801.00
Other	$0.00	$0.00	$0.00
Total	$8,751,898.00	$5,490.32	$8,746,407.68

HLD15B22
Blackridge Rd SD System at Fairway Rd — **Original Funding Date 07/12/2022**
Interlocal Amount $500,000.00 — **Expiration Date 12/31/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$500,000.00	$0.00	$500,000.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$500,000.00	$0.00	$500,000.00

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

ENTITY: Las Vegas

LAS04F22
Meadows/Charleston-Via Olivero, Montessouri to Buffalo
Interlocal Amount $1,129,000.00

Original Funding Date 01/13/2022
Expiration Date 01/30/2027

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$2,000.00	$0.00	$2,000.00
Pre-Design	$0.00	$0.00	$0.00
Design	$1,025,000.00	$727,974.64	$297,025.36
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$2,000.00	$0.00	$2,000.00
Entity Costs	$100,000.00	$64,996.53	$35,003.47
Other	$0.00	$0.00	$0.00
Total	$1,129,000.00	$792,971.17	$336,028.83

LAS05L20
Meadows-Charleston SD, Essex to Lindell
Interlocal Amount $817,308.00

Original Funding Date 07/09/2020
Expiration Date 06/30/2026

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$2,000.00	$0.00	$2,000.00
Pre-Design	$0.00	$0.00	$0.00
Design	$713,308.00	$571,264.92	$142,043.08
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$2,000.00	$0.00	$2,000.00
Entity Costs	$100,000.00	$99,935.34	$64.66
Other	$0.00	$0.00	$0.00
Total	$817,308.00	$671,200.26	$146,107.74

LAS05M20
Meadows Detention Basin Upgrade
Interlocal Amount $263,063.00

Original Funding Date 07/09/2020
Expiration Date 06/30/2026

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$2,000.00	$0.00	$2,000.00
Pre-Design	$0.00	$0.00	$0.00
Design	$239,063.00	$0.00	$239,063.00
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$2,000.00	$0.00	$2,000.00
Entity Costs	$20,000.00	$10,462.74	$9,537.26
Other	$0.00	$0.00	$0.00
Total	$263,063.00	$10,462.74	$252,600.26

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

LAS05N22
Meadows-Charleston Storm Drain, Essex to Lindell **Original Funding Date 04/14/2022**
Interlocal Amount $23,579,393.00 **Expiration Date 06/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$22,619,393.00	$266,064.39	$22,353,328.61
Const Engineering	$860,000.00	$0.00	$860,000.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$100,000.00	$2,194.58	$97,805.42
Other	$0.00	$0.00	$0.00
Total	$23,579,393.00	$268,258.97	$23,311,134.03

LAS19E20
Owens Ave System-Vegas SD, Shadow Mtn to Jones **Original Funding Date 07/09/2020**
Interlocal Amount $854,000.00 **Expiration Date 06/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$2,000.00	$0.00	$2,000.00
Pre-Design	$0.00	$0.00	$0.00
Design	$750,000.00	$567,607.39	$182,392.61
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$2,000.00	$0.00	$2,000.00
Entity Costs	$100,000.00	$81,374.82	$18,625.18
Other	$0.00	$0.00	$0.00
Total	$854,000.00	$648,982.21	$205,017.79

LAS22U19
Brent Drainage System-Durango to OHare Ave **Original Funding Date 07/11/2019**
Interlocal Amount $1,100,000.00 **Expiration Date 06/30/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$2,000.00	$0.00	$2,000.00
Pre-Design	$0.00	$0.00	$0.00
Design	$1,096,000.00	$884,497.90	$211,502.10
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$2,000.00	$0.00	$2,000.00
Entity Costs	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$1,100,000.00	$884,497.90	$215,502.10

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

LAS23J21
Centennial Pkwy Channel West-Farm Rd, Oso Blanca to TeePee **Original Funding Date 05/20/2021**
Interlocal Amount $953,903.00 **Expiration Date 05/31/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$2,000.00	$0.00	$2,000.00
Pre-Design	$0.00	$0.00	$0.00
Design	$799,903.00	$570,065.97	$229,837.03
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$2,000.00	$0.00	$2,000.00
Entity Costs	$150,000.00	$60,728.11	$89,271.89
Other	$0.00	$0.00	$0.00
Total	$953,903.00	$630,794.08	$323,108.92

LAS23L23
Centennial Pkwy Channel West – Farm Rd, Tee Pee to Hualapai **Original Funding Date 12/14/2023**
Interlocal Amount $982,789.04 **Expiration Date 12/31/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$2,000.00	$0.00	$2,000.00
Pre-Design	$0.00	$0.00	$0.00
Design	$828,789.04	$160,437.27	$668,351.77
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$2,000.00	$0.00	$2,000.00
Entity Costs	$150,000.00	$3,576.38	$146,423.62
Other	$0.00	$0.00	$0.00
Total	$982,789.04	$164,013.65	$818,775.39

LAS25C20
Las Vegas Wash - Stewart, Las Vegas Wash to Mojave Rd. **Original Funding Date 09/10/2020**
Interlocal Amount $3,839,927.00 **Expiration Date 09/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$650,000.00	$381,580.20	$268,419.80
Pre-Design	$0.00	$0.00	$0.00
Design	$2,845,927.00	$871,777.83	$1,974,149.17
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$4,000.00	$0.00	$4,000.00
Entity Costs	$340,000.00	$37,179.65	$302,820.35
Other	$0.00	$0.00	$0.00
Total	$3,839,927.00	$1,290,537.68	$2,549,389.32

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

LAS29C16
Flamingo-Maryland-Bldr, Maryland Pky Sys **Original Funding Date 09/08/2016**
Interlocal Amount $2,888,829.00 **Expiration Date 06/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$400.00	$0.00	$400.00
Pre-Design	$0.00	$0.00	$0.00
Design	$2,790,475.00	$2,757,657.79	$32,817.21
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$6,000.00	$0.00	$6,000.00
Entity Costs	$91,954.00	$57,035.95	$34,918.05
Other	$0.00	$0.00	$0.00
Total	$2,888,829.00	$2,814,693.74	$74,135.26

LAS29D17
Flamingo-Boulder Hwy North, Charleston, Main to Maryland **Original Funding Date 08/10/2017**
Interlocal Amount $2,129,674.00 **Expiration Date 06/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$2,000.00	$1,023.58	$976.42
Pre-Design	$0.00	$0.00	$0.00
Design	$1,740,674.00	$1,390,161.49	$350,512.51
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$2,000.00	$0.00	$2,000.00
Entity Costs	$385,000.00	$88,631.11	$296,368.89
Other	$0.00	$0.00	$0.00
Total	$2,129,674.00	$1,479,816.18	$649,857.82

LAS29F20
Flamingo-Boulder Hwy N Charleston-Maryland Pkwy System **Original Funding Date 05/21/2020**
Interlocal Amount $44,039,173.00 **Expiration Date 01/31/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$41,000,000.00	$38,429,156.74	$2,570,843.26
Const Engineering	$1,752,160.00	$896,620.57	$855,539.43
Environmental	$0.00	$0.00	$0.00
Entity Costs	$1,287,013.00	$738,349.87	$548,663.13
Other	$0.00	$0.00	$0.00
Total	$44,039,173.00	$40,064,127.18	$3,975,045.82

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

LAS29G23
Flamingo–Boulder Hwy N, Charleston–Main St to Maryland Pkwy **Original Funding Date 11/09/2023**
Interlocal Amount $35,745,716.00 **Expiration Date 10/31/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$33,220,295.00	$0.00	$33,220,295.00
Const Engineering	$2,325,421.00	$0.00	$2,325,421.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$200,000.00	$0.00	$200,000.00
Other	$0.00	$0.00	$0.00
Total	$35,745,716.00	$0.00	$35,745,716.00

LAS30A13
Gowan - Alexander Road, Decatur Boulevard to Torrey Pines Drive **Original Funding Date 07/11/2013**
Interlocal Amount $1,731,938.00 **Expiration Date 06/30/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$3,000.00	$0.00	$3,000.00
Pre-Design	$0.00	$0.00	$0.00
Design	$1,696,938.00	$801,271.49	$895,666.51
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$2,000.00	$0.00	$2,000.00
Entity Costs	$30,000.00	$0.00	$30,000.00
Other	$0.00	$0.00	$0.00
Total	$1,731,938.00	$801,271.49	$930,666.51

LAS32A21
LVW - Iron Mountain, Bradley to Decatur **Original Funding Date 05/20/2021**
Interlocal Amount $302,000.00 **Expiration Date 05/31/2027**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$2,000.00	$255.11	$1,744.89
Pre-Design	$0.00	$0.00	$0.00
Design	$248,000.00	$139,536.71	$108,463.29
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$2,000.00	$0.00	$2,000.00
Entity Costs	$50,000.00	$43,568.82	$6,431.18
Other	$0.00	$0.00	$0.00
Total	$302,000.00	$183,360.64	$118,639.36

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

LAS33A22
Owens Avenue East - LV Wash to Eastern **Original Funding Date 03/10/2022**
Interlocal Amount $2,332,191.00 **Expiration Date 03/31/2027**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$550,000.00	$0.00	$550,000.00
Pre-Design	$0.00	$0.00	$0.00
Design	$1,567,191.00	$490,372.13	$1,076,818.87
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$15,000.00	$0.00	$15,000.00
Entity Costs	$200,000.00	$4,622.46	$195,377.54
Other	$0.00	$0.00	$0.00
Total	$2,332,191.00	$494,994.59	$1,837,196.41

LLD31A22
El Capitan SD - Moccasin Rd to Ruston Rd **Original Funding Date 07/14/2022**
Interlocal Amount $1,200,000.00 **Expiration Date 06/30/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$1,200,000.00	$0.00	$1,200,000.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$1,200,000.00	$0.00	$1,200,000.00

ENTITY: Mesquite

MES01E17
Town Wash-Mesa Boulevard, El Dorado to Town Wash **Original Funding Date 09/14/2017**
Interlocal Amount $670,197.75 **Expiration Date 06/30/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$32,600.00	$32,600.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$551,624.00	$551,624.00	$0.00
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$85,973.75	$85,973.75	$0.00
Entity Costs	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$670,197.75	$670,197.75	$0.00

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

MES04A15
Virgin River Flood Wall **Original Funding Date 11/12/2015**
Interlocal Amount $1,433,903.00 **Expiration Date 07/30/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$18,680.00	$0.00	$18,680.00
Pre-Design	$208,278.00	$207,278.00	$1,000.00
Design	$886,060.00	$886,060.00	$0.00
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$157,630.00	$25,803.21	$131,826.79
Entity Costs	$0.00	$0.00	$0.00
Other	$163,255.00	$0.00	$163,255.00
Total	$1,433,903.00	$1,119,141.21	$314,761.79

ENTITY: North Las Vegas

NLV01K22
North Las Vegas Detention Basin Upgrade **Original Funding Date 04/14/2022**
Interlocal Amount $1,640,000.00 **Expiration Date 12/31/2027**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$50,000.00	$195.36	$49,804.64
Pre-Design	$0.00	$0.00	$0.00
Design	$1,500,000.00	$404,760.55	$1,095,239.45
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$90,000.00	$43,067.18	$46,932.82
Other	$0.00	$0.00	$0.00
Total	$1,640,000.00	$448,023.09	$1,191,976.91

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

NLV04K17
Gowan Outfall, Alexander Rd - Decatur to Simmons Street **Original Funding Date 02/09/2017**
Interlocal Amount $2,306,156.00 **Expiration Date 06/30/2027**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$1,921,156.00	$1,691,978.22	$229,177.78
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$10,000.00	$0.00	$10,000.00
Entity Costs	$375,000.00	$207,865.45	$167,134.55
Other	$0.00	$0.00	$0.00
Total	$2,306,156.00	$1,899,843.67	$406,312.33

NLV09E11
Vandenberg North Detention Basin & Outfall **Original Funding Date 04/14/2011**
Interlocal Amount $1,534,770.00 **Expiration Date 06/30/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$64,673.77	$56,022.24	$8,651.53
Pre-Design	$123,326.23	$123,326.23	$0.00
Design	$1,220,000.00	$1,206,239.22	$13,760.78
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$126,770.00	$121,770.00	$5,000.00
Entity Costs	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$1,534,770.00	$1,507,357.69	$27,412.31

NLV09L24
Range Wash - Beltway Conveyance and Collection System - Pecos **Original Funding Date 01/11/2024**
Interlocal Amount $1,550,000.00 **Expiration Date 12/31/2029**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$50,000.00	$1,897.06	$48,102.94
Pre-Design	$0.00	$0.00	$0.00
Design	$1,400,000.00	$204,293.00	$1,195,707.00
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$100,000.00	$9,794.92	$90,205.08
Other	$0.00	$0.00	$0.00
Total	$1,550,000.00	$215,984.98	$1,334,015.02

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

NLV10L19
Las Vegas Wash Cartier Channel **Original Funding Date 10/10/2019**
Interlocal Amount $1,485,293.00 **Expiration Date 06/30/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$20,000.00	$4,984.18	$15,015.82
Pre-Design	$0.00	$0.00	$0.00
Design	$1,463,293.00	$895,721.18	$567,571.82
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$2,000.00	$0.00	$2,000.00
Entity Costs	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$1,485,293.00	$900,705.36	$584,587.64

NLV10M21
Lake Mead SD, LVW to Civic Center **Original Funding Date 03/11/2021**
Interlocal Amount $1,070,020.00 **Expiration Date 12/31/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$50,000.00	$4,554.96	$45,445.04
Pre-Design	$0.00	$0.00	$0.00
Design	$930,020.00	$895,675.47	$34,344.53
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$90,000.00	$84,972.41	$5,027.59
Other	$0.00	$0.00	$0.00
Total	$1,070,020.00	$985,202.84	$84,817.16

NLV10N24
Las Vegas Wash Cartier Channel Phase 1 - Carey Ave to Lake Mead Blvd **Original Funding Date 09/12/2024**
Interlocal Amount $12,750,000.00 **Expiration Date 06/30/2029**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$12,000,000.00	$0.00	$12,000,000.00
Const Engineering	$650,000.00	$0.00	$650,000.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$100,000.00	$0.00	$100,000.00
Other	$0.00	$0.00	$0.00
Total	$12,750,000.00	$0.00	$12,750,000.00

Current Project Expense Summary

PAY-AS-YOU-GO FUNDED PROJECTS

NLV19A19
Carey-Lake Mead DB Outfall Modification **Original Funding Date 10/10/2019**
Interlocal Amount $205,000.00 **Expiration Date 06/30/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$20,000.00	$5,354.33	$14,645.67
Design	$135,000.00	$104,957.00	$30,043.00
Construction	$0.00	$0.00	$0.00
Const Engineering	$0.00	$0.00	$0.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$50,000.00	$35,087.09	$14,912.91
Other	$0.00	$0.00	$0.00
Total	$205,000.00	$145,398.42	$59,601.58

Pay-As-You-Go Totals

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$9,796,146.81	$3,138,000.95	$6,658,145.86
Pre-Design	$351,604.23	$335,958.56	$15,645.67
Design	$51,562,660.82	$33,485,333.47	$18,077,327.35
Construction	$218,644,120.00	$81,629,400.95	$137,014,719.05
Const Engineering	$14,957,190.00	$4,403,938.25	$10,553,251.75
Environmental	$1,868,347.25	$1,339,982.59	$528,364.66
Entity Costs	$6,748,351.00	$2,395,909.20	$4,352,441.80
Other	$846,954.29	$268,999.97	$577,954.32
Total	$304,775,374.40	$126,997,523.94	$177,777,850.46
Construction Projects = 19		Design / Other Projects = 51	

Current Project Expense Summary

BOND FUNDED PROJECTS

ENTITY: Boulder City

BOU01E19
Hemenway System, Phase IIB Improvements **Original Funding Date 11/14/2019**
Interlocal Amount $5,202,802.00 **Expiration Date 06/30/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$4,464,236.00	$4,460,659.88	$3,576.12
Const Engineering	$715,566.00	$713,173.25	$2,392.75
Environmental	$0.00	$0.00	$0.00
Entity Costs	$23,000.00	$21,960.68	$1,039.32
Other	$0.00	$0.00	$0.00
Total	$5,202,802.00	$5,195,793.81	$7,008.19

ENTITY: Clark County

CLA01G24
Flamingo, Cimarron Branch - Russell Road to Patrick Lane **Original Funding Date 08/08/2024**
Interlocal Amount $8,977,511.00 **Expiration Date 06/30/2029**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$8,212,511.00	$0.00	$8,212,511.00
Const Engineering	$700,000.00	$0.00	$700,000.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$65,000.00	$0.00	$65,000.00
Other	$0.00	$0.00	$0.00
Total	$8,977,511.00	$0.00	$8,977,511.00

Current Project Expense Summary

BOND FUNDED PROJECTS

CLA38B20
Silverado Ranch DB, Collection & Outfall **Original Funding Date 03/12/2020**
Interlocal Amount $19,500,000.00 **Expiration Date 06/30/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$16,620,745.00	$15,753,876.95	$866,868.05
Const Engineering	$2,379,255.00	$1,768,319.04	$610,935.96
Environmental	$0.00	$0.00	$0.00
Entity Costs	$500,000.00	$63,067.24	$436,932.76
Other	$0.00	$0.00	$0.00
Total	$19,500,000.00	$17,585,263.23	$1,914,736.77

ENTITY: Henderson

HEN07G20
Whitney Ranch Channel Replacement **Original Funding Date 11/12/2020**
Interlocal Amount $18,353,248.17 **Expiration Date 12/31/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$18,170,243.59	$17,629,220.52	$541,023.07
Const Engineering	$183,004.58	$173,004.58	$10,000.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$0.00	$0.00	$0.00
Other	$0.00	$0.00	$0.00
Total	$18,353,248.17	$17,802,225.10	$551,023.07

Current Project Expense Summary

BOND FUNDED PROJECTS

ENTITY: Las Vegas

LAS05O24
Meadows Detention Basin Upgrade **Original Funding Date 05/23/2024**
Interlocal Amount $4,340,400.00 **Expiration Date 05/31/2027**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$3,980,400.00	$0.00	$3,980,400.00
Const Engineering	$210,000.00	$0.00	$210,000.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$150,000.00	$0.00	$150,000.00
Other	$0.00	$0.00	$0.00
Total	$4,340,400.00	$0.00	$4,340,400.00

LAS23K23
Centennial Pkwy Chanl W Farm, Oso Blanca - Tee Pee **Original Funding Date 03/09/2023**
Interlocal Amount $9,526,125.00 **Expiration Date 03/01/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$8,809,462.00	$0.00	$8,809,462.00
Const Engineering	$616,663.00	$0.00	$616,663.00
Environmental	$0.00	$0.00	$0.00
Entity Costs	$100,000.00	$0.00	$100,000.00
Other	$0.00	$0.00	$0.00
Total	$9,526,125.00	$0.00	$9,526,125.00

LAS24N21
Gowan North-El Capitan, Ann Rd to Centennial Pkwy **Original Funding Date 10/14/2021**
Interlocal Amount $11,233,750.00 **Expiration Date 12/31/2024**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$10,474,240.00	$9,586,066.40	$888,173.60
Const Engineering	$590,730.00	$495,682.96	$95,047.04
Environmental	$0.00	$0.00	$0.00
Entity Costs	$168,780.00	$116,063.83	$52,716.17
Other	$0.00	$0.00	$0.00
Total	$11,233,750.00	$10,197,813.19	$1,035,936.81

Current Project Expense Summary

BOND FUNDED PROJECTS

ENTITY: Mesquite

MES01F24
Town Wash-Mesa Boulevard, El Dorado to Town Wash **Original Funding Date 03/14/2024**
Interlocal Amount $15,405,844.15 **Expiration Date 12/31/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$14,848,642.15	$0.00	$14,848,642.15
Const Engineering	$487,202.00	$12,514.63	$474,687.37
Environmental	$0.00	$0.00	$0.00
Entity Costs	$70,000.00	$0.00	$70,000.00
Other	$0.00	$0.00	$0.00
Total	$15,405,844.15	$12,514.63	$15,393,329.52

ENTITY: North Las Vegas

NLV04L21
Gowan Outfall-Alexander-Decatur-Simmons,Simmons-Clayton **Original Funding Date 05/20/2021**
Interlocal Amount $45,288,550.00 **Expiration Date 06/30/2026**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$42,483,550.00	$41,025,143.66	$1,458,406.34
Const Engineering	$2,505,000.00	$1,336,683.99	$1,168,316.01
Environmental	$0.00	$0.00	$0.00
Entity Costs	$300,000.00	$177,319.25	$122,680.75
Other	$0.00	$0.00	$0.00
Total	$45,288,550.00	$42,539,146.90	$2,749,403.10

Current Project Expense Summary

BOND FUNDED PROJECTS

NLV09K19
Vandenberg North DB, Collection & Outfall, Phase II **Original Funding Date 08/08/2019**
Interlocal Amount $25,999,000.00 **Expiration Date 06/20/2025**

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$24,004,000.00	$22,545,951.18	$1,458,048.82
Const Engineering	$1,620,000.00	$1,017,943.90	$602,056.10
Environmental	$0.00	$0.00	$0.00
Entity Costs	$375,000.00	$71,081.55	$303,918.45
Other	$0.00	$0.00	$0.00
Total	$25,999,000.00	$23,634,976.63	$2,364,023.37

Bond Totals

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$152,068,029.74	$111,000,918.59	$41,067,111.15
Const Engineering	$10,007,420.58	$5,517,322.35	$4,490,098.23
Environmental	$0.00	$0.00	$0.00
Entity Costs	$1,751,780.00	$449,492.55	$1,302,287.45
Other	$0.00	$0.00	$0.00
Total	$163,827,230.32	$116,967,733.49	$46,859,496.83
Construction Projects = 10		Design / Other Projects = 0	

Capital Improvement Program - Open Projects Summary

Pay-As-You-Go And Bond Totals

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$9,796,146.81	$3,138,000.95	$6,658,145.86
Pre-Design	$351,604.23	$335,958.56	$15,645.67
Design	$51,562,660.82	$33,485,333.47	$18,077,327.35
Construction	$370,712,149.74	$192,630,319.54	$178,081,830.20
Const Engineering	$24,964,610.58	$9,921,260.60	$15,043,349.98
Environmental	$1,868,347.25	$1,339,982.59	$528,364.66
Entity Costs	$8,500,131.00	$2,845,401.75	$5,654,729.25
Other	$846,954.29	$268,999.97	$577,954.32
Total	$468,602,604.72	$243,965,257.43	$224,637,347.29
Construction Projects = 29		Design / Other Projects = 51	

Pay-As-You-Go Totals

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$9,796,146.81	$3,138,000.95	$6,658,145.86
Pre-Design	$351,604.23	$335,958.56	$15,645.67
Design	$51,562,660.82	$33,485,333.47	$18,077,327.35
Construction	$218,644,120.00	$81,629,400.95	$137,014,719.05
Const Engineering	$14,957,190.00	$4,403,938.25	$10,553,251.75
Environmental	$1,868,347.25	$1,339,982.59	$528,364.66
Entity Costs	$6,748,351.00	$2,395,909.20	$4,352,441.80
Other	$846,954.29	$268,999.97	$577,954.32
Total	$304,775,374.40	$126,997,523.94	$177,777,850.46
Construction Projects = 19		Design / Other Projects = 51	

Bond Totals

Category	ILC Funding Allocation	Amount Spent	Total Remaining
Right of Way	$0.00	$0.00	$0.00
Pre-Design	$0.00	$0.00	$0.00
Design	$0.00	$0.00	$0.00
Construction	$152,068,029.74	$111,000,918.59	$41,067,111.15
Const Engineering	$10,007,420.58	$5,517,322.35	$4,490,098.23
Environmental	$0.00	$0.00	$0.00
Entity Costs	$1,751,780.00	$449,492.55	$1,302,287.45
Other	$0.00	$0.00	$0.00
Total	$163,827,230.32	$116,967,733.49	$46,859,496.83
Construction Projects = 10		Design / Other Projects = 0	

Regional Flood Control District
Capital Improvement Projects - Cumulative Reporting
Pay-As-You-Go Funding

Boulder City

PROJECT	NAME	STATUS	TOTAL
BOU01A87	Hemenway Wash	Closed	$4,649,000.00
BOU01B88	Hemenway Wash Debris Basin	Closed	$0.00
BOU01C10	Hemenway System, Phase II Improvements	Open	$935,500.00
BOU01D17	Hemenway System, Phase IIA Improvements	Open	$2,495,000.00
BOU02A88	Georgia Avenue Channel	Closed	$613,590.23
BOU02B22	Avenue I Storm Drain Improvements	Open	$863,498.10
BOU03A88	Buchanan Blvd. Channel	Closed	$412,719.91
BOU03B98	Buchanan Watershed Facilities	Closed	$420,240.41
BOU03C10	Buchanan Blvd., Phase III Improvements	Closed	$344,263.01
BOU03D11	Buchanan Blvd., Phase III Improvements	Closed	$0.00
BOU03E12	Buchanan Blvd., Phase III Improvements	Closed	$4,689,402.24
BOU04A96	West Airport Watershed	Closed	$128,138.69
BOU04B97	West Airport Watershed Construction	Closed	$1,839,686.60
BOU04C01	Hemenway Wash	Closed	$101,580.75
BOU05A98	North Railroad Watershed (Industrial Road Facility)	Closed	$448,873.75
BOU05B00	North Railroad Watershed, Veteran Memorial Dr Culvert	Closed	$129,206.79
BOU05G07	Yucca Street Drainage	Closed	$71,036.09
BOU05H07	Bootleg Canyon Detention Basin Outfall	Closed	$521,408.23
BOU05J10	North Railroad Conveyance	Closed	$509,462.22
BOU05K11	Bootleg Canyon Detention Basin, Phase II	Closed	$829,854.43
BOU05L11	North Railroad Conveyance	Closed	$3,503,502.20
BOU05M18	North Railroad Conveyance, Phase II	Closed	$2,370,058.67
BOU05N22	Wells Drive Levee Lining	Open	$156,345.90
BOU06A99	Ville Drive Flood Control Facilities	Closed	$144,261.08
BOU06B01	Ville Drive Flood Control Facilities	Closed	$747,314.67
			$26,923,943.97

Clark County

PROJECT	NAME	STATUS	TOTAL
CLA01A87	Upper Flamingo Wash Detention Basin & Outfall	Closed	$6,932,932.63
CLA01B04	F4 Patrick Lane/Ft Apache Road Lateral	Closed	$482,000.00
CLA01D07	Flamingo Hacienda	Closed	$4,037,385.53
CLA01F21	Flamingo, Cimarron Branch-Russell Rd to Patrick Lane	Open	$620,000.00
CLA02A88	Rawhide Channel	Closed	$69,932.30
CLA02B90	Rawhide Channel/Eastern Av Drainage Structure	Closed	$155,540.00
CLA02C90	Rawhide Channel/Eastern Outfall	Closed	$115,000.00
CLA02D90	Rawhide Channel/Eastern-Topaz	Closed	$1,069,252.07
CLA02E91	Rawhide Channel/McLeod-Mtn Vista	Closed	$166,990.74
CLA02G99	Rawhide Channel at Sagebrush Street	Closed	$441,753.51
CLA03A88	Van Buskirk Channel - Predesign	Closed	$118,463.30
CLA03B90	Van Buskirk Channel Outfall	Closed	$3,332,227.08
CLA03C90	Van Buskirk Channel - ROW	Closed	($202,889.63)
CLA03D91	Van Buskirk System/Spencer-Rochelle	Closed	$808,963.97
CLA03H93	Van Buskirk Channel / Phases IIA & VI Construction	Closed	$6,112,843.32
CLA03I23	Van Buskirk – Paradise Detention Basin	Open	$4,061,885.00

Regional Flood Control District
Capital Improvement Projects - Cumulative Reporting
Pay-As-You-Go Funding

PROJECT	NAME	STATUS	TOTAL
CLA04A89	Flamingo Wash Bridge @ Eastern	Closed	$61,900.00
CLA04B89	Flamingo Wash Bridge @ Arville	Closed	$294,818.61
CLA04C90	Flamingo Wash Bridge @ Paradise & Palos Verde	Closed	$1,711,276.60
CLA04D93	Flamingo Wash - Winnick Ave. Improvements	Closed	$2,739,120.64
CLA04E99	Flamingo Wash, McLeod Dr to Maryland PKWY	Closed	$2,575,702.59
CLA04F99	Flamingo Wash, I-515 to McLeod Dr	Closed	$1,252,537.43
CLA04G00	Flamingo Wash at Boulder Highway	Closed	$860,102.20
CLA04H00	Flamingo Wash, Boulder Highway to Mojave Rd	Closed	$6,284,809.40
CLA04I01	Flamingo Wash, Spencer Street Bridge & Approach Channel	Closed	$2,436,743.83
CLA04M06	Flamingo - Boulder HWY N, Sahara Ave to Flamingo Wash	Closed	$1,027,029.82
CLA04Q08	Flamingo Wash, Nellis Blvd to I-515	Closed	$995,990.90
CLA04R08	Flamingo Wash, Desert Inn to Eastern Avenue	Closed	$7,869,248.66
CLA04U10	Flamingo-Boulder Highway North, Sahara Ave to Flamingo Wash	Closed	$10,933,404.28
CLA04V10	Flamingo Wash, Nellis Boulevard to I-515	Closed	$11,132,175.16
CLA04Y19	Flamingo Wash, Maryland Pkwy to Palos Verdes Street	Open	$680,000.00
CLA04Z23	Flamingo Wash, Maryland Pkwy to Cambridge Street	Open	$15,114,000.00
CLA05A91	Duck Creek Bridges @ Tomiyasu & La Casita	Closed	$814,243.47
CLA06A91	Range Wash Confluence Detention Basin Facilities	Closed	$479,952.25
CLA07A92	Sloan Channel (Las Vegas Wash to Owens)	Closed	$4,820,788.11
CLA07B01	Sloan Channel, Las Vegas Wash to Charleston	Closed	$340,747.81
CLA08A92	Lower Duck Creek Detention Basin Predesign	Closed	$807,918.53
CLA08B93	Lower Duck Creek DB ROW	Closed	$5,921,794.42
CLA08C98	Lower Duck Creek Detention Basin & Outfall Channel	Closed	($11,828.26)
CLA08D01	Duck Creek, Lower Detention Basin to I-15	Closed	$9,691,844.67
CLA08F03	Duck Creek, Lower Detention Basin to Silverado Ranch Blvd	Closed	$3,717,281.04
CLA08H05	Duck Creek, Railroad Detention Basin	Closed	$673,683.44
CLA08K07	Duck Creek Channel, Silverado Ranch Blvd to Las Vegas Blvd	Closed	$8,698,135.53
CLA08M08	Duck Creek, Railroad Detention Basin	Closed	$13,302,732.94
CLA08Q13	Duck Creek at Dean Martin	Closed	$413,865.28
CLA08R13	Duck Creek, Las Vegas Boulevard	Closed	$414,932.34
CLA08S13	Silverado Ranch Detention Basin and Outfall Facilities	Open	$1,593,400.00
CLA08W16	Duck Creek at Dean Martin	Closed	$3,058,969.76
CLA09A97	Durango Collector (Hacienda to Twain)	Closed	$366,253.18
CLA09B99	Durango Collector (Twain to Hacienda)	Closed	$100,005.00
CLA09C06	Durango Collector (Twain to Hacienda)	Closed	$1,126.53
CLA10A97	Tropicana Wash (Paradise Road to Koval Lane)	Closed	$228,665.56
CLA10D07	Tropicana Wash at Swenson Street	Closed	$1,253,646.20
CLA10F10	Flamingo Wash, UPRR to Hotel Rio Drive	Open	$506,000.00
CLA10G12	Tropicana Wash at Swenson Street	Closed	$7,070,883.06

Regional Flood Control District
Capital Improvement Projects - Cumulative Reporting
Pay-As-You-Go Funding

PROJECT	NAME	STATUS	TOTAL
CLA10H13	Airport Channel - Naples	Open	$2,060,000.00
CLA10I19	Wagon Trail Chnl, Sunset Rd to Teco Avenue	Open	$368,800.00
CLA10J21	Wagon Trail Chnl-Sunset Rd to Teco Ave	Open	$2,950,008.00
CLA10K22	Harry Reid Airport Peaking Basin - East Outfall	Open	$7,989,465.00
CLA12A97	Desert Inn Detention Basin & Collection System	Closed	$346,843.68
CLA12B98	Desert Inn Detention Basin & Collection System/DI Lateral	Closed	$43,197.00
CLA12C99	Desert Inn Detention Basin & Collection System	Closed	$689.01
CLA13A97	Lakes Detention Basin, Collection System, & Outfall	Closed	$531,803.87
CLA13B98	Lakes Detention Basin Collection System & Outfall	Closed	$788,631.74
CLA13C98	Lakes DB Collection System	Closed	$783,619.03
CLA14A97	Duck Creek (Hollywood to Stephanie Street)	Closed	$138,962.97
CLA14B99	Duck Creek Channel (Hollywood Blvd to Stephaine St)--ROWA	Closed	$375,552.00
CLA14C99	Duck Creek, Sunset Road to Eastern Ave	Closed	$560,650.99
CLA14D99	Duck Creek, Hollywood Blvd to Stephanie Street	Closed	$1,651,449.79
CLA14E99	Duck Creek, Stephanie St to Green Valley PKWY	Closed	$321,054.87
CLA14F00	Duck Creek, Emerald Avenue to Stephanie St	Closed	$5,987,176.80
CLA14G00	Duck Creek at Robindale Road	Closed	$1,066,974.02
CLA14H00	Duck Creek,Tomiyasu Lane to Topaz St	Closed	$3,548,160.77
CLA14I02	Duck Creek, US 95 Branch	Closed	$1,107,637.45
CLA14L02	Duck Creek, Phase II and Lower Pittman	Closed	$13,651,024.74
CLA14R04	Duck Creek, Mountain Vista Street to Green Valley PKWY	Closed	$707,824.31
CLA14S07	Duck Creek, Eldorado Lane to Spencer Street	Closed	$6,139,169.42
CLA14U09	Duck Creek, Robindale to I-215	Closed	$23,516.83
CLA14V10	Duck Creek, Mtn. Vista to Green Valley Parkway	Closed	$8,976,052.51
CLA14X21	Sunset Park-Duck Creek Wash to Eastern Avenue	Open	$2,130,000.00
CLA15B99	Colorado Avenue Storm Drain System	Closed	($41,517.92)
CLA15C09	Las Vegas Wash, Sloan Lane to Stewart Ave	Closed	$193,555.23
CLA15D12	LVW Sloan-Bonanza, Flam W below Nellis	Closed	$5,761,059.82
CLA16A98	Upr Duck Ck, Ctrl Duck Ck, Lwr Blue Diamond & Bird Sp/ROW	Closed	$2,226,784.41
CLA16B00	Upr Duck, Ctrl Duck, Lower Blue Dia, & Bird Springs DB	Closed	$1,363,624.69
CLA16F04	Lower Blue Diamond Detention Basin Collector Channel	Closed	$8,060,995.11
CLA16G05	Blue Diamond Wash Wigwam, UPRR to Jones Boulevard	Closed	$535,000.00
CLA16H06	Blue Dia Wash S Rainbow, Pebble - Raven & Wigwam - Ford	Closed	$2,444,155.20
CLA16I07	Lower Blue Diamond Detention Basin Outfall	Closed	$1,694,368.59
CLA16J07	Blue Diamond Wash Wigwam, Jones Blvd to Rainbow	Closed	$357,603.89
CLA16K07	Upper Duck Creek Detention Basin	Closed	$3,000,000.00

Regional Flood Control District
Capital Improvement Projects - Cumulative Reporting
Pay-As-You-Go Funding

PROJECT	NAME	STATUS	TOTAL
CLA16O19	Blue Diamond Wash, Arville Street to I-15	Open	$650,000.00
CLA16P21	Blue Diamond Channel, Amigo to Haven	Open	$1,881,254.00
CLA16Q21	Blue Diamond Wash, Arville Street to I-15	Open	$8,171,346.00
CLA17E04	Blue Diamond Channel, Rainbow Branch	Closed	$1,495,409.16
CLA19A99	Red Rock Channel, Naples Branch	Closed	$1,333,173.93
CLA19C02	Red Rock Channel, Naples Branch - Flamingo Connector	Closed	$674,561.31
CLA20A99	Washington Collection System	Closed	$69,701.68
CLA20B00	Washington Collection System	Closed	$680,964.62
CLA21A00	Orchard Detention Basin	Open	$5,049,700.00
CLA21B12	Orchard Detention Basin	Closed	$4,929,886.35
CLA22A00	Flamingo Diversion - Jones Branch	Closed	$100,001.71
CLA22B03	Flamingo Diversion - Jones Branch	Closed	$1,100,000.00
CLA26C08	Flam Div - South Buffalo Branch, Flamingo Wash to Patrick Lane	Closed	$776,336.79
CLA27C08	Flamingo Diversion - Rainbow Branch	Closed	$980,601.33
CLA28D18	Vandenberg North DB, Collection & Outfall, Phase I	Closed	$3,458,301.61
CLA35A11	Tropicana Avenue Conveyance, LVW to Mtn. Vista	Closed	$249,789.19
CLA35B23	Tropicana Avenue Conveyance - LV Wash to Andover Drive	Open	$1,670,000.00
CLA36A18	Jim McGaughey DB, Collection Basin and Outfall	Open	$4,432,870.00
CLA36B23	Jim McGaughey DB, Collection and Outfall	Open	$26,154,327.00
CLA38C20	Duck Creek Haven Street Storm Drain	Closed	$50,022.18
CLA38D20	Duck Creek Haven Street Storm Drain	Closed	$3,218,407.63
CLA38E20	Duck Creek - Jones Boulevard Storm Drain	Open	$3,650,769.00
CLA38F20	Blue Diamond Channel 02, Decatur-Le Baron to Richmar Phase 1	Open	$2,004,641.00
CLA38G20	Blue Diamond Railroad Channel	Open	$1,637,520.00
CLA39A19	Duck Creek/Blue Diamond, Bermuda Rd to LV Blvd	Open	$1,753,000.00
CLA40A21	LVW-Branch 02-Monson Chnl-Jimmy Durante to Boulder Highway	Open	$1,150,000.00
CLA41A24	Sloan Chnl E Branch, LV Blvd to Valmark Drive	Open	$412,000.00
CLD02A11	Annie Oakley Drive at Rawhide Channel Storm Drain	Closed	$84,203.00
CLD04A08	Twain at Pecos-McLeod Storm Drain	Closed	$442,521.57
CLD07A07	Sunrise Area Storm Drain	Closed	$914,982.31
CLD07B08	Carey Avenue Storm Drain	Closed	$1,351,525.62
CLD07C10	Sunrise Ave. Storm Drain, Fogg St. to Clayton St.	Closed	$154,935.40
CLD07D12	Toiyabe Street Storm Drain	Closed	$0.00
CLD14A10	Tunis Ave and Karvel Street Storm Drain	Closed	$189,391.53
CLD15A09	Olive Street Storm Drain, US-95 to Palm Street	Closed	$800,286.13
CLD17A09	Las Vegas Blvd/Serene Ave Storm Drain	Closed	$133,338.79
CLD19A17	Katie Avenue Storm Drain	Closed	$724,665.88
CLD20A12	Washington/Hollywood Storm Drain	Closed	$259,862.20
CLD97A20	Craig Road SD-El Capitan to Fort Apache	Closed	$1,198,199.50
CLD98A06	Hickam Avenue Storm Drain	Closed	$465,091.07
CLD99A05	Red Coach Ave/Cimarron Rd Improvements	Closed	$388,200.00

Regional Flood Control District
Capital Improvement Projects - Cumulative Reporting
Pay-As-You-Go Funding

$331,241,862.11

Clark County Outlying

PROJECT	NAME	STATUS	TOTAL
BUN01A90	Bunkerville Channel (aka Windmill Channel)	Closed	$817,795.45
BUN01B98	Bunkerville Flood Control Improvements	Closed	$5,734,536.80
BUN01C05	Windmill Wash Outfall	Closed	$2,839,135.00
BUN01D11	Windmill Wash DB Exp & Jess Waite Levee Facilities	Open	$1,430,000.00
GSP01A88	Goodsprings Flood Control Improvements	Closed	$72,275.84
GSP01B10	Goodsprings - Phase I	Open	$133,400.00
IND01A98	Indian Springs Flood Control Improvements	Closed	$579,193.24
LAU01A89	Unnamed Wash, Laughlin	Closed	$349,995.99
LAU02A89	Hiko Springs, Laughlin	Closed	$369,974.40
LAU02B92	Hiko Springs, Laughlin, Remap	Closed	$8,000.00
LAU02D21	Hiko Springs Wash Detention Basin Expansion	Closed	$346,290.59
LAU03A96	Hiko Springs Outfall Channel	Closed	$7,771,291.25
LAU04A08	SR 163 at Casino Drive	Open	$898,500.00
LAU04C24	SR 163 Phase 2 - Sediment Basin - Original	Open	$1,860,670.00
LAU05A23	Thomas Edison Detention Basin, Collection and Outfall	Open	$963,205.00
MOA01A89	Cooper Ave. Crossing - Moapa Valley	Closed	$185,000.00
MOA01B89	Muddy River West Levee, Moapa Valley	Closed	$12,906,432.82
MOA01C06	Muddy River, Gubler Avenue Bridge	Closed	$745,638.67
MOA01D07	Muddy River, Gubler Avenue Bridge	Closed	$5,319,472.98
MOA01E08	Muddy River & Trib - Cooper Ave to Yamashita St	Closed	$966,120.32
MOA01F10	Muddy River Logandale Levee	Closed	$1,749,495.34
MOA01G11	Muddy River, Cooper Street Bridge	Closed	$15,793,908.74
MOA01H15	Muddy River Logandale Levee	Closed	$8,209,488.28
MOA02A89	Logan Wash (aka Benson), Moapa Valley	Closed	$235,040.74
MOA02B92	Logan Wash Construction	Closed	$3,510,528.60
MOA03A11	Fairgrounds Detention Basin and Outfall	Open	$1,231,500.00
MOA03B21	Fairgrounds DB and Outfall	Open	$27,072,873.00
NEL01A88	Nelson Flood Control Improvements	Closed	$2,961.95
SEA01A88	Searchlight Flood Control Improvements	Closed	$861,099.97
SEA01B99	Searchlight Flood Control Improvements	Closed	$5,500.00
SEA02A07	Searchlight - West, US-95	Closed	$162,000.00
SEA02B19	Searchlight West - State Highway 164	Open	$990,500.00
SEA03A09	Searchlight - South, Encinitas St Storm Drain	Closed	$31,272.42
SEA03B17	Searchlight-South, Encinitas St. Storm Drain	Closed	$2,052,208.21
			$106,205,305.60

COE/Clark County

PROJECT	NAME	STATUS	TOTAL
COEESCRO	COE Escrow Account	Closed	$15,126,215.56
COEG194	COE General Project Information	Closed	$97,744.28
COEG294	Tropicana & Flamingo Washes	Closed	$35,882,514.85
COETF	TROPFLAM-Haz Mat	Closed	$280,550.00
			$51,387,024.69

Henderson

PROJECT	NAME	STATUS	TOTAL

Regional Flood Control District
Capital Improvement Projects - Cumulative Reporting
Pay-As-You-Go Funding

PROJECT	NAME	STATUS	TOTAL
HEN01A87	Pittman Wash Channel Design (Phases I, II, III)	Closed	$533,554.14
HEN01B87	Warm Springs & Stephanie Street Bridges	Closed	$1,660,108.81
HEN01C90	Pittman Wash Channel - Phase I Construction	Closed	$2,744,110.10
HEN01F00	Pittman Wash Lower Reach	Closed	$324,343.79
HEN01H09	Pittman Wash, Duck Creek at I-515	Closed	$349,813.57
HEN01I14	Pittman Wash, Duck Creek at I-515	Closed	$2,295,044.97
HEN02A89	Green Valley Parkway Bridge	Closed	$1,128,513.78
HEN03A91	UPRR Channel	Closed	$117,073.57
HEN04A91	C-1 Predesign / Mission Hills Design	Closed	$1,009,074.06
HEN04B93	C-1 Channel / Lake Mead Dr. to Burkholder Design	Closed	$173,333.98
HEN04E96	Mission Hills Western Interceptor Diversion	Closed	$2,636,599.02
HEN04F97	Black Mountain Detention Basin	Closed	$275,048.92
HEN04I98	C-1 Channel (Culvert) at Lake Mead	Closed	$907,210.00
HEN04K99	Upper and Middle Reaches of the C-1 Channel	Closed	$521,871.29
HEN04O09	C-1, Four Kids Wash - Lake Mead to Eagle Rock	Closed	$22,905.46
HEN04P09	Racetrack Channel, Drake to Burkholder	Closed	$76,414.93
HEN04Q15	Racetrack Channel, Drake to Burkholder	Closed	$833,948.46
HEN04R23	Cadiz Storm Drain - Racetrack to Pueblo	Open	$625,000.00
HEN05A92	Sunset D B, Collection Sys, & Outfall (Pioneer DB)	Closed	$3,749,294.23
HEN05C01	Pioneer Detention Basin	Closed	$4,323,566.57
HEN05D09	Pioneer Detention Basin Expansion and Inflow	Closed	$325,840.81
HEN05E09	Pittman, Horizon Ridge Detention Basin	Closed	$785,441.55
HEN06A93	Equestrian Drive Detention Basin	Closed	$388,624.49
HEN06B95	Equestrian Detention Basin	Closed	$6,128,895.08
HEN06C02	Equestrian Detention Basin Outfall	Closed	$681,288.27
HEN06D05	C-1 Equestrian Tributary	Closed	$227,591.57
HEN06F08	C-1 Equestrian Tributary	Closed	$2,711,795.15
HEN06G08	Equestrian Detention Basin Outfall - Heritage Channel	Closed	$4,200,444.03
HEN06H09	Equestrian Detention Basin Expansion	Closed	$335,247.64
HEN06IO9	Equestrian Tributary Phase II	Closed	$405,636.14
HEN07A96	Pittman Park Detention Basin	Closed	$1,546,249.59
HEN07B09	Pittman Wash, UPRR to Santiago	Closed	$843,016.21
HEN07D09	Whitney Wash Channel	Closed	$130,264.67
HEN07E11	Pittman Wash, UPRR to Santiago	Closed	$8,796,470.83
HEN07F18	Whitney Ranch Channel Replacement Project	Open	$931,138.61
HEN08A96	Railroad East Detention Basin	Closed	$6,416,341.47
HEN08B08	Pittman Railroad East Conveyance	Closed	$444,380.89
HEN08C08	Pittman Railroad East Conveyance	Closed	$8,518,517.91
HEN09A99	Pittman East Detention Basin (collapse with HEN09A97)	Closed	$119,918.19
HEN09B00	Pittman Eastern Detention Basin	Closed	$6,099,436.41
HEN09D09	Pittman Seven Hills Park Channel	Closed	$0.00
HEN10B99	South Pittman Detention Basin	Closed	$3,202,101.72
HEN12A99	Gibson Channel at Sunset Road	Closed	$40,125.00
HEN12B01	Gibson Channel Culvert at Sunset Road	Closed	$364,211.76
HEN12C02	Gibson Conveyance System	Closed	$237,718.78

Regional Flood Control District
Capital Improvement Projects - Cumulative Reporting
Pay-As-You-Go Funding

PROJECT	NAME	STATUS	TOTAL
HEN12F05	Pittman Gibson, Warm Springs Road to Kelso Dunes Avenue	Closed	$10,000.00
HEN12GO6	Pittman Wash - Burns	Closed	$4,251,084.08
HEN12H09	Pittman Burns, Sunset to Galleria	Closed	$770,231.86
HEN12I09	Pittman, West Horizon - Palm Hills	Closed	$249,028.80
HEN12K19	Pittman - Sunset, Galleria to Foster	Open	$909,973.00
HEN12L23	Pittman Sunset, Galleria to Sunset	Closed	$0.00
HEN12M24	Pittman Sunset-Burns to Foster, Ph 2 - Boulder Highway Crossing	Open	$8,534,521.00
HEN13A00	Boulder Highway Channel	Closed	$360,070.00
HEN14A00	Pittman Pecos West Conveyance & Eastern Ave Tributary	Closed	$2,355,800.39
HEN14B06	Pittman Pecos West Conveyance & Eastern Ave Tributary	Closed	$6,787,948.72
HEN15A00	Pittman Wash Railroad Channel	Closed	$568,801.51
HEN16A01	Pittman North Detention Basin & Outfall	Closed	$2,250,746.85
HEN16D15	Pittman North Detention Basin and Outfall, Phase 1	Closed	$3,458,916.31
HEN16E15	Pittman North DB & Outfall, Phase II - Starr Avenue	Closed	$1,865,136.31
HEN16F17	Pittman North Detention Basin & Outfall, Phase III	Closed	$24,671,072.17
HEN19B06	Northeast Detention Basin Outfall	Closed	$337,852.88
HEN19C07	Northeast Detention Basin, Levee and Outfall	Closed	$13,366,601.89
HEN21A05	Pittman Railroad, MacDonald Ranch Channel	Closed	$253,025.49
HEN21B08	Pittman Railroad, MacDonald Ranch Channel	Closed	$2,025,749.22
HEN22A09	Anthem Pkwy Channel, Horizon Ridge to Sienna Heights	Closed	$94,222.77
HEN22B21	Anthem Pkwy Chnl-Horizon Ridge to Siena Heights	Closed	$114,258.63
HEN22C22	Anthem Parkway Channel-Horizon Ridge to Siena Heights	Closed	$3,182,814.02
HEN23A09	Center Street Storm Drain	Closed	$564,095.75
HEN24A11	Duck Creek, Sunset to Sandhill	Closed	$535,983.84
HEN24B13	Duck Creek, Sunset to Sandhill	Closed	$3,475,829.83
HEN25B19	Pittman Pabco - Boulder Highway Crossing	Closed	$1,264,160.10
HEN25C23	Pittman Pabco Boulder Highway, Water St to Lake Mead Pkwy	Open	$266,623.00
HEN25D24	Pittman-Pabco, Water St to Lake Mead Pkwy	Open	$8,751,898.00
HLD06B19	Chickasaw Storm Drain	Closed	$2,194,001.32
HLD15A06	Blackridge Road Storm Drain System	Closed	$529,071.04
HLD15B22	Blackridge Rd SD System at Fairway Rd	Open	$500,000.00
			$172,687,045.20

Las Vegas

PROJECT	NAME	STATUS	TOTAL
LAS01A87	Angel Park Detention Basin Outflow Structure	Closed	$397,978.73
LAS01B95	Angel Park Detention Basin Expansion	Closed	$1,356,534.40
LAS01D09	Angel Park North - Detention Basin	Closed	$597,382.00
LAS02A87	Buffalo Channel	Closed	$4,167,183.73
LAS02B91	Buffalo Channel/Summerlin PKWY - Vegas Drive	Closed	$126,491.20
LAS02C91	Buffalo Channel/Westcliff-Summerlin Pkwy	Closed	$471,594.88

Regional Flood Control District
Capital Improvement Projects - Cumulative Reporting
Pay-As-You-Go Funding

PROJECT	NAME	STATUS	TOTAL
LAS02D92	Buffalo Channel/Doe Av.-Westcliff Dr	Closed	$84,175.72
LAS02F93	Buffalo Channel / Doe-Westcliff	Closed	$1,685,430.55
LAS03A89	Gowan Rd Detention System	Closed	$195,685.16
LAS03B89	Gowan Detention Basin & Outfall	Closed	$4,813,519.80
LAS03D98	Gowan South Detention Basin Expansion	Closed	$126,398.42
LAS03E00	Gowan South DB Expansion	Closed	$2,609,639.23
LAS04A87	Oakey Boulevard System	Closed	$111,106.72
LAS04B90	Oakey Bl System	Closed	$631,418.63
LAS04C91	Oakey Bl System/Decatur Bl Crossing	Closed	$35,000.00
LAS04E94	Oakey Conveyance Phase II	Closed	$1,083,848.86
LAS04F22	Meadows/Charleston-Via Olivero, Montessouri to Buffalo	Open	$1,129,000.00
LAS05A87	Meadows Detention Basin	Closed	$120,000.00
LAS05B87	Meadows Detention Basin	Closed	$3,432,123.00
LAS05C00	Meadows Detention Basin Expansion (Resol 00-2)	Closed	$150,000.00
LAS05D01	Meadows Detention Basin Expansion (Resol 01-3)	Closed	$3,422,258.00
LAS05H08	Alta Parallel System	Closed	$8,165,350.58
LAS05I08	Oakey-Meadows Storm Drain, Phase I	Closed	$12,686,286.59
LAS05J10	Oakey Meadows Storm Drain-Phase II	Closed	$9,822,984.14
LAS05L20	Meadows-Charleston SD, Essex to Lindell	Open	$817,308.00
LAS05M20	Meadows Detention Basin Upgrade	Open	$263,063.00
LAS05N22	Meadows-Charleston Storm Drain, Essex to Lindell	Open	$23,579,393.00
LAS06A87	Major Conveyance System West of I-15	Closed	$229,005.59
LAS06B87	Major Conveyance System East of I-15	Closed	$29,022.50
LAS06C93	Freeway Channel/Sahara - Ivanhoe	Closed	$670,067.29
LAS07A89	Durango Storm Drain	Closed	$596,059.22
LAS08A89	Carey Ave./Lake Mead Detention & Conveyance System	Closed	$6,148,651.98
LAS09A89	Washington Ave. System	Closed	$313,726.91
LAS09B91	Washington Ave. System/Sandhill-Bruce	Closed	$497,000.00
LAS09D92	Washington Ave./Sandhill-Virgil	Closed	$1,594,925.69
LAS09F93	Washington/Sagman-LV Creek Right-of-Way	Closed	$245,428.78
LAS09G94	Washington Ave. / Lena-Eastern (LOMR)	Closed	$4,643,824.92
LAS09H94	Upper Washington Channel & Freeway Channel	Closed	$1,206,684.74
LAS09I96	Washington/Eastern-Sagman	Closed	$3,078,027.28
LAS09J97	Freeway Channel System - Alta Drive to UPRR	Closed	$13,839,202.95
LAS09K97	Upper Washington Avenue - Sagman to Bonanza	Closed	$4,421,963.25
LAS09L98	Freeway Channel - Alta Dr to Sahara Avenue	Closed	$2,778,531.48
LAS09M98	Freeway Channel North/ Washington Avenue - Vegas Drive	Closed	$257,916.45
LAS09O99	Freeway Channel - Alta Dr to Sahara Ave & Bypass Facility	Closed	($5,613.65)
LAS09P00	Freeway Channel - Alta to Sahara & Bypass Facilities (CM)	Closed	$2,280,263.22
LAS09R01	Las Vegas Creek Channel - Parallel System at Decatur Blvd (Resol 01-4)	Closed	$247,000.00
LAS09U05	Las Vegas Creek Channel - Parallel System	Closed	$5,628,281.00

Regional Flood Control District
Capital Improvement Projects - Cumulative Reporting
Pay-As-You-Go Funding

PROJECT	NAME	STATUS	TOTAL
LAS09V05	Oakey Drain, Birch Street to Cahlan Drive	Closed	$851,548.86
LAS09W08	Oakey Drain, Birch Street to Cahlan Drive	Closed	$6,500,607.90
LAS09Y09	Oakey Drain - Cahlan Dr to Barnard Dr	Closed	$370,483.19
LAS10A91	Gowan North Channel	Closed	$110,000.00
LAS10B93	CAM-10 & Lone Mtn. Detention Basins Predesign	Closed	$212,800.00
LAS10C94	Lone Mtn. Detention Basin	Closed	$905,972.72
LAS10D95	Gowan North Channel - Gowan North Detention Basin	Closed	$904,292.71
LAS10E97	Gowan North Channel - Gowan Detention Basin to Buffalo	Closed	$3,150,210.59
LAS10F97	Gowan Outfall Lone Mtn Branch - Ferrell St to Kenny Way	Closed	$111,327.87
LAS10H98	Gowan North Buffalo Branch (Chnl) - Atwood to Lone Mtn Rd	Closed	$285,859.78
LAS10J98	Gowan North Chnl-Alexander Dr to Lone Mtn Rd & LM Outfall	Closed	$651,405.16
LAS10K99	CAM 10 Detention Basin (aka Ann Road DB)	Closed	$682,577.04
LAS10L99	Gowan North-Buffalo Branch	Closed	$162,106.81
LAS10M00	Gowan North - Buffalo Branch (Gowan Road & Buckskin Ave)	Closed	$608,179.39
LAS10N00	Gowan Outfall, Lone Mountain Branch (Allen Lane-Ferrell)	Closed	$1,545,053.54
LAS10P00	Gowan/Lone Mountain System - Gilmore Channel (CM)	Closed	$8,492.19
LAS10Q01	Gowan/Lone Mountain System - Gilmore Channel (Developer Participation)	Closed	$1,383,723.00
LAS10R00	Gowan North - Buffalo Branch (Cheyenne Avenue to Lone Mtn Road)	Closed	$2,462,085.23
LAS10W04	Lone Mountain System, Lone Mtn DB Outfall to Durango	Closed	$0.00
LAS10Y05	Gowan Lone Mountain System - Cliff Shadows Park	Closed	$1,549,850.67
LAS11A92	Rampart Storm Drain (Angel Park-Peccole 1)	Closed	$44,809.03
LAS11B93	Rampart Storm Drain Construction	Closed	$185,842.34
LAS12A92	Alta Storm Drain (Meadows V)	Closed	$851,465.76
LAS13A92	Cheyenne Channel / Buffalo - Gowan Design	Closed	$86,475.85
LAS13B94	Cheyenne Channel Crossings Developer Participation	Closed	$709,000.00
LAS13C93	Cheyenne Channel / Buffalo - Gowan	Closed	$1,107,787.47
LAS14A95	Washington Avenue - I-15 to Martin Luther King	Closed	$74,429.00
LAS14B00	Washington Avenue & Freeway Channel North	Closed	$4,887,278.94
LAS14C11	Freeway Channel-Washington, MLK to Rancho Drive	Closed	$1,025,545.29
LAS15A95	Oakey Storm Drain - I-15 to Decatur Blvd	Closed	$391,238.42
LAS16A98	Ann Road Channel West/ Allen Lane - Rancho Drive	Closed	$657,583.31
LAS16B99	Rancho Road System/Centennial PKWY to Rancho DB	Closed	$1,198,151.00
LAS16C99	Rancho Road System/Centennial PKWY to Rancho DB	Closed	$17,697.53
LAS16G07	Rancho Detention Basin, Phase II	Closed	$3,953,168.82

Regional Flood Control District
Capital Improvement Projects - Cumulative Reporting
Pay-As-You-Go Funding

PROJECT	NAME	STATUS	TOTAL
LAS16H07	Rancho Drive System - El Campo Grande Storm Drain	Closed	$4,634,244.76
LAS16I09	Ann Rd Channel West - Rainbow Blvd	Closed	$475,475.33
LAS16J09	Rancho System - Beltway to Elkhorn	Closed	$927,245.27
LAS16L11	Rancho Road System - Elkhorn, Ft Apache to Grand Canyon	Closed	$394,023.05
LAS16M12	Ann Road Channel West - Rainbow Boulevard	Closed	$3,474,459.19
LAS16N13	Rancho System - Beltway to Elkhorn Road	Closed	$8,681,088.21
LAS16O13	Rancho Rd System-Elkhorn, Fort Apache to Grand Canyon	Closed	$2,287,600.29
LAS16P15	Rancho Road System - Elkhorn, Grand Canyon to Hualapai	Closed	$626,451.69
LAS16Q18	Rancho Road System-Elkhorn, Grand Canyon to Hualapai	Closed	$4,772,370.59
LAS17A98	Las Vegas Wash/ Rancho Drive System (Peak Dr - Lake Mead)	Closed	$419,095.42
LAS17D02	Las Vegas Wash - Rancho Drive System (Carey/Lake Mead DB to Peak Dr)	Closed	$6,273,291.56
LAS17F07	Peak Drive System (Jones Blvd to Michael Way)	Closed	$4,501,941.03
LAS18A98	Las Vegas Wsh/Smoke Ranch Sys: Peak Dr/Torrey Pines-Jones	Closed	$147,617.92
LAS18B00	Las Vegas Wash - Smoke Ranch System (Peak Drive: Torrey Pines - Jones)	Closed	$1,782,103.78
LAS19A99	Owens Avenue System: Rancho Drive to I-15	Closed	$292,162.08
LAS19B01	Owens Avenue System (Rancho Drive to I-15)	Closed	$4,430,278.94
LAS19D11	Vegas Dr Storm Drain - Rancho to Shadow Mountain	Closed	$10,997,022.53
LAS19E20	Owens Ave System-Vegas SD, Shadow Mtn to Jones	Open	$854,000.00
LAS20A00	Rancho Rd System: Durango to US-95 Interchange	Closed	$448,364.70
LAS22B05	Las Vegas Wash - Jones Blvd, Elkhorn Rd to Farm Rd	Closed	$92,244.72
LAS22C06	Las Vegas Wash - Elkhorn (Rainbow Blvd to Torrey Pines Drive)	Closed	$274,272.89
LAS22D06	N & S Environ Enhancement Areas - Floyd Lamb Park	Closed	$2,252,837.16
LAS22E06	Las Vegas Wash - Decatur Blvd (Centennial PKWY to Farm Road)	Closed	$2,454,915.36
LAS22F07	Las Vegas Wash - Rainbow (Elkhorn Road to Grand Teton Drive)	Closed	$951,355.17
LAS22G07	Elkhorn Springs and Buffalo Storm Drain	Closed	$280,782.51
LAS22H07	Las Vegas Wash - Elkhorn Rd, Rainbow Blvd to Torrey Pines Dr	Closed	$6,561,592.06
LAS22I08	Las Vegas Wash - Decatur Blvd (Elkhorn Rd to Farm Rd)	Closed	$2,950,783.84
LAS22J08	Las Vegas Wash - Jones Blvd, Elkhorn to Farm	Closed	$1,683,390.48
LAS22K08	LVW - Grand Teton, Mountain Spa to DurangoDrive	Closed	$850,522.21
LAS22L08	LVW - Grand Teton, Buffalo Drive to Durango Drive	Closed	$172,513.02
LAS22R12	LVW-Grand Teton, Mountain Spa to Durango Drive	Closed	$12,250,368.51

Regional Flood Control District
Capital Improvement Projects - Cumulative Reporting
Pay-As-You-Go Funding

PROJECT	NAME	STATUS	TOTAL
LAS22S13	Brent Drainage System-Floyd Lamb Park to Durango Drive	Closed	$450,299.59
LAS22T15	Brent Drainage System - Floyd Lamb Park to Durango Drive	Closed	$4,812,849.19
LAS22U19	Brent Drainage System-Durango to OHare Ave	Open	$1,100,000.00
LAS23C08	Horse Drive Interchange	Closed	$5,392,419.91
LAS23D13	Centennial Parkway Channel West - US95 Crossing	Closed	$1,379,460.87
LAS23E13	Centennial Pkwy Channel West-CC 215, Pioneer Way to US95	Closed	$818,649.59
LAS23F14	Centennial Parkway Channel West-CC215, Pioneer Way to US95	Closed	$12,609,882.75
LAS23G15	Centennial Parkway Channel West-US95, CC215 to Durango	Closed	$1,048,786.02
LAS23H15	Centennial Parkway Channel West-US95, Durango to Grand Teton	Closed	$568,546.49
LAS23I17	Cent Pkwy Chnl West-US95, CC215 to Grand Teton, Kyle Cyn	Closed	$23,937,814.47
LAS23J21	Centennial Pkwy Channel West-Farm Rd, Oso Blanca to TeePee	Open	$953,903.00
LAS23L23	Centennial Pkwy Channel West – Farm Rd, Tee Pee to Hualapai	Open	$982,789.04
LAS24B06	Gowan North Channel - El Capitan Way to the Western Beltway	Closed	$7,636,880.18
LAS24D06	Gowan Lone Mountain System - Branch 4	Closed	$2,824,592.10
LAS24E07	Gowan Outfall - Lone Mountain Branch (Rancho Drive to Decatur Boulevard)	Closed	$1,595,874.26
LAS24H13	Gowan North-Buffalo Branch,Lone Mtn to Washburn Rd	Closed	$953,701.76
LAS24I15	Gowan Box Canyon - Lone Mountain Road	Closed	$423,742.73
LAS24J15	Gowan North - El Capitan Branch, Lone Mountain to Ann Road	Closed	$802,275.43
LAS24K17	Gowan North-Buffalo Branch, Lone Mtn to Washburn Rd	Closed	$8,180,517.28
LAS24L17	Gowan North - El Capitan Branch, Ann Road to Centennial Parkway	Closed	$731,465.08
LAS24M17	Gowan North-El Capitan Branch, Lone Mtn to Ann Rd.	Closed	$8,839,320.65
LAS25B13	Cedar Avenue Channel Improvements	Closed	$701,786.07
LAS25C20	Las Vegas Wash - Stewart, Las Vegas Wash to Mojave Rd.	Open	$3,839,927.00
LAS26A07	Grand Teton Overpass - Storm Drain	Closed	$612,614.83
LAS26B08	Grand Teton Overpass - Storm Drain	Closed	$1,936,755.45
LAS26C13	Grand Teton - Hualapai to Tee Pee	Closed	$401,560.15
LAS27A09	Boulder HWY Sahara Ave - Mojave Rd to Boulder HWY	Closed	$411,967.68
LAS28B11	Oakey Drain - Cahlan to Barnard	Closed	$5,372,969.90
LAS28C12	Las Vegas Wash - Sloan Channel to Cedar Avenue	Closed	$88,302.56
LAS29A10	Flamingo Wash, Boulder Highway North-Main Street	Closed	$346,572.69
LAS29B15	Flamingo-Boulder HWY N-Boulder HWY Sahara to Charleston	Closed	$1,551,456.94
LAS29C16	Flamingo-Maryland-Bldr, Maryland Pky Sys	Open	$2,888,829.00

Regional Flood Control District
Capital Improvement Projects - Cumulative Reporting
Pay-As-You-Go Funding

PROJECT	NAME	STATUS	TOTAL
LAS29D17	Flamingo-Boulder Hwy North, Charleston, Main to Maryland	Open	$2,129,674.00
LAS29E18	Flamingo - Boulder Hwy North - Boulder Hwy, Sahara to Charleston	Closed	$27,093,685.12
LAS29F20	Flamingo-Boulder Hwy N Charleston-Maryland Pkwy System	Open	$44,039,173.00
LAS29G23	Flamingo–Boulder Hwy N, Charleston–Main St to Maryland Pkwy	Open	$35,745,716.00
LAS30A13	Gowan - Alexander Road, Decatur Boulevard to Torrey Pines Drive	Open	$1,731,938.00
LAS31A17	LVW-Moccasin, Skye Canyon Park to Upper LVW	Closed	$95,820.97
LAS31B18	LVW - Moccasin, Skye Canyon Park to Upper LVW	Closed	$16,118,959.35
LAS32A21	LVW - Iron Mountain, Bradley to Decatur	Open	$302,000.00
LAS33A22	Owens Avenue East - LV Wash to Eastern	Open	$2,332,191.00
LLD04A03	Holmby Channel	Closed	$621,698.68
LLD04B07	Oakey Boulevard & Tenaya Way Storm Drain	Closed	$574,017.45
LLD05A08	Jones Blvd - Alta to Borden Storm Drain	Closed	$716,389.74
LLD08A11	Lexington Street Storm Drain	Closed	$926,610.34
LLD09A04	Bruce Street Storm Drain	Closed	$431,221.89
LLD10A05	Jay Avenue Improvements	Closed	$548,443.62
LLD10B13	Buckskin Avenue Storm Drain	Closed	$1,010,515.08
LLD12A04	Brush Street Storm Drain	Closed	$411,351.53
LLD13A02	Crystal Water Way, Lake South Dr to Desert Inn Rd	Closed	$227,132.20
LLD18A02	Peak Drive, Rainbow Blvd to Torrey Pines Dr	Closed	$371,781.85
LLD19A18	Luning Drive Storm Drain	Closed	$1,192,668.00
LLD31A22	El Capitan SD - Moccasin Rd to Ruston Rd	Open	$1,200,000.00
LLD99A09	Gilmore Ave - Decatur Blvd to Thom Blvd Storm Drain	Closed	$410,867.01
			$498,050,955.11

Mesquite

PROJECT	NAME	STATUS	TOTAL
MES01A88	Town Wash Detention Basin (Right-of-Way)	Closed	$9,600.50
MES01B89	Town Wash Detention Basin (Design & Construction)	Closed	$660,000.00
MES01C02	Town Wash Conveyance, I-15 to Virgin River	Closed	$977,665.86
MES01E17	Town Wash-Mesa Boulevard, El Dorado to Town Wash	Open	$670,197.75
MES02A00	Abbott Wash Channel, I-15 to Virgin River	Closed	$632,380.00
MES04A15	Virgin River Flood Wall	Open	$1,433,903.00
			$4,383,747.11

North Las Vegas

PROJECT	NAME	STATUS	TOTAL
NLD14A15	Oak Island Drive Storm Drain	Closed	$0.00
NLV01A87	Las Vegas Wash/I-15 to Pecos (Facility Study)	Closed	$304,000.00
NLV01B87	Las Vegas Wash/Craig-Civic Center (King Charles)	Closed	$2,415,411.73
NLV01C00	Upper Las Vegas Wash	Closed	$2,590,459.93
NLV01E07	Tropical Parkway Channel East	Closed	$1,161,535.61
NLV01G11	Ann Road Channel East, ULVW to Fifth Street	Closed	$960,970.98

Regional Flood Control District
Capital Improvement Projects - Cumulative Reporting
Pay-As-You-Go Funding

PROJECT	NAME	STATUS	TOTAL
NLV01H13	Las Vegas Wash - "N" Channel, Cheyenne to Gowan	Closed	$302,073.21
NLV01J15	Las Vegas Wash - "N" Channel, Cheyenne to Gowan	Closed	$3,044,495.91
NLV01K22	North Las Vegas Detention Basin Upgrade	Open	$1,640,000.00
NLV02A87	W. Trib Las Vegas Wash/Craig -Alexander	Closed	$1,268,170.85
NLV02B88	W. Trib Las Vegas Wash/Craig Ranch Golf Course-Craig	Closed	$1,057,430.33
NLV03A88	West Range Wash Detention Basin (Facility Study)	Closed	$273,068.12
NLV03B88	East Range Wash Detention Basin (Facility Study)	Closed	$30,000.00
NLV03C91	West Range Wash Diversion Dike	Closed	$339,338.71
NLV03E13	Hollywood System, Dunes South DB to Centennial Parkway	Closed	$2,051,424.82
NLV03F17	Range Wash - Ann Branch	Closed	$626,038.57
NLV03G17	Hollywood System, Centennial Pkwy-Speedway #2 DB	Closed	$1,194,407.74
NLV03H17	Hollywood System, Dunes S DB to Centennial Pkwy-Phase I	Closed	$11,189,513.59
NLV03I18	Range Wash - Ann Branch, Phase I	Closed	$2,662,886.95
NLV04A89	Gowan Outfall Structure	Closed	$13,373,572.56
NLV04B00	Gowan Outfall, Craig to Channel	Closed	$301,821.67
NLV04C01	Gowan Outfall, Craig to Channel	Closed	$1,566,299.84
NLV04F07	Simmons Street Drainage Improvements - Carey to Craig	Closed	$2,110,016.45
NLV04G07	Gowan Outfall - Lone Mountain Branch, Decatur Blvd to Channel	Closed	$15,057,798.44
NLV04I11	Simmons Street - Phase II, Carey to Cheyenne	Closed	$5,464,819.43
NLV04K17	Gowan Outfall, Alexander Rd - Decatur to Simmons Street	Open	$2,306,156.00
NLV05A89	Upper Las Vegas Wash Detention Basin	Closed	$1,342,892.36
NLV06A91	Kyle Detention Basin	Closed	$601,126.71
NLV06B93	Kyle Detention Basin	Closed	$8,452,713.96
NLV07A92	Camino Al Norte Culvert	Closed	$86,191.00
NLV08A94	Lower Las Vegas Wash Detention Basin	Closed	$2,650,037.50
NLV08B97	Lower Las Vegas Wash Detention Basin Construction	Closed	$3,316,222.35
NLV09A94	Range Wash Chnl W Trib/Confl DB-LV Blvd. + Vandenberg DB	Closed	$2,299,092.06
NLV09C03	Range Wash - Lamb Blvd Storm Drain	Closed	$337,143.54
NLV09D07	Range Wash - Lamb Blvd Storm Drain	Closed	$5,733,340.83
NLV09E11	Vandenberg North Detention Basin & Outfall	Open	$1,534,770.00
NLV09F13	Beltway Detention Basin and Channel	Closed	$0.00
NLV09G13	Centennial Collector	Closed	$50,086.74
NLV09I13	Beltway Detention Basin and Channel	Closed	$1,463,857.36
NLV09L24	Range Wash - Beltway Conveyance and Collection System - Pecos	Open	$1,550,000.00
NLV10A97	A - Channel/Lake Mead Blvd. - Alexander Road	Closed	$1,822,067.69
NLV10B99	Cheyenne Peaking Basin	Closed	$3,445,309.49
NLV10F02	Las Vegas Wash Main Branch, Cheyenne Avenue to Lake Mead Boulevard	Closed	$353,900.87

Regional Flood Control District
Capital Improvement Projects - Cumulative Reporting
Pay-As-You-Go Funding

PROJECT	NAME	STATUS	TOTAL
NLV10H07	Las Vegas Wash - Lake Mead Blvd to Las Vegas Blvd	Closed	$2,069,215.34
NLV10I09	Las Vegas Wash - Las Vegas Blvd to Cheyenne Ave	Closed	$697,124.80
NLV10K11	LVW - LV Blvd to Cheyenne Avenue	Closed	$6,382,656.86
NLV10L19	Las Vegas Wash Cartier Channel	Open	$1,485,293.00
NLV10M21	Lake Mead SD, LVW to Civic Center	Open	$1,070,020.00
NLV10N24	Las Vegas Wash Cartier Channel Phase 1 - Carey Ave to Lake Mead Blvd	Open	$12,750,000.00
NLV11A97	W. Trib Las Vegas Wash (Camino Al Norte to Ann Rd)	Closed	$1,494,634.14
NLV11B97	W. Trib Las Vegas Wash, Ph II (Ann Rd to Centennial PKWY)	Closed	$2,154,439.86
NLV12A97	Clayton Channel- WTLVW >Centennial PKWY> Allen Ln	Closed	$40,408.90
NLV13A98	Tributary to the Western Tributary @ Craig Rd	Closed	$801,419.92
NLV13B02	Tributary to the Western Tributary at Craig Road	Closed	$5,443,730.21
NLV14A00	Tributary to the Western Tributary @ Alexander Rd	Closed	$735,930.14
NLV15A00	Las Vegas Wash - Losee Project	Closed	$87,613.81
NLV16A00	Simmons Street Channel	Closed	$1,013,785.70
NLV17A00	Centennial Parkway Channel East	Closed	$2,486,927.42
NLV17B08	Centennial Parkway Channel East	Closed	$19,334,832.52
NLV17C16	Fifth Street Collector, Centennial Pkwy to Deer Springs Way	Closed	$419,976.43
NLV17D18	Fifth St Collector, Centennial Pkwy to Deer Spgs Way	Closed	$4,716,057.46
NLV18A07	Colton Channel	Closed	$1,175,047.77
NLV18B07	Brooks Channel	Closed	$594,278.02
NLV18C07	Freeway Channel - Owens Avenue to Miller Avenue	Closed	$1,528,308.05
NLV18D09	Freeway Channel - Owens Ave to Miller Ave, Phase I	Closed	$4,389,989.00
NLV18E11	Freeway Channel - Owens Ave to Miller Avenue - Phase II	Closed	$6,441,348.71
NLV18F13	Central Freeway Channel At Cheyenne	Closed	$694,097.08
NLV18H14	Brooks Channel	Closed	$4,689,970.93
NLV18I16	Central Freeway Channel at Cheyenne	Closed	$9,663,354.07
NLV19A19	Carey-Lake Mead DB Outfall Modification	Open	$205,000.00
			$200,895,924.04
		Grand Total	**$1,391,775,807.83**

Regional Flood Control District
Capital Improvement Projects - Cumulative Reporting
Bond Funding

Boulder City

PROJECT	NAME	STATUS	TOTAL
BOU01A87	Hemenway Wash	Closed	$867,000.00
BOU01E19	Hemenway System, Phase IIB Improvements	Open	$5,202,802.00
BOU04D02	West Airport Facilities	Closed	$568,602.56
BOU04E03	Valley View, Red Mountain and DD Facilities	Closed	$76,468.23
BOU04F05	Valley View and DD Facilities	Closed	$632,017.12
BOU05D04	Veterans Memorial Detention Basin	Closed	$3,236,343.92
BOU05E04	Yucca Debris Basin, Collection & Outfall	Closed	$69,028.25
BOU05F04	Bootleg Canyon Facilities	Closed	$365,646.88
BOU05I10	Yucca Debris Basin, Collection and Outfall	Closed	$1,189,960.47
			$12,207,869.43

Clark County

PROJECT	NAME	STATUS	TOTAL
CLA01G24	Flamingo, Cimarron Branch - Russell Road to Patrick Lane	Open	$8,977,511.00
CLA02F92	Rawhide Channel Improv/McLeod-Mtn Vista	Closed	$2,678,784.24
CLA03E92	Van Buskirk Channel/ Phase III Construction	Closed	$884,145.27
CLA03F92	Van Buskirk Channel/Phase V/Harmon-Harrison & Tropicana	Closed	$1,318,316.18
CLA03G92	Van Buskirk Channel / Phase IV	Closed	$949,302.79
CLA03H93	Van Buskirk Channel / Phases IIA & VI Construction	Closed	$7,076,269.80
CLA04J03	Flamingo Wash, Algonquin Dr to Maryland Parkway	Closed	$3,708,620.21
CLA04K03	Flamingo Wash, I-515 to Boulder Highway	Closed	$4,358,838.58
CLA04L03	Lower Flamingo Detention Basin	Closed	$1,078,896.68
CLA04T09	Lower Flamingo Detention Basin	Closed	$3,387,621.44
CLA04W16	Flamingo Wash, Eastern Avenue	Closed	$1,462,409.75
CLA06B93	Range Wash Confluence DB ROW & Construction	Closed	$9,575,705.90
CLA07C03	Sloan Channel, Las Vegas Wash to Charleston	Closed	$11,371,793.05
CLA08C98	Lower Duck Creek Detention Basin & Outfall Channel	Closed	$12,823,423.07
CLA08T14	Duck Creek, Las Vegas Boulevard	Closed	$6,981,477.12
CLA09B99	Durango Collector (Twain to Hacienda)	Closed	$9,485,138.68
CLA10B99	Tropicana Wash, Paradise Road to Koval Lane	Closed	$2,087,199.75
CLA10C03	Tropicana North Branch Detention Basin	Closed	$3,763,800.00
CLA10E09	Tropicana North Branch Detention Basin	Closed	$950,229.12
CLA12A97	Desert Inn Detention Basin & Collection System	Closed	$0.00
CLA12C99	Desert Inn Detention Basin & Collection System	Closed	$5,327,982.96
CLA13C98	Lakes DB Collection System	Closed	$17,986,141.42
CLA14B99	Duck Creek Channel (Hollywood Blvd to Stephaine St)--ROWA	Closed	$1,598,918.50
CLA14M03	Duck Creek, Broadbent Blvd Bridge and Channel	Closed	$2,176,640.38
CLA14N03	Duck Creek, Broadbent Blvd to Boulder Highway	Closed	$5,832,117.22
CLA14P03	Duck Creek, Eldorado Lane to Spencer Street	Closed	$343,994.59
CLA14Q04	Duck Creek, Topaz Street to Eastern Avenue	Closed	$2,119,552.08

Regional Flood Control District
Capital Improvement Projects - Cumulative Reporting
Bond Funding

PROJECT	NAME	STATUS	TOTAL
CLA14W11	Duck Creek, Robindale to I-215	Closed	$650,561.15
CLA15B99	Colorado Avenue Storm Drain System	Closed	$15,259,421.39
CLA15E13	LVW-Sloan to Stewart-Flam Wash below Nellis	Closed	$83,210,143.20
CLA15F16	Las Vegas Wash - Water Reclamation Channel	Closed	$3,400,000.00
CLA16L09	Lower Blue Diamond Detention Basin	Closed	$2,581,701.25
CLA16M09	Blue Diamond Wash Wigwam, UPRR to Rainbow Blvd	Closed	$5,067,171.04
CLA16N09	Blue Diamond Wash Wigwam, UPRR to Jones Blvd	Closed	$0.00
CLA17A98	Blue Diamond Chnl/Durango Dr - Rainbow Blvd (Beltway 7B)	Closed	$1,021,760.73
CLA17D04	Blue Diamond Channel - Jones Branch	Closed	$641,602.04
CLA18A98	Red Rock Channel/Russell Rd - Hualapai Way	Closed	$1,793,162.82
CLA19D03	Red Rock Channel, Naples Branch	Closed	$9,885,005.24
CLA26D11	Flamingo Diversion-South Buffalo Branch, Flamingo Wash to Sunset Rd	Closed	$7,030,263.37
CLA27D13	Flamingo Diversion - Rainbow Branch	Closed	$9,654,169.07
CLA38B20	Silverado Ranch DB, Collection & Outfall	Open	$19,500,000.00
			$287,999,791.08

Clark County Outlying

PROJECT	NAME	STATUS	TOTAL
IND01B04	Indian Springs Detention Basin	Closed	$2,650,794.34
LAU01B92	Unnamed Wash, Laughlin	Closed	$2,577,722.08
LAU02C94	Hiko Springs, Laughlin	Closed	$1,200,000.00
LAU04B17	SR 163 at Casino Drive	Closed	$1,920,382.17
			$8,348,898.59

Henderson

PROJECT	NAME	STATUS	TOTAL
HEN01D91	Pittman Wash Channel - Phase II Construction	Closed	$2,071,148.80
HEN01E93	Pittman Wash Channel Phase IIIA Construction	Closed	$776,682.83
HEN03B92	UPRR Channel Construction	Closed	$2,149,477.47
HEN04C93	Mission Hills System Construction	Closed	$5,503,671.37
HEN04D94	C-1 Channel / Lake Mead Dr. - Burkholder	Closed	$3,398,432.50
HEN04E96	Mission Hills Western Interceptor Diversion	Closed	$2,100,000.00
HEN04J99	Black Mountain Detention Basin & Outfall	Closed	$5,233,184.00
HEN04L01	C-1 Chnl, Mdl & Upr Reaches-PhI: Burkholder - Boulder HWY	Closed	$4,784,787.10
HEN04M03	C-1 Channel, Upper & Middle Reaches - Vermillion Dr - Boulder HWY	Closed	$3,689,653.67
HEN05B98	Pioneer DB Outfall	Closed	$2,952,988.96
HEN05F12	Pioneer Detention Basin Expansion and Inflow	Closed	$1,330,852.11
HEN05G16	Horizon Ridge Detention Basin	Closed	$6,784,863.71
HEN06J13	Equestrian Detention Basin Expansion	Closed	$1,025,764.52
HEN06K13	Equestrian Tributary, Phase II	Closed	$2,147,066.76
HEN07C11	Pittman Park Peaking Basin Modification	Closed	$0.00
HEN07G20	Whitney Ranch Channel Replacement	Open	$18,353,248.17

Regional Flood Control District
Capital Improvement Projects - Cumulative Reporting
Bond Funding

PROJECT	NAME	STATUS	TOTAL
HEN12D03	Pittman Wash - Burns	Closed	$257,326.75
HEN12E05	Gibson Conveyance System	Closed	$2,164,571.54
HEN12J16	Palm Hills Channel	Closed	$1,880,256.03
HEN13B03	Boulder Highway Channel	Closed	$6,534,523.99
HEN15B02	Pittman Wash Railroad Channel, Phase I (Resol. No. 02-6)	Closed	$1,989,679.32
HEN15C04	Pittman Wash Railroad Channel, US-95 to Major Avenue	Closed	$5,537,919.81
HEN18A03	Drake Channel	Closed	$75,265.32
HEN19A03	Northeast Detention Basin and Levee	Closed	$1,134,804.61
HEN20B04	C-1 Channel, US-95 Tributary 1	Closed	$1,522,849.50
HEN23B16	Center Street Storm Drain	Closed	$8,266,384.95
HLD06A15	Appaloosa Storm Drain, Local Drainage Project	Closed	$925,332.15
			$92,590,735.94

Las Vegas

PROJECT	NAME	STATUS	TOTAL
LAS01E13	Angel Park Detention Basin Expansion	Closed	$4,085,640.34
LAS02E92	Buffalo Channel/Summerlin Pkwy-Vegas Dr.	Closed	$1,911,377.65
LAS03C91	Gowan Detention Basin	Closed	$7,184,517.75
LAS04D92	Oakey Detention Basin & Conveyance	Closed	$6,887,121.59
LAS05E03	Oakey - Meadows Storm Drain	Closed	$5,221,885.40
LAS05F03	Alta Parallel System	Closed	$2,093,934.39
LAS05K15	Oakey-Meadows Storm Drain, Phase III	Closed	$24,265,142.63
LAS05O24	Meadows Detention Basin Upgrade	Open	$4,340,400.00
LAS09C91	Washington Ave./Sandhill Outlet	Closed	$1,496,312.93
LAS09E93	Washington Ave. / Virgil-Lena	Closed	$2,862,675.33
LAS09N99	Upr Wash Ave Conv Sys, Ph II: Veterans Memorial Dr - UPRR	Closed	$6,279,449.66
LAS09O99	Freeway Channel - Alta Dr to Sahara Ave & Bypass Facility	Closed	$36,285,968.75
LAS09T04	Freeway Channel, Charleston Lateral	Closed	$4,336,897.56
LAS10C94	Lone Mtn. Detention Basin	Closed	$315,482.25
LAS10I98	Gowan North Channel, Ph II/Durango Dr	Closed	$5,455,374.03
LAS10T02	Gowan North System - Ph III: Alexander Rd to Lone Mtn Rd	Closed	$7,539,040.96
LAS10V03	GNC - Lone Mountain Road (El Capitan Way to the Western Beltway)	Closed	$634,984.37
LAS10W04	Lone Mountain System, Lone Mtn DB Outfall to Durango	Closed	$2,734,160.02
LAS10X05	Ann Road Detention Basin Facilities (CAM 10 DB)	Closed	$9,317,720.04
LAS14D14	Freeway Channel-Washington, MLK to Rancho Drive	Closed	$10,663,228.56
LAS16D01	Ann Road, Allen Lane to Rancho Drive	Closed	$7,069,867.82
LAS16E04	Rancho Detention Basin, Phase II	Closed	$464,510.86
LAS16F04	Rancho Road System (El Campo Grande Storm Drain)	Closed	$573,652.99
LAS17E03	Peak Drive System (Jones Blvd to Michael Way)	Closed	$456,338.90

Regional Flood Control District
Capital Improvement Projects - Cumulative Reporting
Bond Funding

PROJECT	NAME	STATUS	TOTAL
LAS19C05	Owens Avenue System (Vegas Dr Storm Drain) - Michael Way to Rancho Drive	Closed	$1,596,671.67
LAS21A03	Upper Las Vegas Wash Facility Study	Closed	$243,392.60
LAS22A03	Decatur/Elkhorn/Rainbow System Predesign	Closed	$368,594.70
LAS22M09	Las Vegas Wash - Rainbow (Elkhorn Rd to Grand Teton Dr)	Closed	$7,696,565.04
LAS22N09	Las Vegas Wash - Decatur & Elkhorn, CC 215	Closed	$25,788,320.03
LAS22O09	N & S Environ Enhancement Areas - Floyd Lamb Park	Closed	$25,314,907.94
LAS22P09	Elkhorn Springs & Buffalo Storm Drain	Closed	$1,567,520.54
LAS23K23	Centennial Pkwy Chanl W Farm, Oso Blanca - Tee Pee	Open	$9,526,125.00
LAS24F10	Gowan Outfall - Lone Mountain Branch (Rancho to Decatur)	Closed	$10,109,824.95
LAS24N21	Gowan North-El Capitan, Ann Rd to Centennial Pkwy	Open	$11,233,750.00
LAS26D14	Grand Teton - Hualapai to Tee Pee	Closed	$6,245,247.37
LAS28A10	Langtry Channel Bonanza to Washington Avenue	Closed	$1,002,676.43
			$253,169,281.05

Mesquite

PROJECT	NAME	STATUS	TOTAL
MES01B89	Town Wash Detention Basin (Design & Construction)	Closed	$3,692,545.65
MES01D10	Town Wash Conveyance, I-15 to the Virgin River	Closed	$7,366,966.99
MES01F24	Town Wash-Mesa Boulevard, El Dorado to Town Wash	Open	$15,405,844.15
MES02B03	Abbott Wash Conveyance System, Pioneer Blvd to the Virgin River	Closed	$10,625,472.16
			$37,090,828.95

North Las Vegas

PROJECT	NAME	STATUS	TOTAL
NLV01D03	Upper Las Vegas Wash	Closed	$31,132,709.75
NLV01F09	Tropical Parkway Channel East	Closed	$5,900,026.83
NLV01I14	Ann Road Channel East, ULVW to Fifth Street	Closed	$5,580,349.42
NLV03D93	West Range Wash Diversion Dike	Closed	$2,251,608.79
NLV03J19	Hollywood System, Phase II, NAFB Reach	Closed	$17,108,195.09
NLV03K19	Range Wash - Ann Branch, Phase II	Closed	$6,400,455.52
NLV03L20	Hollywood System, Centennial Pkwy to Speedway #2 DB	Closed	$9,652,520.29
NLV04D04	Gowan Outfall - Lone Mountain Branch, Decatur Blvd to Channel	Closed	$1,179,589.48
NLV04H09	Simmons Street Drainage Improvements - Gowan Outfall	Closed	$2,280,988.68
NLV04J14	Simmons Street Drainage Impvments-Alexander to Gowan Outfall	Closed	$14,878,224.09
NLV04L21	Gowan Outfall-Alexander-Decatur-Simmons,Simmons-Clayton	Open	$45,288,550.00
NLV05B92	Upper Las Vegas Wash Detention Basin Construction	Closed	$8,010,318.87

Regional Flood Control District
Capital Improvement Projects - Cumulative Reporting
Bond Funding

PROJECT	NAME	STATUS	TOTAL
NLV06B93	Kyle Detention Basin	Closed	$5,037,000.00
NLV08B97	Lower Las Vegas Wash Detention Basin Construction	Closed	$4,433,240.98
NLV09B99	Vandenberg Detention Basin	Closed	$5,347,006.76
NLV09H14	Centennial Collector	Closed	$2,256,922.92
NLV09J19	Beltway Detention Basin, Collection and Outfall	Closed	$13,281,623.95
NLV09K19	Vandenberg North DB, Collection & Outfall, Phase II	Open	$25,999,000.00
NLV10E03	"A" Channel Three Bridges Project (Cheyenne Ave, Las Vegas Blvd, and Carey Ave)	Closed	$9,966,315.63
NLV10G03	Cheyenne Peaking Basin, Collection & Outfall - Alexander Rd to Cheyenne Ave	Closed	$15,482,525.64
NLV10J10	LV Wash Main Branch-LV Blvd. to Lake Mead Blvd.	Closed	$21,161,048.84
NLV11C98	W. Trib Las Vegas Wash Chnl, Ph I (Ann Rd - Clayton St)	Closed	$7,898,144.87
NLV11D99	W. Trib Las Vegas Wash, Ph III (LLVWDB to Camino Al Norte)	Closed	$2,499,963.56
NLV11E99	W. Trib of the Las Vegas Wash, Ph II (Ann to Centennial)	Closed	$7,772,320.98
NLV14B03	Tributary to the Western Tributary @ Alexander Rd	Closed	$7,636,332.88
NLV15B03	Las Vegas Wash - Losee Road	Closed	$1,142,595.43
NLV16B03	Simmons Street Channel	Closed	$4,885,102.93
NLV18G14	Colton Avenue Flood Control Improvements	Closed	$6,811,918.64
			$291,274,600.82
		Grand Total	**$982,682,005.86**

2023-2024 PROJECTS FUNDED SUMMARY

Facility Description	Project Number	Project Scope (1)	Year-1 Programmed (2)	Year-2/Year-3 Programmed (2)/(3)	Funding Amount (4)	Approval Date	Item #
HENDERSON (Southeast Las Vegas Valley)							
Pittman Sunset, Galleria to Sunset - Original	HEN12L23	Construction	2,000,000.00	0.00	2,000,000.00	8/10/2023	11a
Pittman-Sunset, Burns to Foster, Phase 2-Boulder Highway Crossing (Original)	HEN12M24	Construction	0.00	8,534,521.00	8,534,521.00	4/11/2024	13b
Pittman Pabco, Boulder Hwy., Water St. to Lake Mead Pkwy - Original	HEN25C23	Design	236,623.00	0.00	236,623.00	7/13/2023	14
Pittman Pabco, Boulder Hwy., Water St. to Lake Mead Pkwy - 1st Supplemental	HEN25C23	Design	30,000.00	0.00	30,000.00	4/11/2024	12
Pittman Pabco, Water St. to Lake Mead - (Original)	HEN25D24	Construction	0.00	8,751,898.00	8,751,898.00	4/11/2024	14b
Cadiz Storm Drain - Racetrack to Pueblo - Original	HEN04R23	Design	346,317.00	0.00	346,317.00	9/14/2023	10
Cadiz Storm Drain - Racetrack to Pueblo - 1st Supplemental	HEN04R23	Design	278,683.00	0.00	278,683.00	2/8/2024	14
Anthem Parkway Channel - Horizon Ridge to Siena Heights - Closeout	HEN22C22	Construction	(225,390.98)	0.00	(225,390.98)	11/9/2023	9
		Henderson Total	**$2,666,232.02**	**$17,286,419.00**	**$19,952,651.02**		

HENDERSON 3-YEAR TOTALS:	
PROJECTS PROGRAMMED	**$19,952,651.02**
ESTIMATED RESOURCES	**$23,991,020.00**
REMAINING RESOURCES	**$4,038,368.98**

LAS VEGAS (Central Las Vegas Valley)							
Lake Mead - Carey - Lake Mead Detention Basin Outfall		Construction	0.00	556,831.00	0.00		
Las Vegas Wash - Stewart, Las Vegas Wash to Mojave Road - 3rd Supplemental	LAS25C20	Design	1,516,737.00	0.00	1,516,737.00	8/10/2023	9
Meadows Detention Basin Upgrade - Original	LAS05O24	Construction	0.00	4,340,400.00	4,340,400.00	5/23/2024	14b
Meadows/Charleston-Via Olivero, Montessouri to Buffalo		Construction	0.00	10,444,712.00	0.00		
Las Vegas Wash - Stewart, Lamb to Mojave		Construction	0.00	45,360,065.00	0.00		
Flamingo - Boulder Highway North, Charleston - Main Street to Maryland Parkway - Original	LAS29G23	Construction	35,745,716.00	0.00	35,745,716.00	11/9/2023	14b
Gowan - Alexander Road, Decatur Boulevard to Torrey Pines Drive	LAS30A13	Design	1,020,000.00	0.00	1,020,000.00	7/13/2023	13
Brent Drainage System - Durango to OHare		Construction	0.00	19,308,050.00	0.00		
Centennial Pkwy Channel West - Farm Rd - Tee Pee to Hualapai - Original	LAS23L23	Design	982,789.04	0.00	982,789.04	12/14/2023	14
		Las Vegas Total	**$39,265,242.04**	**$80,010,058.00**	**$43,605,642.04**		

LAS VEGAS 3-YEAR TOTALS:	
PROJECTS PROGRAMMED	**$119,275,300.04**
ESTIMATED RESOURCES	**$142,191,929.00**
REMAINING RESOURCES	**$98,586,286.96**

NORTH LAS VEGAS (Northern Las Vegas Valley)							
North Las Vegas Detention Basin Upgrade		Construction	0.00	17,503,799.00	0.00		
Beltway Detention Basin, Collection and Outfall - Closeout	NLV09J19	Construction	(3,496,819.79)	0.00	(3,496,819.79)	8/10/2023	7
Hollywood System, Centennial Parkway-Speedway #2 DB - Closeout	NLV03G17	Design	(392,442.26)	0.00	(392,442.26)	2/8/2024	7
Hollywood System, Centennial Parkway-Speedway #2 DB - Closeout	NLV03L20	Construction	(702,479.71)	0.00	(702,479.71)	2/8/2024	7
Las Vegas Wash - Iron Mountain, Bradley to Decatur		Construction	5,000,000.00	0.00	0.00		
Lake Mead Storm Drain, Las Vegas Wash to Civic Center		Construction	8,905,604.00	0.00	0.00		
Las Vegas Wash Cartier Channel Phase 1		Construction	0.00	12,044,028.00	0.00		
Las Vegas Wash Cartier Channel Phase 2		Right-of-Way	0.00	1,158,770.00	0.00		
Las Vegas Wash Cartier Channel Phase 2		Construction	0.00	30,579,388.00	0.00		
Orchard Collector - Charleston to Linden		Construction	6,939,465.00	0.00	0.00		
Jim McGaughey Detention Basin & Outfall - Original		Right-of-Way	800,000.00	0.00	0.00		
Jim McGaughey Detention Basin, Collection & Outfall - Original	CLA36B23	Construction	19,654,327.00	0.00	19,654,327.00	7/13/2023	17b
Jim McGaughey Detention Basin, Collection and Outfall - 1st Supplemental	CLA36B23	Construction	6,500,000.00	0.00	6,500,000.00	3/14/2024	12
Range Wash - Beltway Conveyance and Collection System at Pecos - Original	NLV09L24	Design	1,550,000.00	0.00	1,550,000.00	1/11/2024	13
Sloan Channel East Branch, Las Vegas Blvd to Valmark Dr - Original	CLA41A24	Design	380,000.00	0.00	380,000.00	5/23/2024	13
		North Las Vegas Total	**$45,137,654.24**	**$61,285,985.00**	**$23,492,585.24**		

NORTH LAS VEGAS 3-YEAR TOTALS:	
PROJECTS PROGRAMMED	**$106,423,639.24**
ESTIMATED RESOURCES	**$137,731,760.00**
REMAINING RESOURCES	**$114,239,174.76**

CLARK COUNTY (Southwest Las Vegas Valley and Outlying Areas)							
Flamingo, Cimarron Branch - Russell Road to Patrick Lane		Construction	0.00	5,909,339.00	0.00		
Airport Channel - Naples - 6th Supplemental	CLA10H13	Design	350,000.00	0.00	350,000.00	7/13/2023	12
Airport Channel - Naples Channel and Peaking Basin		Construction	29,960,000.00	0.00	0.00		
Vegas Valley Drive - Mojave to Burnham		Design	747,781.00	0.00	0.00		
Flamingo Wash - Industrial Road. To Hotel Rio Dr.		Construction	5,796,000.00	0.00	0.00		
Flamingo Wash - Maryland Parkway to Palos Verdes Street - 3rd Supplemental	CLA04Y19	Design	80,000.00	0.00	80,000.00	7/13/2023	11a
Tropicana Avenue Conveyance - Las Vegas Wash to Boulder Highway	CLA35B23	Design	1,554,000.00	0.00	1,554,000.00	8/1/2023	10
Tropicana Avenue Conveyance - Las Vegas Wash to Boulder Highway	CLA35B23	ROW	116,000.00	0.00	116,000.00	8/1/2023	10
Las Vegas Wash - Sloan Channel to Bonanza Road and Flamingo Wash below Nellis Boulevard - Closeout	CLA15D12	Design	(560,940.18)	0.00	(560,940.18)	2/8/2024	7
Las Vegas Wash - Sloan Channel to Stewart Avenue and Flamingo Wash below Nellis Boulevard - Closeout	CLA15E13	Construction	(973,856.80)	0.00	(973,856.80)	7/13/2023	8
Las Vegas Wash - Branch 02 - Monson Channel - Jimmy Durante to Boulder Hwy		Construction	0.00	15,799,956.00	0.00		
Duck/Cr./Blue Diamond, Bermuda Road to Las Vegas Blvd.		Construction	11,280,953.00	0.00	0.00		
Blue Diamond Channel, Amigo to Haven		Construction	0.00	9,030,981.00	0.00		

2023-2024 PROJECTS FUNDED SUMMARY

Facility Description	Project Number	Project Scope (1)	Year-1 Programmed (2)	Year-2/Year-3 Programmed (2)/(3)	Funding Amount (4)	Approval Date	Item #
CLARK COUNTY (Southwest Las Vegas Valley and Outlying Areas) - CONT.							
Blue Diamond Channel 02, Decatur - LeBaron to Richmar - Phase 2		Construction	0.00	3,500,000.00	0.00		
Blue Diamond Railroad Channel		Construction	27,000,000.00	0.00	0.00		
Blue Diamond Wash, Arville Street to I-15 - 2nd Supplemental	CLA16Q21	Construction	250,000.00	0.00	250,000.00	7/13/2023	15a
Sunset Park - Duck Creek Wash to Eastern Avenue		Construction	0.00	24,592,910.00	0.00		
Goodsprings - Phase I		Right-of-Way	434,107.00	0.00	0.00		
Goodsprings - Phase I		Construction	2,930,202.00	0.00	0.00		
SR 163 at Casino Drive - 7th Supplemental	LAU04A08	Design	70,000.00	0.00	70,000.00	7/13/2023	11b
SR 163 at Casino Drive - Phase 2		Construction	0.00	2,100,000.00	0.00		
SR 163 at Casino Drive - Closeout	LAU04B17	Construction	(329,617.83)	0.00	(329,617.83)	4/11/2024	8
Searchlight - West - State Hwy 164		Construction	8,666,240.00	0.00	0.00		
Thomas Edison Detention Basin, Collection and Outfall - Original	LAU05A23	Design	913,205.00	0.00	913,205.00	11/9/2023	13
Thomas Edison Detention Basin, Collection and Outfall - Original	LAU05A23	ROW	50,000.00	0.00	50,000.00	11/9/2023	13
Windmill Wash Detention Basin Expansion and Jess Waite Levee Facilities		Construction	1,841,142.00	0.00	0.00		
	Clark County Total		**$90,175,215.19**	**$60,933,186.00**	**$1,518,790.19**		

CLARK COUNTY 3-YEAR TOTALS:	
PROJECTS PROGRAMMED	**$151,108,401.19**
ESTIMATED RESOURCES	**$165,738,854.00**
REMAINING RESOURCES	**$164,220,063.81**

CITY OF MESQUITE							
Town Wash - Mesa Boulevard, El Dorado to Town Wash - Original	MES01F24	Construction	13,336,743.00	0.00	13,336,743.00	3/14/2024	14b
Leavitt Lane Crossing		Construction	660,000.00	0.00	0.00		
Virgin River Flood Wall		Construction	0.00	10,700,000.00	0.00		
	City of Mesquite Total		**$13,996,743.00**	**$10,700,000.00**	**$13,336,743.00**		

MESQUITE 3-YEAR TOTALS:	
PROJECTS PROGRAMMED	**$24,696,743.00**
ESTIMATED RESOURCES	**$26,599,801.00**
REMAINING RESOURCES	**$13,263,058.00**

BOULDER CITY							
Avenue I Storm Drain		Construction	0.00	5,115,290.00	0.00		
Wells Drive Levee Lining		Construction	0.00	325,084.00	0.00		
	Boulder City Total		**$0.00**	**$5,440,374.00**	**$0.00**		

BOULDER CITY 3-YEAR TOTALS:	
PROJECTS PROGRAMMED	**$5,440,374.00**
ESTIMATED RESOURCES	**$6,535,720.00**
REMAINING RESOURCES	**$6,535,720.00**

SUMMARY	
TOTAL 3-YEAR PROJECTS PROGRAMMED[2]	**$426,897,108.49**
TOTAL ESTIMATED RESOURCES (Year-1)	**$240,410,063.00**
TOTAL REMAINING DESIGN PROJECTS (Year-1)	**$747,781.00**
TOTAL PROJECTS FUNDED (Year-1)	**$101,906,411.49**
CURRENT AVAILABLE CONSTRUCTION RESOURCES (Year-1)	**$137,755,870.51**

LOCAL DRAINAGE (5)							
Luning Drive Storm Drain - Closeout	LLD19A18	Construction	(9,297.00)	0.00	(9,297.00)	8/10/2023	7
Chickasaw Storm Drain - Closeout	HLD06B19	Construction	(58,368.68)	0.00	(58,368.68)	10/12/2023	6
Craig Road Storm Drain - El Capitan to Fort Apache - Closeout	CLD97A20	Construction	(1,800.50)	0.00	(1,800.50)	2/8/2024	7
	Local Drainage Total		**($69,466.18)**	**$0.00**	**($69,466.18)**		

Notes:
(1) Construction typically includes Construction and/or Construction Administration. Design typically includes Predesign, Design, Right-of-way, Environmental, and/or Other.
(2) Includes amendments to the Ten-Year Construction Program.
(3) Year-2/Year-3 do not include design projects. Design projects are not eligible for acceleration.
(4) Action is being taken in current month on projects in bold/italics.
(5) Local Drainage projects are not part of the Ten-Year Construction Program.

2024-2025 PROJECTS FUNDED SUMMARY

Facility Description	Project Number	Project Scope (1)	Year-1 Programmed (2)	Year-2/Year-3 Programmed (2)/(3)	Funding Amount (4)	Approval Date	Item #
HENDERSON (Southeast Las Vegas Valley)							
Pittman Sunset, Burns to Foster - Phase 3		Construction	0.00	5,465,281.00	0.00		
Pittman Sunset, Burns to Foster - Phase 1		Construction	0.00	2,094,375.00	0.00		
Anthem Pkwy Chnl-Horizon Ridge to Siena Heights - Closeout	HEN22B21	Design	(56,694.37)	0.00	(56,694.37)	9/12/2024	7
Cadiz Storm Drain - Racetrack to Pueblo		Construction	0.00	3,486,423.00	0.00		
Cadiz Storm Drain - Racetrack to Pueblo - 2nd Supplemental	***HEN04R23***	***Design***	***97,705.00***		***97,705.00***	***11/14/2024***	
Whitney Ranch Channel Replacement Project - 3rd Supplemental	HEN07G20	Construction	(919,978.83)	0.00	(919,978.83)	9/12/2024	11
Whitney Ranch Channel Replacement Project - Closeout	HEN07F18	Design	(133,410.39)	0.00	(133,410.39)	10/10/2024	8
Pittman Sunset, Galleria to Sunset - Closeout	HEN12L23	Construction	(2,000,000.00)	0.00	(2,000,000.00)	8/8/2024	7
		Henderson Total	**($3,012,378.59)**	**$11,046,079.00**	**($3,012,378.59)**		

HENDERSON 3-YEAR TOTALS:	**PROJECTS PROGRAMMED**	**$8,033,700.41**
	ESTIMATED RESOURCES	**$21,298,870.00**
	REMAINING RESOURCES	**$24,311,248.59**

LAS VEGAS (Central Las Vegas Valley)							
Lake Mead - Carey - Lake Mead Detention Basin Outfall		Construction	2,140,000.00	0.00	0.00		
Las Vegas Wash - Stewart, Las Vegas Wash to Eastern		Construction	0.00	47,015,471.00	0.00		
Meadows/Charleston-Via Olivero, Montessouri to Buffalo		Construction	0.00	10,589,560.00	0.00		
Meadows - Charleston Storm Drain, Essex to Lindell - 1st Supplemental	LAS05N22	Construction	7,541,393.00		7,541,393.00	10/10/2024	15a
Boulder Highway Sahara Avenue - Boulder Hwy. to Eastern		Design	2,304,889.00	0.00	0.00		
Gowan, Alexander Rd, Decatur Boulevard to Torrey Pines Drive		Construction	0.00	22,385,625.00	0.00		
Ann Road Channel West - Jones, Ann to Tropical		Design	510,912.00	0.00	0.00		
Brent Drainage System - Durango to OHare		Construction	19,378,256.00	0.00	0.00		
Centennial Pkwy Channel West - Farm Rd - Tee Pee to Hualapai		Construction	0.00	7,673,632.00	0.00		
Centennial Parkway Channel West - US95, CC215 to Grand Teton and US95 Crossing at Kyle Canyon Road Closeout	LAS23I17	Construction	(147,392.23)	0.00	(147,392.23)	7/11/2024	9
Gowan North - El Capitan Branch, Ann Road to Centennial Parkway - Closeout	LAS24L17	Construction	(130,204.92)		(130,204.92)	8/8/2024	7
		Las Vegas Total	**$31,597,852.85**	**$87,664,288.00**	**$7,263,795.85**		

LAS VEGAS 3-YEAR TOTALS:	**PROJECTS PROGRAMMED**	**$119,262,140.85**
	ESTIMATED RESOURCES	**$121,536,034.00**
	REMAINING RESOURCES	**$114,272,238.15**

Meadows - Charleston Storm Drain, Essex to Lindell	LAS05N22	Construction

NORTH LAS VEGAS (Northern Las Vegas Valley)							
North Las Vegas Detention Basin Upgrade		Construction	39,677,537.00	0.00	0.00		
Las Vegas Wash - Iron Mountain, Bradley to Decatur		Construction	5,000,000.00	0.00	0.00		
Lake Mead Storm Drain, Las Vegas Wash to Civic Center		Construction	0.00	18,005,059.00	0.00		
Las Vegas Wash Cartier Channel Phase 1 - Carey Ave to Lake Mead Blvd - Original	NLV10N24	Construction	12,750,000.00	0.00	12,750,000.00	9/12/2024	13b
Orchard Collector - Charleston to Linden		Construction	9,510,690.00	0.00	0.00		
Orchard Detention Basin - 17th Supplemental	CLA21A00	ROW	1,600,000.00	0.00	1,600,000.00	9/12/2024	12a
Range Wash - Beltway Conveyance and Collection System - Pecos		Construction	0.00	18,103,267.00	0.00		
Sloan Channel East Branch, Las Vegas Blvd to Valmark Dr - 1st Supplemental	CLA41A24	Design	32,000.00	0.00	32,000.00	10/10/2024	14a
Sloan Channel East Branch, Las Vegas Boulevard to Valmark Drive		Construction	0.00	2,625,172.00	0.00		
		North Las Vegas Total	**$68,570,227.00**	**$38,733,498.00**	**$14,382,000.00**		

NORTH LAS VEGAS 3-YEAR TOTALS:	**PROJECTS PROGRAMMED**	**$107,303,725.00**
	ESTIMATED RESOURCES	**$130,541,153.00**
	REMAINING RESOURCES	**$116,159,153.00**

CLARK COUNTY (Southwest Las Vegas Valley and Outlying Areas)							
Blue Diamond - Buffalo Branch - Badura to Warm Springs		Design	445,172.00	0.00	0.00		
Flamingo Wash, Cimarron Branch - Russell Road to Patrick Lane - Original	CLA01G24	Construction	8,977,511.00	0.00	8,977,511.00	8/8/2024	15b
Flamingo, Cimarron Branch - Russell Road to Patrick Lane - 3rd Supplemental	CLA01F21	Design	50,000.00	0.00	50,000.00	10/10/2024	14b
Flamingo Wash, Maryland Parkway to Cambridge Street (Formerly Flamingo Wash, Maryland Parkway to Palos Verdes Street)		Construction	5,350,000.00	0.00	0.00		
Airport Channel - Naples Channel and Peaking Basin		Construction	29,960,000.00	0.00	0.00		
Flamingo Wash - UPRR to Hotel Rio Dr.		Construction	5,796,000.00	0.00	0.00		
Flamingo Diversion - Jones		Design	99,115.00	0.00	0.00		
Flamingo Wash, UPRR to Hotel Rio Drive - 4th Supplemental	***CLA10F10***	***Design***	***75,000.00***	***0.00***	***75,000.00***	***11/14/2024***	
Tropicana Avenue Conveyance - Las Vegas Wash to Andover Drive		Construction	0.00	32,725,790.00	0.00		
Las Vegas Wash - Branch 02 - Monson Channel - Jimmy Durante to Boulder Hwy		Construction	17,890,217.00	0.00	0.00		
Las Vegas Wash - Branch 02 - Monson Channel - Jimmy Durante to Boulder Hwy - 3rd Supplemental	CLA40A21	Design	195,000.00	0.00	195,000.00	10/10/2024	14c
Duck Cr. / Blue Diamond, Bermuda Road to Las Vegas Blvd.		Construction	0.00	27,884,924.00	0.00		
Duck Creek - Jones Boulevard Storm Drain - Closeout	***CLA38E20***	***Construction***	***(477,855.30)***	***0.00***	***(477,855.30)***	***11/14/2024***	
Blue Diamond Channel 02, Decatur - Le Baron to Serene - Phase 2		Construction	3,500,000.00	0.00	0.00		
Blue Diamond Railroad Channel		Construction	27,000,000.00	0.00	0.00		
Sunset Park - Duck Creek Wash to Eastern Avenue	CLA14X21	Design	500,000.00	0.00	500,000.00	9/12/2024	12b
Sunset Park - Duck Creek Wash to Eastern Avenue		Construction	0.00	20,105,401.00	0.00		
Goodsprings - Phase 1 - Closeout	***GSP01B10***	***Design***	***(12,293.26)***	***0.00***	***(12,293.26)***	***11/14/2024***	
Fairgrounds Detention Basin and Outfall - 2nd Supplemental	MOA03B21	Construction	2,003,000.00	0.00	2,003,000.00	10/10/2024	15b
Hiko Springs Wash Detention Basin Expansion - Closeout	LAU02D21	Design	(273,709.41)	0.00	(273,709.41)	9/12/2024	7
SR 163, Phase 2 - Sediment Basin - Original	LAU04C24	Construction	1,860,670.00	0.00	1,860,670.00	8/8/2024	14b
Laughlin Marina to Desert Marina Drive		Design	260,167.00	0.00	0.00		
Searchlight - West - State Highway 164 - 3rd Supplemental	SEA02B19	Design	250,000.00	0.00	250,000.00	9/12/2024	12c
Searchlight - West - State Highway 164		Construction	8,086,651.00	0.00	0.00		
Windmill Wash Detention Basin and Jess Waite Levee Facilities		Construction	0.00	1,943,694.00	0.00		
		Clark County Total	**$111,534,645.03**	**$82,659,809.00**	**$13,147,323.03**		

CLARK COUNTY 3-YEAR TOTALS:	**PROJECTS PROGRAMMED**	**$194,194,454.03**
	ESTIMATED RESOURCES	**$205,212,746.00**
	REMAINING RESOURCES	**$192,065,422.97**

2024-2025 PROJECTS FUNDED SUMMARY

Facility Description	Project Number	Project Scope (1)	Year-1 Programmed (2)	Year-2/Year-3 Programmed (2)/(3)	Funding Amount (4)	Approval Date	Item #
CITY OF MESQUITE							
Leavitt Lane Crossing		Construction	660,000.00	0.00	0.00		
Virgin River Flood Wall		Construction	0.00	10,700,000.00	0.00		
Town Wash - Mesa Boulevard, El Dorado to Town Wash - 1st Supplemental	MES01F24	Construction	2,069,101.15		2,069,101.15	8/8/2024	13a
	City of Mesquite Total		**$2,729,101.15**	**$10,700,000.00**	**$2,069,101.15**		
MESQUITE 3-YEAR TOTALS:	**PROJECTS PROGRAMMED**		**$13,429,101.15**				
	ESTIMATED RESOURCES		**$13,805,258.00**				
	REMAINING RESOURCES		**$11,736,156.85**				
BOULDER CITY							
Avenue I Storm Drain		Construction	0.00	5,090,698.00	0.00		
Wells Drive Levee Lining		Construction	0.00	323,521.00	0.00		
	Boulder City Total		**$0.00**	**$5,414,219.00**	**$0.00**		
BOULDER CITY 3-YEAR TOTALS:	**PROJECTS PROGRAMMED**		**$5,414,219.00**				
	ESTIMATED RESOURCES		**$5,747,857.00**				
	REMAINING RESOURCES		**$5,747,857.00**				

SUMMARY	
TOTAL 3-YEAR PROJECTS PROGRAMMED[2]	**$447,637,340.44**
TOTAL ESTIMATED RESOURCES (Year-1)	**$235,938,104.00**
TOTAL REMAINING DESIGN PROJECTS (Year-1)	**$3,620,255.00**
TOTAL PROJECTS FUNDED (Year-1)	**$33,849,841.44**
CURRENT AVAILABLE CONSTRUCTION RESOURCES (Year-1)	**$198,468,007.56**

LOCAL DRAINAGE (5)							
	Local Drainage Total		**$0.00**	**$0.00**	**$0.00**		

Notes:
(1) Construction typically includes Construction and/or Construction Administration. Design typically includes Predesign, Design, Right-of-way, Environmental, and/or Other.
(2) Includes amendments to the Ten-Year Construction Program.
(3) Year-2/Year-3 do not include design projects. Design projects are not eligible for acceleration.
(4) Action is being taken in current month on projects in bold/italics.
(5) Local Drainage projects are not part of the Ten-Year Construction Program.

ESTIMATED FUNDING SCHEDULE

Month-Year	Funding Requests Received			Estimated Resources for CIP		Priority Date	Notes
	Facility Description	Project #	Amount	Resources (1)	Available (1)		
Nov-24					$114,464,104		
	Cadiz Storm Drain - Racetrack to Pueblo - 2nd Supplemental	HEN04R23	$97,705		$114,366,399		
	Flamingo Wash, UPRR to Hotel Rio Drive - 4th Supplemental	CLA10F10	$75,000		$114,291,399		
	Duck Creek - Jones Boulevard Storm Drain - Closeout	CLA38E20	($477,855)		$114,769,255		
	Goodsprings - Phase I - Closeout	GSP01B10	($12,293)		$114,781,548		
	No Projects Awaiting Funding						

Notes: (1) Estimated CIP resources are from the FY2024-25 Ten-Year Construction Program and may be adjusted for current economic conditions.

Form 4408LGF QUARTERLY ECONOMIC SURVEY

ENTITY: **Clark County Regional Flood Control District** **QUARTER ENDING:** **30-Sep-24**

DATE PREPARED: **15-Oct-24**

QUESTIONS REGARDING ECONOMIC CONDITIONS

		Yes	No	Since the last filing:
1	Clark County		X	Has any employer that accounts for 15 % or more of the employment in the area closed or significantly reduced operations since the previous report? If yes, please provide details on page 2.
2	Clark County	X		Has your entity experienced a cumulative increase or decrease of 10% or more in population or assessed valuation in the past two years? If yes, please provide details on page 2.
3	Clark County		X	Has there been any significant event(s) in the region which could affect your entity positively? If yes, please provide details on page 2.
4	Clark County	X		Has there been any significant event(s) in the region which could affect your entity negatively? If yes, please provide details on page 2.
5	Clark County		X	Has anything significant occurred which could affect your expected level of revenues? If yes, please provide details on page 2.

QUESTIONS REGARDING OPERATIONS

6.	CCRFCD		X	Has the ending fund balance in your general (principal operating) fund had an unexplained, unbudgeted, or unanticipated decline for the past two fiscal years? If yes, please provide details on page 2.
7.	CCRFCD		x	Has the entity entered into any new debt arrangements since the previous report? If yes, please provide details on page 2.
8.	CCRFCD		X	Has the entity borrowed money to pay for current operations? If yes, please provide details on page 2.
9.	CCRFCD		X	Has the entity made an interfund loan(s) to pay for current operations? If yes, please provide details on page 2.
10.	CCRFCD		X	Has the entity failed to pay timely any contributions to governmental agencies for the benefits of its employees, (for example, PERS, Workmen's Comp or Federal taxes)? If yes, please provide details on page 2.
11.	CCRFCD		X	Has the entity failed to make timely payments for debt service, to vendors or others? If yes, please provide details on page 2.
12.	CCRFCD		X	Has the entity augmented the appropriated expenses for any proprietary fund since the previous report? If yes, please provide details on page 2.

13. Cash and cash equivalents (unaudited) as of quarter ending 9/30/2024:
(Enterprise Fund(s) Only)

	Prior Year	Current Year
(CCRFCD)	N/A	N/A

14. General Fund Ending Balance (unaudited) as of quarter ending 9/30/2024:

	Prior Year	Current Year
(CCRFCD)	$ 20,983,959.70	$ 10,136,887.18

15. Cash and cash equivalents (unaudited) as of quarter ending 9/30/2024:
(General Fund Only)

	Prior Year	Current Year
(CCRFCD)	$ 21,050,846.08	$ 10,217,978.33

Form 4408LGF

QUARTERLY ECONOMIC SURVEY

DETAILS OF POSITIVE RESPONSES TO QUESTIONS ON PAGE 1

1-5 (Clark County) **Question 1**

(Clark County) **Question 2**

CLARK COUNTY	**Population**	**Assessed Value**
FY 2023 (Actual)	2,320,551	115,981,318,714
FY 2024 Estimate)	2,338,127	132,090,463,013
FY 2025 (Budget)	2,361,285	146,284,576,844
Cumulative Increases/Decreases	40,734	30,303,258,130
	1.76%	26.13%

(Clark County) **Question 3**

(Clark County) **Question 4** $80 million proposed settlement with Gypsum Resources planned housing development near Red Rock Canyon National Conservation Area

(Clark County) **Question 5**

6. (CCRFCD)

7. (CCRFCD)

Date	Type	Amount

8. (CCRFCD)

Date _____ Lender _____ Amount $ _____

Date _____ Lender _____ Amount $ _____

9. (CCRFCD)

Date	From Fund	To Fund	Amount $

10-11. (CCRFCD)

12. (CCRFCD)

Date	Fund	Amount
Date	Fund	Amount $

13-15. (CCRFCD)

Regarding our operations fund balance, there are inherent timing differences between the receipt of resources, payment of expenditures and transfers of resources to other funds. The current (FY 2024-25) fund balance and cash represented on lines 14 & 15 (page 1) of this report, is in line with 8% to 10% of our budgeted operational obligations. The District maintains sufficient fund balance to support operational obligations such as debt services, maintenance work and capital improvements to ensure that all commitments can be made on a timely basis.

PREPARED BY: Carol Trujillo, Fiscal Services Adminstrator (Name/Title) Carol Trujillo (Signature)

PERSON SIGNING CERTIFIES ALL INFORMATION PROVIDED IS TRUE & CORRECT FOR THE PERIOD INDICATED.

REVIEWED BY: Jessica Honour, Administrative Services Director (Name/Title) _____ (Signature)

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

TEN-YEAR CONSTRUCTION PROGRAM AMENDMENTS

RECOMMENDATION SUMMARY

STAFF: Approve.

TECHNICAL ADVISORY: Approve.

CITIZENS ADVISORY: Approve.

RFCD AGENDA
ITEM #06
DATE: 11/14/2024

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT
AGENDA ITEM

SUBJECT: TEN-YEAR CONSTRUCTION PROGRAM AMENDMENTS
PETITIONER: STEVEN C. PARRISH, P.E., GENERAL MANAGER/CHIEF ENGINEER
RECOMMENDATION OF PETITIONER: ADOPT AMENDMENTS TO THE TEN-YEAR CONSTRUCTION PROGRAM (FOR POSSIBLE ACTION)

FISCAL IMPACT: None.

BACKGROUND: In accordance with Policies and Procedures Section II.B.9 general amendments can be processed to address scheduling changes and/or the need for additional funding. This agenda item addresses requested changes in funding, positive and negative, associated with this agenda as they impact the Ten-Year Construction Program (TYCP). Amendments to the TYCP are shown for:

Project Description	Action	Current TYCP Amount	Difference	Requested Amendment Amount
Duck Creek – Jones Boulevard Storm Drain – CLA38E20	Closeout	$ 0.00	($477,855.30)	($477,855.30)
Goodsprings – Phase 1-GSP01B10	Closeout	$ 0.00	($12,293.26)	($12,293.26)
Cadiz Storm Drain – Racetrack to Pueblo – HEN04R23	2nd Supplemental	$ 0.00	$97,705.00	$97,705.00
Flamingo Wash, UPRR to Hotel Rio Drive – CLA10F10	4th Supplemental	$ 0.00	$75,000.00	$75,000.00

TAC AGENDA ITEM #05 Date: 10/31/2024	RFCD AGENDA ITEM #06 Date: 11/14/2024
CAC AGENDA ITEM #05 Date: 11/04/2024	

Respectfully submitted,

Steven C. Parrish, P.E.
General Manager/Chief Engineer

Regional Flood Control District
AGENDA ITEM DEVELOPMENT

Staff Discussion:

Date: 10/21/2024

TEN YEAR CONSTRUCTION PROGRAM AMENDMENTS

In accordance with Policies and Procedures Section II.B.9, general amendments can be processed to address scheduling changes and/or the need for additional funding. This agenda item addresses requested changes in funding, positive and negative, associated with this agenda as they impact the Ten-Year Construction Program (TYCP).

Staff Recommendation:

Approve.

Discussion by Technical Advisory Committee:

AGENDA #05 Date: 10/31/2024

Recommendation:

Approve.

Discussion by Citizens Advisory Committee:

AGENDA #05 Date: 11/04/2024

Recommendation:

Approve.

111424 TYCP-aid

EXHIBIT C

CITY OF HENDERSON

10-YEAR CONSTRUCTION PROGRAM

Amended November 14, 2024

					FIRST FIVE YEARS 7/2024 THRU 6/2029						
	Fac. ID Mile Range	Existing Value/ Comments	Project Cost Per MPU	**Total Plan**	(Year 1) FY 24/25	(Year 2) FY 25/26	(Year 3) FY 26/27				
TOTAL PLAN			Annual Resources	**$1,273,115,265**	**$97,434,451**	**$179,533,746**	**$82,670,067**				
Unencumbered from previous year	$138,503,653		Cumulative Available Resources	**$1,242,452,332**	$24,518,657	$74,380,394	$41,804,029				
ENTITY RESOURCES			Annual Resources	**$98,709,315**	($4,892,114)	$17,933,246	$8,257,738				
Unencumbered from previous year	($14,624,635)		Cumulative Available Resources		($1,879,735)	$7,733,172	$9,475,555				
								Board Date	Amount	Amendment?	Project No.
ENTITY TOTAL		**$1,236,936,639**	**$342,120,740**	**$86,380,055**	**($3,012,379)**	**$8,320,338**	**$6,515,355**		**($3,012,379)**		
HYDROGRAPHIC BASIN: PITTMAN		**$947,176,439**	**$188,944,017**	**$68,384,067**	**($3,110,084)**	**$4,833,916**	**$6,515,355**		**($3,110,084)**		
SYSTEM: Pittman Burns		**$150,662,138**	**$32,282,361**	**$5,559,656**	**($2,000,000)**	**$2,094,375**	**$5,465,281**		**($2,000,000)**		
PROJECT: Pittman Sunset, Burns to Foster - Phase 3											
Design/Admin	PTSU 0067, 0068, 0069	Design Started 19/20	$841,173	$5,465,281			$496,844				
Right-of-way		HEN12K19	$672,939								
Construction			$4,205,867				$4,968,437				
PROJECT: Pittman Sunset, Burns to Foster - Phase 1											
Design/Admin	PTSU 0034	Design Started 19/20	$374,732	$2,094,375		$155,139					
Right-of-way		HEN12K19	$299,785								
Construction			$1,873,658			$1,939,236					
PROJECT: Pittman Sunset, Galleria to Sunset											
Design/Admin	PTSU 0000, 0008, 0023,0032		$860,783	($2,000,000)							
Right-of-way		HEN12L23	$688,626								
CLOSEOUT Construction		Developer Participation	$4,303,915		($2,000,000)			8/8/2024	($2,000,000)	YES	HEN12L23
SYSTEM: Pittman Beltway		**$414,168,999**	**$34,848,884**	**($56,694)**	**($56,694)**	**$0**	**$0**		**($56,694)**		
PROJECT: Pittman Anthem Parkway Channel, Siena Heights to Horizon Ridge											
CLOSEOUT Design/Admin	PTAP 0018	Design Started 20/21		($56,694)	($56,694)			9/12/2024	($56,694)	YES	HEN22B21
Right-of-way		HEN22B21									
Construction											
SYSTEM: Lower Pittman		**$264,438,583**	**$41,013,778**	**($1,053,389)**	**($1,053,389)**	**$0**	**$0**		**($1,053,389)**		
PROJECT: Whitney Ranch Channel Replacement Project											
CLOSEOUT Design/Admin	WWDC 0001, 0016, 0031, 0034, 0053, 0056, 0070	Design Started 18/19		($1,053,389)	($133,410)			10/10/2024	($133,410)	YES	HEN07F18
Design/Admin		HEN07F18									
Right-of-way											
3rd Supplement Construction		Eng. Est.			($919,979)			9/12/2024	($919,979)	YES	HEN07G20
SYSTEM: Upper Pittman		**$84,801,877**	**$74,676,248**	**$63,934,494**	**$0**	**$2,739,541**	**$1,050,074**		**$0**		
PROJECT: Southeast Pittman Detention Basin											
Design/Admin	PTBE 0039, 0040, 0064		$2,524,436	$16,540,337		$1,567,675					
Right-of-way			$2,019,549								
Construction			$12,622,181								
PROJECT: Pittman, Larson Lane											
Design/Admin	PTSD 0040, 0070 & PTLL 0000		$1,352,044	$9,216,611							
Right-of-way			$1,081,636								
Construction			$6,760,222								
PROJECT: Southwest Pittman Detention Basin											
Design/Admin	PTSD 0233, 0234 & PTN2 0167		$1,887,062	$12,364,206		$1,171,866					
Right-of-way			$1,509,650								
Construction			$9,435,312								
PROJECT: Pittman Wash South Phase 1 - Pittman North Detention Basin to Larson Lane											
Design/Admin	PTSD 0000, 0016, 0017, PTLB 0000, 0018		$1,657,785	$12,507,300			$1,050,074				
Right-of-way			$1,326,228								
Construction			$8,288,925								
PROJECT: Pittman Wash South Phase 2 – Gilespie Street, Roban Avenue to Via Inspirada Road											
Design/Admin	PTSD 0135		$1,913,676	$13,306,042							
Right-of-way			$1,530,941								
Construction			$9,568,380								

EXHIBIT C

CITY OF HENDERSON

10-YEAR CONSTRUCTION PROGRAM

Amended November 14, 2024

					FIRST FIVE YEARS 7/2024 THRU 6/2029						
	Fac. ID Mile Range	Existing Value/ Comments	Project Cost Per MPU	**Total Plan**	(Year 1) FY 24/25	(Year 2) FY 25/26	(Year 3) FY 26/27				
TOTAL PLAN			Annual Resources	**$1,273,115,265**	**$97,434,451**	**$179,533,746**	**$82,670,067**				
Unencumbered from previous year	$138,503,653		Cumulative Available Resources	**$1,242,452,332**	$24,518,657	$74,380,394	$41,804,029				
ENTITY RESOURCES			Annual Resources	**$98,709,315**	($4,892,114)	$17,933,246	$8,257,738				
Unencumbered from previous year	($14,624,635)		Cumulative Available Resources		($1,879,735)	$7,733,172	$9,475,555				
								Board Date	Amount	Amendment?	Project No.
ENTITY TOTAL		**$1,236,936,639**	**$342,120,740**	**$86,380,055**	**($3,012,379)**	**$8,320,338**	**$6,515,355**		**($3,012,379)**		
HYDROGRAPHIC BASIN: C-1		**$289,760,201**	**$89,420,040**	**$15,176,257**	**$97,705**	**$3,486,423**	**$0**		**$97,705**		
SYSTEM: C-1		**$289,760,201**	**$89,420,040**	**$15,176,257**	**$97,705**	**$3,486,423**	**$0**		**$97,705**		
PROJECT: Cadiz Storm Drain - Racetrack to Pueblo											
2nd Supplement Design/Admin	C1CA 0000	Design Started 23/24	$623,801	$3,584,128	**$97,705**	$258,254		11/14/2024	$97,705	YES	HEN04R23
Right-of-way		HEN04R23	$499,041								
Construction			$3,119,004			$3,228,169					
PROJECT: C-1 Channel, SNWA Drop Structure to Galleria											
Design/Admin	C1CH 0161		$304,784	$2,119,200							
Right-of-way			$243,827								
Construction			$1,523,918								
PROJECT: C-1 Channel Boulder Hwy., Nevada State College											
Design/Admin	C1BH 0207, 0216, 0230		$319,696	$2,267,343							
Right-of-way			$255,756								
Construction			$1,598,478								
PROJECT: C-1 Channel Boulder Hwy., Ramp S Boulder US95 to Conestoga											
Design/Admin	C1BH 0151, 0185, 0197		$460,946	$3,205,021							
Right-of-way			$368,757								
Construction			$2,304,732								
PROJECT: C-1 Channel Boulder Hwy., UPRR Henderson Spur											
Design/Admin	C1BH 0251, 0253, 0255, 0300, 0302		$553,020	$4,000,566							
Right-of-way			$442,416								
Construction			$2,765,099								
HYDROGRAPHIC BASIN: Eldorado Valley		**$0**	**$63,756,683**	**$2,819,730**	**$0**	**$0**	**$0**		**$0**		
SYSTEM: Eldorado Valley		**$0**	**$63,756,683**	**$2,819,730**	**$0**	**$0**	**$0**		**$0**		
PROJECT: Eldorado Valley Detention Basin Outfall											
Design/Admin	ELDV 0000, 0002, 0031		$3,952,890	$2,819,730							
Right-of-way			$3,162,312								
Construction			$20,336,120								

EXHIBIT C

CLARK COUNTY
10-YEAR CONSTRUCTION PROGRAM
Amended November 14, 2024

	Fac. ID / Mile Range	Existing Value / Comments	Project Cost Per MPU	Total Plan	FIRST FIVE YEARS 7/2024 THRU 6/2029 (Year 1) FY 24/25	(Year 2) FY 25/26	(Year 3) FY 26/27	Funding Requests 24/25 Board Date	Amount	Amendment?	Project No.
TOTAL PLAN			Annual Resources	**$1,273,115,265**	**$97,434,451**	**$179,533,746**	**$82,670,067**				
Unencumbered from previous year	$138,503,653		Cumulative Available Resources	**$1,242,452,332**	$24,518,657	$74,380,394	$41,804,029				
ENTITY RESOURCES			Annual Resources	**$452,977,192**	$121,384,337	$57,398,205	$26,430,204				
Unencumbered from previous year	$90,233,855		Cumulative Available Resources		$9,849,691	$17,153,490	$8,914,210				
ENTITY TOTAL		**$2,196,795,648**	**$1,085,024,377**	**$451,861,343**	**$111,534,646**	**$50,094,407**	**$34,669,484**		**$13,147,323**		
HYDROGRAPHIC BASIN: TROPICANA/FLAMINGO		**$1,341,319,089**	**$249,904,406**	**$218,973,078**	**$68,838,015**	**$1,900,073**	**$32,725,790**		**$9,297,511**		
SYSTEM: Tropicana Flamingo Project		**$694,903,975**	**$29,657,522**	**$19,022,243**	**$9,472,683**	**$530,444**	**$0**		**$9,027,511**		
PROJECT: Blue Diamond - Buffalo Branch - Badura to Warm Springs											
Design/Admin	BDBF 0010		$741,954	$4,759,483	$445,172						
Design/Admin			$593,563								
Construction			$3,709,770								
PROJECT: Blue Diamond - Buffalo Branch - Warm Springs to Mesa Verde											
Design/Admin	BDBF 0076, 0125		$1,503,403	$5,235,248		$530,444					
Right-of-way			$32,350,447								
Construction			$7,517,015								
PROJECT: Flamingo, Cimarron Branch - Russell Road to Patrick Lane											
3rd Supplement Design/Admin	FLCM 0003, 0020, 0026, 0028, 0052	Design Started 21/22		$8,977,511	**$50,000**			10/10/2024	$50,000	YES	CLA01F21
Design/Admin		CLA01F21	$854,177		**$765,000**			8/8/2024	$765,000	YES	CLA01G24
Right-of-way		Eng. Est.	$683,341								
Construction			$4,270,883		**$8,212,511**			8/8/2024	$8,212,511	YES	CLA01G24
SYSTEM: Flamingo Decatur		**$129,576,958**	**$6,430,941**	**$5,705,639**	**$0**	**$0**	**$0**		**$0**		
PROJECT: Flamingo Wash - Jones to Tropicana											
Design/Admin	FLWA 1153, 1204		$835,414	$5,705,639							
Right-of-way			$668,331								
Construction			$4,177,068								
SYSTEM: Lower Flamingo		**$486,388,958**	**$111,097,313**	**$100,654,249**	**$41,280,115**	**$867,394**	**$0**		**$75,000**		
PROJECT: Flamingo Wash, Maryland to Cambridge (Formerly Palos Verde)											
Design/Admin	Ph 1: FLWA 0621, 0622, 0623, 0642	Design Started 18/19		$5,350,000							
Right-of-way		CLA04Y19				.					
Construction Ph. 1											
Design/Admin	Ph 2: FLWA 0673, 0674, 0686, 0690, 0691, 0694				$350,000						
Right-of-way											
Construction Ph. 2			$5,000,000		$5,000,000						
PROJECT: Airport Channel - Naples Channel and Peaking Basin											
Design/Admin	TRMC 0013, 0014, 0031, 0033, & TRSW 0080	Design Started 13/14		$29,960,000							
Design/Admin		CLA10H13	$1,945,301		$1,960,000						
Right-of-way		Eng. Est.	$1,556,241								
Construction			$9,726,507		$28,000,000						
PROJECT: Vegas Valley Drive - Mojave to Burnham											
Design/Admin	VAVD 0025		$1,396,770	$9,151,764		$867,394					
Right-of-way			$1,117,416								
Construction			$6,983,850								
PROJECT: Flamingo Wash - UPRR to Hotel Rio Dr.											
Design/Admin	FLWA 0893 & 0896	Design Started 09/10	$96,242	$5,871,000	$100,000						
4th Supplement Design/Admin		CLA10F10			**$75,000**			**11/14/2024**	**$75,000**	**YES**	**CLA10F10**
Right-of-way		Eng. Est.	$76,994								
Construction			$481,212		$5,696,000						
PROJECT: Las Vegas Wash - Christy											
Design/Admin	LVCH 0037, 0114		$4,585,136	$31,881,052							
Right-of-way			$3,668,108								
Construction			$22,925,678								
PROJECT: Las Vegas Wash Charleston											
Design/Admin	LVCA 0000		$2,544,873	$17,380,764							
Right-of-way			$2,035,898								
Construction			$12,724,365								
PROJECT: Flamingo Diversion - Jones											
Design/Admin	FLJO 0126		$165,191	$1,059,669	$99,115						
Right-of-way			$132,153								
Construction			$825,957								

EXHIBIT C

CLARK COUNTY
10-YEAR CONSTRUCTION PROGRAM
Amended November 14, 2024

	Fac. ID / Mile Range	Existing Value/ Comments	Project Cost Per MPU	Total Plan	FIRST FIVE YEARS 7/2024 THRU 6/2029 (Year 1) FY 24/25	(Year 2) FY 25/26	(Year 3) FY 26/27	Funding Requests 24/25 Board Date	Amount	Amendment?	Project No.
TOTAL PLAN			Annual Resources	**$1,273,115,265**	**$97,434,451**	**$179,533,746**	**$82,670,067**				
Unencumbered from previous year	$138,503,653		Cumulative Available Resources	**$1,242,452,332**	$24,518,657	$74,380,394	$41,804,029				
ENTITY RESOURCES			Annual Resources	**$452,977,192**	$121,384,337	$57,398,205	$26,430,204				
Unencumbered from previous year	$90,233,855		Cumulative Available Resources		$9,849,691	$17,153,490	$8,914,210				
ENTITY TOTAL		**$2,196,795,648**	**$1,085,024,377**	**$451,861,343**	**$111,534,646**	**$50,094,407**	**$34,669,484**		**$13,147,323**		
SYSTEM: Lower LV Wash Tributaries		**$30,449,198**	**$102,718,630**	**$93,590,948**	**$18,085,217**	**$502,235**	**$32,725,790**		**$195,000**		
PROJECT: Tropicana Avenue Conveyance - Morris to Mountain Vista											
Design/Admin	LV01 0151, 0176		$1,211,378	$8,273,370				10/10/2024		YES	
Right-of-way			$969,102								
Construction			$6,056,890								
PROJECT: Tropicana Avenue Conveyance - Las Vegas Wash to Andover Drive											
Design/Admin	LV01 0001, 0038, 0080, 0118	Design Started 23/24	$5,515,115	$32,725,790			$725,790				
Right-of-way		CLA35B23	$4,412,092								
Construction		Eng. Est from CLA35A11	$27,575,574				$32,000,000				
PROJECT: Tropicana Avenue Conveyance - Andover Drive to Morris											
Design/Admin	LV01 0135		$808,753	$5,299,022		$502,235		10/10/2024		YES	
Right-of-way			$647,002								
Construction			$4,043,764					10/10/2024		YES	
PROJECT: Las Vegas Wash - Branch 02 - Monson Channel - Jimmy Durante to Boulder Hwy											
3rd Supplement Design/Admin	LV02 0128, 0209, 0211, 0273, 0275, 0282, 0289, 0294	Design Started 20/21		$17,890,217	$195,000			10/10/2024	$195,000	YES	CLA04A21
Design/Admin		CLA40A21	$2,659,275		$1,063,710						
Right-of-way		Eng Est	$2,127,420								
Construction			$13,296,377		$16,826,507						
PROJECT: Las Vegas Wash - Branch 02 - Monson Channel - Las Vegas Wash to Flamingo											
Design/Admin	LV02 0001, 0125, 0127		$2,312,682	$15,485,263							
Right-of-way			$1,850,146								
Construction			$11,563,412								
PROJECT: Las Vegas Wash - Boulder Hwy. - Tropicana to Harmon											
Design/Admin	LVBH 0000		$1,973,540	$13,722,285							
Right-of-way			$1,578,832								
Construction			$9,867,701								
HYDROGRAPHIC BASIN: DUCK CREEK/BLUE DIAMOND		**$757,233,836**	**$556,161,487**	**$162,218,589**	**$30,522,145**	**$47,990,325**	**$0**		**$22,145**		
SYSTEM: Blue Diamond Tributaries		**$93,363,718**	**$97,842,313**	**$69,169,040**	**$0**	**$27,884,924**	**$0**		**$0**		
PROJECT: Duck Cr. / Blue Diamond, Bermuda Road to Las Vegas Blvd.											
Design/Admin	DCBD 0075, 0082, 0084, 0168	Design Started 18/19	$3,336,449	$27,884,924		$1,381,290					
Right-of-way		CLA39A19	$2,669,159								
Construction		Eng Est	$16,682,246			$26,503,634					
PROJECT: Blue Diamond Channel, Amigo to Haven											
Design/Admin	BDWA 0087, 0111, 0113, 0137, 0139, 0174, 0175	Design Started 20/21	$2,160,381	$12,562,175				10/10/2024		YES	
Right-of-way		CLA16P21	$1,728,305								
Construction			$10,801,906					10/10/2024		YES	
PROJECT: Blue Diamond Wash - Wigwam - Rainbow to Buffalo, and Buffalo - Wigwam to Ford											
Design/Admin	BDW1 0122, 0220		$2,298,886	$16,630,233							
Right-of-way			$1,839,109								
Construction			$11,494,432								
PROJECT: Blue Diamond Wash - Pebble, Jones to Rainbow											
Design/Admin	BDW4 0009		$1,805,864	$12,091,708							
Right-of-way			$1,444,691								
Construction			$9,029,321								
SYSTEM: Upper Duck Creek		**$230,934,377**	**$182,838,110**	**$68,351,410**	**$30,022,145**	**$0**	**$0**		**($477,855)**		
PROJECT: Duck Creek - Jones Boulevard											
Design/Admin	DCJB 0000, 0020, 0043	RTC Project		($477,855)							
Right-of-way											
CLOSEOUT Construction					**($477,855)**			**11/14/2024**	**($477,855)**	**YES**	**CLA38E20**
PROJECT: Blue Diamond Channel 02, Decatur - Le Baron to Serene - Phase 2											
Design/Admin	BD02 0330, 0334, 0449		$819,707	$3,500,000	$500,000						
Right-of-way			$655,765								
Construction		Phase 2	$4,098,533		$3,000,000						
PROJECT: Blue Diamond Railroad Channel											
Design/Admin	BDW5 0026, 0040, 0043, 0076, 0079, 0106, 0116 & BDW2 0000	Design Started 20/21	$3,164,104	$27,000,000	$1,890,000						
Right-of-way		CLA38G20	$2,531,283								
Construction			$15,820,519		$25,110,000				.		

EXHIBIT C

CLARK COUNTY
10-YEAR CONSTRUCTION PROGRAM
Amended November 14, 2024

	Fac. ID / Mile Range	Existing Value / Comments	Project Cost Per MPU	Total Plan	FIRST FIVE YEARS 7/2024 THRU 6/2029 (Year 1) FY 24/25	(Year 2) FY 25/26	(Year 3) FY 26/27	Funding Requests 24/25 Board Date	Amount	Amendment?	Project No.
TOTAL PLAN			Annual Resources	**$1,273,115,265**	**$97,434,451**	**$179,533,746**	**$82,670,067**				
Unencumbered from previous year	$138,503,653		Cumulative Available Resources	**$1,242,452,332**	$24,518,657	$74,380,394	$41,804,029				
ENTITY RESOURCES			Annual Resources	**$452,977,192**	$121,384,337	$57,398,205	$26,430,204				
Unencumbered from previous year	$90,233,855		Cumulative Available Resources		$9,849,691	$17,153,490	$8,914,210				
ENTITY TOTAL		**$2,196,795,648**	**$1,085,024,377**	**$451,861,343**	**$111,534,646**	**$50,094,407**	**$34,669,484**		**$13,147,323**		
PROJECT: Blue Diamond Channel 3, Agate - I-15 to Decatur											
Design/Admin	BD03 0093		$2,630,091	$18,653,118							
Right-of-way			$2,104,073								
Construction			$13,150,455								
PROJECT: Blue Diamond Railroad - Buffalo to Durango											
Design/Admin	BDW5 0142, 0150, 0159, 0183, 0203, 0235		$1,404,872	$10,162,898							
Right-of-way			$1,123,898								
Construction			$7,024,360								
PROJECT: Blue Diamond Railroad - Fort Apache to Blue Diamond											
Design/Admin	BDW5 0358, BDHW 0001		$931,005	$664,117							
Right-of-way			$744,804								
Construction			$4,655,025								
PROJECT: Duck Creek Wash Tributary 4 - Fort Apache to Upper Duck Creek Detention Basin											
Design/Admin	DCW4 0847		$1,272,683	$8,849,133							
Right-of-way			$1,018,146								
Construction			$6,363,415								
SYSTEM: Lower Duck Creek		**$239,124,325**	**$45,268,884**	**$20,605,401**	**$500,000**	**$20,105,401**	**$0**		**$500,000**		
PROJECT: Sunset Park - Duck Creek Wash to Eastern Avenue											
1st Supplement Design/Admin	DCSP 0000, 0115	Design Started 21/22		$20,105,401	**$500,000**			9/12/2024	$500,000	YES	CLA14X21
Design/Admin		CLA14X21	$3,597,316			$1,489,289					
Right-of-way			$2,877,853								
Construction			$17,986,582			$18,616,112					
SYSTEM: Central Duck Creek		**$193,811,416**	**$230,212,179**	**$4,092,738**	**$0**	**$0**	**$0**		**$0**		
PROJECT: Duck Creek Gilespie Channel - Richmar to Silverado Pines and Silverado Ranch Rd to MacSnap Ave											
Design/Admin	DCGL 0001, 0037		$564,691	$4,092,738							
Right-of-way			$451,753								
Construction			$2,823,453								
HYDROGRAPHIC BASIN: OUTLYING AREAS		**$98,242,723**	**$278,958,484**	**$70,669,676**	**$12,174,486**	**$204,008**	**$1,943,694**		**$3,827,667**		
SYSTEM: Goodsprings		**$144,121**	**$5,720,856**	**($12,293)**	**($12,293)**	**$0**	**$0**		**($12,293)**		
PROJECT: Goodsprings - Phase I											
Design/Admin	GSPA 0000, 0018, 0019, 0027 & 0029	Design Started 09/10	$462,501	($12,293)				10/10/2024		YES	
CLOSEOUT Design/Admin					**($12,293)**			**11/14/2024**	**($12,293)**	**YES**	**GSP01B10**
Right-of-way		GSP01B10	$370,002					10/10/2024		YES	
Construction			$2,312,498					10/10/2024		YES	
SYSTEM: Muddy River & Tributaries		**$37,360,300**	**$158,619,300**	**$43,126,170**	**$2,003,000**	**$0**	**$0**		**$2,003,000**		
PROJECT: Fairgrounds - Detention Basin (Whipple Street)											
2nd Supplement Design/Admin	FGWS 0000, 0030, 0070, 0075, 0105, 0128, 0164, 0165, 0166 & FGLS 0000	Design Started 10/11	$2,164,140	$2,003,000	**$25,000**			10/10/2024	$25,000	YES	MOA03B21
Right-of-way		MOA03A11	$0								
2nd Supplement Construction		Eng. Est.	$10,820,700		**$1,978,000**			10/10/2024	$1,978,000	YES	MOA03B21
PROJECT: Muddy River - Cooper to Yamashita											
Design/Admin	MRLV 0395, 0423, 0424, 0442, 0443, 0458, 0459, 0507, 0508		$2,083,490	$18,963,946							
Right-of-way			$1,526,610								
Construction			$10,417,450								
PROJECT: Muddy River - Lewis to Ryan Avenue											
Design/Admin	MRLV 0184, 0198, 0240, 0268, 0276		$2,663,070	$22,159,224							
Right-of-way			$0								
Construction			$13,315,310								
SYSTEM: Mount Charleston		**$24,198**	**$1,587,384**	**$1,904,347**	**$0**	**$0**	**$0**		**$0**		
PROJECT: Rainbow Canyon Boulevard Bridge											
Design/Admin	MTCH 0001		$233,439	$1,904,347							
Right-of-way			$186,751								
Construction			$1,167,194								

EXHIBIT C

CLARK COUNTY
10-YEAR CONSTRUCTION PROGRAM
Amended November 14, 2024

	Fac. ID / Mile Range	Existing Value / Comments	Project Cost / Per MPU	Total Plan	FIRST FIVE YEARS 7/2024 THRU 6/2029 (Year 1) FY 24/25	(Year 2) FY 25/26	(Year 3) FY 26/27	Funding Requests 24/25 Board Date	Amount	Amendment?	Project No.
TOTAL PLAN			Annual Resources	**$1,273,115,265**	**$97,434,451**	**$179,533,746**	**$82,670,067**				
Unencumbered from previous year	$138,503,653		Cumulative Available Resources	**$1,242,452,332**	$24,518,657	$74,380,394	$41,804,029				
ENTITY RESOURCES			Annual Resources	**$452,977,192**	$121,384,337	$57,398,205	$26,430,204				
Unencumbered from previous year	$90,233,855		Cumulative Available Resources		$9,849,691	$17,153,490	$8,914,210				
ENTITY TOTAL		**$2,196,795,648**	**$1,085,024,377**	**$451,861,343**	**$111,534,646**	**$50,094,407**	**$34,669,484**		**$13,147,323**		
SYSTEM: Laughlin		**$45,336,505**	**$103,177,772**	**$13,218,635**	**$1,847,128**	**$0**	**$0**		**$1,586,961**		
PROJECT: Thomas Edison Detention Basin, Collection and Outflow											
Design/Admin	LUED 0019, 0057, 0058, 0059, 0060, 0061	Design Started 23/24	$1,297,253	$8,850,150							
Right-of-way		LAU05A23	$1,037,802								
Construction			$6,486,250								
PROJECT: Hiko Springs Wash Detention Basin Expansion											
CLOSEOUT Design/Admin	LUHS 0244	Design Started 20/21	$344,356	($273,709)	**($273,709)**			9/12/2024	($273,709)	YES	LAU02D21
Construction		LAU02D21	$1,721,779								
PROJECT: SR 163 at Casino Drive - Phase 2											
Design/Admin	LUBC 0031	Design Started 08/09	$54,181	$1,860,670	**$145,000**			8/8/2024	$145,000	YES	LAU04C24
Right-of-way		LAU04A08	$43,345								
Construction		Eng. Est.	$270,901		**$1,715,670**			8/8/2024	$1,715,670	YES	LAU04C24
PROJECT: Laughlin Marina to Desert Marina Drive											
Design/Admin	LUMA 0000, 0001, 0013, 0014		$369,580	$2,781,525	$260,167						
Right-of-way			$295,665								
Construction			$1,847,896								
SYSTEM: Searchlight		**$3,608,566**	**$7,201,522**	**$10,489,124**	**$8,336,651**	**$204,008**	**$0**		**$250,000**		
PROJECT: Searchlight - West - State Hwy 164											
3rd Supplement Design/Admin	SRWE 0001, 0002, 0003, 0005, & 0023	Design Started 19/20		$8,086,651	**$250,000**			9/12/2024	$250,000	YES	SEA02B19
Design/Admin		SEA02B19	$779,043		$365,606						
Right-of-way		Eng. Est.	$623,235								
Construction			$3,895,214		$7,721,045						
PROJECT: Searchlight - West											
Design/Admin	SRWE 0049, 0068, 0091		$280,004	$2,152,473		$204,008					
Right-of-way			$224,004								
Construction			$1,400,024								
SYSTEM: Bunkerville		**$11,769,033**	**$2,651,650**	**$1,943,694**	**$0**	**$0**	**$1,943,694**		**$0**		
PROJECT: Windmill Wash Detention Basin and Jess Waite Levee Facilities											
Design/Admin	JEWA 0166, 0168	Design Started 10/11	$84,700	$1,943,694			$41,964				
Right-of-way		BUN01D11	$11,630								
Construction		Eng Est.	$1,535,380				$1,901,730				

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

FISCAL YEAR 2023-24 MAINTENANCE WORK PROGRAM FINAL ACCOUNTING REPORTS AND PROJECT CLOSEOUTS

RECOMMENDATION SUMMARY

STAFF:	Approve and closeout the interlocal contracts for FY 2023-24.
TECHNICAL ADVISORY:	Approve and closeout the interlocal contracts for FY 2023-24.
CITIZENS ADVISORY:	Approve and closeout the interlocal contracts for FY 2023-24.

RFCD AGENDA
ITEM #07
DATE: 11/14/2024

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT
AGENDA ITEM

SUBJECT:

FISCAL YEAR 2023-24 MAINTENANCE WORK PROGRAM – FINAL ACCOUNTING REPORTS AND PROJECT CLOSEOUTS

PETITIONER:

STEVEN C. PARRISH, P.E., GENERAL MANAGER/CHIEF ENGINEER

RECOMMENDATION OF PETITIONER:

THAT THE BOARD ACCEPT THE FINAL ACCOUNTING REPORTS AND CLOSEOUT THE FISCAL YEAR 2023-24 MAINTENANCE WORK PROGRAM INTERLOCAL CONTRACT WITH EACH ENTITY (FOR POSSIBLE ACTION)

FISCAL IMPACT: $5,280,230.44 – Reprogram for the Maintenance Work Program

BACKGROUND: Final accounting reports have been prepared for the fiscal year 2023-24 Maintenance Work Program ending June 30, 2024. The attached reports represent an accurate accounting of the charges and the remaining balances. Any maintenance work that was not completed during fiscal year 2023-24 has been reprogrammed within each entity's fiscal year 2024-25 program. The final accounting reports have been approved by the corresponding entities:

ENTITY	FY 2023-24 BUDGET	EXPENDED	UNEXPENDED
Boulder City	$ 918,550.00	$ 279,531.93	$ 639,018.07
Clark County	5,577,500.00	4,496,170.29	1,081,329.71
Henderson	5,700,000.00	3,318,720.83	2,381,279.17
Las Vegas	4,500,000.00	4,500,000.00	0.00
Mesquite	420,265.00	420,265.00	0.00
North Las Vegas	2,982,800.00	1,804,196.51	1,178,603.49
Totals	$20,099,115.00	$14,818,884.56	$5,280,230.44

TAC AGENDA ITEM # 06 Date: 10/31/2024	RFCD AGENDA ITEM # 07 Date: 11/14/2024
CAC AGENDA ITEM # 06 Date: 11/04/2024	

Respectfully submitted,

JESSICA HONOUR (Oct 21, 2024 10:38 PDT)

Jessica K. Honour
Administrative Services Director

Regional Flood Control District
AGENDA ITEM DEVELOPMENT

Staff Discussion:

Date: 10/21/2024

FISCAL YEAR 2023-24 MAINTENANCE WORK PROGRAM
FINAL ACCOUNTING REPORTS AND PROJECT CLOSEOUTS

Final accounting reports have been prepared for the fiscal year 2023-24 Maintenance Work Program, ending June 30, 2024. The reports represent an accurate accounting of the charges and the remaining balances. Any maintenance work that was not completed during fiscal year 2023-24 has been reprogrammed within each entity's fiscal year 2024-25 program. The final accounting reports have been approved by the corresponding entities:

ENTITY	FY 2023-24 BUDGET	EXPENDED	UNEXPENDED
Boulder City	$ 918,550.00	$ 279,531.93	$ 639,018.07
Clark County	5,577,500.00	4,496,170.29	1,081,329.71
Henderson	5,700,000.00	3,318,720.83	2,381,279.17
Las Vegas	4,500,000.00	4,500,000.00	0.00
Mesquite	420,265.00	420,265.00	0.00
North Las Vegas	2,982,800.00	1,804,196.51	1,178,603.49
Totals	$20,099,115.00	$14,818,884.56	$5,280,230.44

Staff Recommendation:

Approve and closeout the interlocal contracts for FY 2023-24.

Discussion by Technical Advisory Committee:

AGENDA #06 Date: 10/31/2024

Recommendation:
Approve and closeout the interlocal contracts for FY 2023-24

Discussion by Citizens Advisory Committee:

AGENDA #06 Date: 11/04/2024

Recommendation:
Approve and closeout the interlocal contracts for FY 2023-24

Boulder City
FISCAL YEAR 2024 MAINTENANCE WORK PROGRAM
FINAL ACCOUNTING REPORT
As of 9/4/2024

VENDOR	P.O. NUMBER	P.O. AMOUNT	TOTAL EXPENDED	P.O. BALANCE
CITY OF BOULDER CITY	4500374465 00010	96,135.53	96,135.53	0.00
Various Vendors	None	0.00	183,396.40	(183,396.40)
	Totals	**$96,135.53**	**$279,531.93**	**($183,396.40)**

FY 2024 INTERLOCAL AMOUNT/BUDGET	$918,550.00	Total Encumbered	$96,135.53
Total Encumbered	$96,135.53	Total Expended	$279,531.93
Total Unencumbered	**$822,414.47**	Total Unexpended	**($183,396.40)**

Total Authorized	**$918,550.00**
Expended	**$279,531.93**
Amount to Reprogram for MWP	**$639,018.07**

Prepared By:
Clark County Regional Flood Control District Deanna Hughes 10/21/24
DATE

Approved By: Jim Keane 9/17/2024
DATE

I certify that the above described maintenance was performed in accordance with the criteria/standards contained in the District's Operations and Maintenance Manual. Further, the information contained in this Final Accounting Report accurately reflects those costs incurred during the performance of this work. If there are any maintenance problems that have implications for the District as a whole, such as significant deterioration of major conveyence system components or failure of system components to perform as intended, a detailed description will accompany this report as an attachment.

Clark County
FISCAL YEAR 2024 MAINTENANCE WORK PROGRAM
FINAL ACCOUNTING REPORT
As of 9/4/2024

VENDOR	P.O. NUMBER	P.O. AMOUNT	TOTAL EXPENDED	P.O. BALANCE
Various Vendors	None	0.00	4,496,170.29	(4,496,170.29)
	Totals	**$0.00**	**$4,496,170.29**	**($4,496,170.29)**

FY 2024 INTERLOCAL AMOUNT/BUDGET	$5,577,500.00	Total Encumbered	$0.00
Total Encumbered	$0.00	Total Expended	$4,496,170.29
Total Unencumbered	**$5,577,500.00**	Total Unexpended	**($4,496,170.29)**

Total Authorized	**$5,577,500.00**
Expended	**$4,496,170.29**
Amount to Reprogram for MWP	**$1,081,329.71**

Prepared By:
Clark County Regional Flood Control District

Deanna Hughes 10/21/24
DATE

Approved By:

10-16-2024
DATE

I certify that the above described maintenance was performed in accordance with the criteria/standards contained in the District's Operations and Maintenance Manual. Further, the information contained in this Final Accounting Report accurately reflects those costs incurred during the performance of this work. If there are any maintenance problems that have implications for the District as a whole, such as significant deterioration of major conveyence system components or failure of system components to perform as intended, a detailed description will accompany this report as an attachment.

Henderson
FISCAL YEAR 2024 MAINTENANCE WORK PROGRAM
FINAL ACCOUNTING REPORT
As of 9/4/2024

VENDOR	P.O. NUMBER	P.O. AMOUNT	TOTAL EXPENDED	P.O. BALANCE
CITY OF HENDERSON	4500374090 00010	1,787,663.37	1,787,663.37	0.00
Various Vendors	None	0.00	1,531,057.46	(1,531,057.46)
	Totals	**$1,787,663.37**	**$3,318,720.83**	**($1,531,057.46)**

FY 2024 INTERLOCAL AMOUNT/BUDGET	$5,700,000.00	Total Encumbered	$1,787,663.37
Total Encumbered	$1,787,663.37	Total Expended	$3,318,720.83
Total Unencumbered	**$3,912,336.63**	Total Unexpended	**($1,531,057.46)**

Total Authorized	**$5,700,000.00**
Expended	**$3,318,720.83**
Amount to Reprogram for MWP	**$2,381,279.17**

Prepared By:
Clark County Regional Flood Control District

Deanna Hughes 10/21/24
DS DocuSigned by: **DATE**

Approved By:

CKD Albert Jankowiak 10/01/2024 | 8:00 AM PDT
D7909464AA43401... **DATE**

I certify that the above described maintenance was performed in accordance with the criteria/standards contained in the District's Operations and Maintenance Manual. Further, the information contained in this Final Accounting Report accurately reflects those costs incurred during the performance of this work. If there are any maintenance problems that have implications for the District as a whole, such as significant deterioration of major conveyence system components or failure of system components to perform as intended, a detailed description will accompany this report as an attachment.

Las Vegas
FISCAL YEAR 2024 MAINTENANCE WORK PROGRAM
FINAL ACCOUNTING REPORT
As of 9/4/2024

VENDOR	P.O. NUMBER	P.O. AMOUNT	TOTAL EXPENDED	P.O. BALANCE
CITY OF LAS VEGAS	4500374469 00010	2,965,624.82	2,965,624.82	0.00
Various Vendors	None	0.00	1,534,375.18	(1,534,375.18)
	Totals	**$2,965,624.82**	**$4,500,000.00**	**($1,534,375.18)**

FY 2024 INTERLOCAL AMOUNT/BUDGET	$4,500,000.00	Total Encumbered	$2,965,624.82
Total Encumbered	$2,965,624.82	Total Expended	$4,500,000.00
Total Unencumbered	**$1,534,375.18**	Total Unexpended	**($1,534,375.18)**

Total Authorized	**$4,500,000.00**
Expended	**$4,500,000.00**
Amount to Reprogram for MWP	**$0.00**

Prepared By:
Clark County Regional Flood Control District

Deanna Hughes **10/21/24**
DATE

Approved By:

Doug Rigby 9/11/24
DATE

I certify that the above described maintenance was performed in accordance with the criteria/standards contained in the District's Operations and Maintenance Manual. Further, the information contained in this Final Accounting Report accurately reflects those costs incurred during the performance of this work. If there are any maintenance problems that have implications for the District as a whole, such as significant deterioration of major conveyence system components or failure of system components to perform as intended, a detailed description will accompany this report as an attachment.

Mesquite
FISCAL YEAR 2024 MAINTENANCE WORK PROGRAM
FINAL ACCOUNTING REPORT
As of 9/4/2024

VENDOR	P.O. NUMBER	P.O. AMOUNT	TOTAL EXPENDED	P.O. BALANCE
CITY OF MESQUITE	4500374470 00010	392,648.07	392,648.07	0.00
Various Vendors	None	0.00	27,616.93	(27,616.93)
	Totals	**$392,648.07**	**$420,265.00**	**($27,616.93)**

FY 2024 *INTERLOCAL* AMOUNT/BUDGET	$420,265.00	Total Encumbered	$392,648.07
Total Encumbered	$392,648.07	Total Expended	$420,265.00
Total Unencumbered	**$27,616.93**	Total Unexpended	**($27,616.93)**

Total Authorized	**$420,265.00**
Expended	**$420,265.00**
Amount to Reprogram for MWP	**$0.00**

Prepared By:
Clark County Regional Flood Control District

Deanna Hughes 10/21/24
DATE

Approved By:

Travis W. Anderson 9-9-24
DATE

I certify that the above described maintenance was performed in accordance with the criteria/standards contained in the District's Operations and Maintenance Manual. Further, the information contained in this Final Accounting Report accurately reflects those costs incurred during the performance of this work. If there are any maintenance problems that have implications for the District as a whole, such as significant deterioration of major conveyence system components or failure of system components to perform as intended, a detailed description will accompany this report as an attachment.

North Las Vegas
FISCAL YEAR 2024 MAINTENANCE WORK PROGRAM
FINAL ACCOUNTING REPORT
As of 9/4/2024

VENDOR	P.O. NUMBER	P.O. AMOUNT	TOTAL EXPENDED	P.O. BALANCE
CITY OF NORTH LAS VEGAS	4500374468 00010	1,354,031.56	1,354,031.56	0.00
Various Vendors	None	0.00	450,164.95	(450,164.95)
	Totals	**$1,354,031.56**	**$1,804,196.51**	**($450,164.95)**

FY 2024 INTERLOCAL AMOUNT/BUDGET	$2,982,800.00	Total Encumbered	$1,354,031.56
Total Encumbered	$1,354,031.56	Total Expended	$1,804,196.51
Total Unencumbered	**$1,628,768.44**	Total Unexpended	**($450,164.95)**

Total Authorized	**$2,982,800.00**
Expended	**$1,804,196.51**
Amount to Reprogram for MWP	**$1,178,603.49**

Prepared By:
Clark County Regional Flood Control District

Deanna Hughes 10/21/24
DATE

Approved By:

10/10/24
DATE

I certify that the above described maintenance was performed in accordance with the criteria/standards contained in the District's Operations and Maintenance Manual. Further, the information contained in this Final Accounting Report accurately reflects those costs incurred during the performance of this work. If there are any maintenance problems that have implications for the District as a whole, such as significant deterioration of major conveyence system components or failure of system components to perform as intended, a detailed description will accompany this report as an attachment.

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

FINAL ACCOUNTING REPORTS AND PROJECT CLOSEOUTS
CLA38E20, GSP01B10

RECOMMENDATION SUMMARY

STAFF:	Accept the final accounting report and close out the interlocal contract.
TECHNICAL ADVISORY:	Accept the final accounting report and close out the interlocal contract.
CITIZENS ADVISORY:	Accept the final accounting report and close out the interlocal contract.

RFCD AGENDA
ITEM #08
DATE: 11/14/2024

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT
AGENDA ITEM

SUBJECT:

FINAL ACCOUNTING REPORTS AND PROJECT CLOSEOUTS

PETITIONER:
STEVEN C. PARRISH, P.E., GENERAL MANAGER/CHIEF ENGINEER

RECOMMENDATION OF PETITIONER:

THAT THE BOARD ACCEPT THE FINAL ACCOUNTING REPORTS AND CLOSE OUT THE INTERLOCAL CONTRACTS (FOR POSSIBLE ACTION)

FISCAL IMPACT: $490,148.56 Release in Fund 4430

BACKGROUND:

Final accounting reports are routinely prepared for District-funded projects that have been completed. These reports represent an accurate accounting of the charges and the remaining balance for each project. Upon approval, no additional funds can be expended for the projects.

The final accounting reports have been prepared by the District and approved by the corresponding entities for the following projects:

PROJECT	NUMBER	FUND	BALANCE
Duck Creek – Jones Boulevard Storm Drain (construction)	CLA38E20	4430.000	$477,855.30
Goodsprings – Phase 1 (design)	GSP01B10	4430.000	$ 12,293.26
Total Fund 4430			**$490,148.56**

Respectfully submitted,

Steven C. Parrish P.E.
General Manager/Chief Engineer

TAC AGENDA ITEM #07 Date: 10/31/2024	RFCD AGENDA ITEM #08 Date: 11/14/2024
CAC AGENDA ITEM #07 Date: 11/04/2024	

111424 Closeout-item

Regional Flood Control District
AGENDA ITEM DEVELOPMENT

Staff Discussion:

Date: 10/21/2024

FINAL ACCOUNTING REPORTS AND PROJECT CLOSEOUTS

Final accounting reports are routinely prepared for District-funded projects that have been completed. These reports represent an accurate accounting of the charges and the remaining balance for each project. Upon approval, no additional funds can be expended for the projects.

The final accounting reports have been prepared by the District and approved by the corresponding entities for the following projects:

PROJECT	NUMBER	FUND	BALANCE
Duck Creek – Jones Boulevard Storm Drain (construction)	CLA38E20	4430.000	$477,855.30
Goodsprings – Phase 1 (design)	GSP01B10	4430.000	$ 12,293.26
Total – Fund 4430			**$490,148.56**

Staff Recommendation:

Accept the final accounting reports and close out the interlocal contracts.

Discussion by Technical Advisory Committee:

AGENDA #07 Date: 10/31/2024

Recommendation:

Accept the final accounting reports and close out the interlocal contracts.

Discussion by Citizens Advisory Committee:

AGENDA #07 Date: 11/04/2024

Recommendation:

Accept the final accounting reports and close out the interlocal contracts.

Clark County Regional Flood Control District
Final Accounting Report
Report Date 9/9/2024

REGIONAL FLOOD CONTROL DISTRICT

Project: CLA38E20, Duck Creek - Jones Boulevard Storm Drain
Interlocal Value: $3,650,769.00

Funding Category	Right of Way	Predesign	Design	Construction	Construction Mgt	Environmental	Entity Costs	Other
Interlocal Funding Allocation	$0.00	$0.00	$0.00	$3,328,864.00	$271,905.00	$0.00	$50,000.00	$0.00
Amount Spent by Category	$0.00	$0.00	$0.00	$3,114,515.49	$12,562.20	$0.00	$45,836.01	$0.00
Remaining by Category	$0.00	$0.00	$0.00	$214,348.51	$259,342.80	$0.00	$4,163.99	$0.00

Funding / Expenditure Summary

Interlocal Agreement:	**$3,650,769.00**
Minus Amount Spent:	**$3,172,913.70**
Amount to be Returned for Future Use:	**$477,855.30**

ID Miles: DCJB0000, DCJB0020, DCJB0043

Concur:

9-10-24
DATE

Accepted and Approved:

DATE

Project Audit Report

Project: RF.CLA38E20, Duck Creek - Jones Boulevard Storm Drain

Status: Open

9/9/2024

REGIONAL FLOOD CONTROL DISTRICT

Purchase Order - none

Vendor	Invoice #	Invoice Date	Amount	WBS	FY	Memo/Text
REGIONAL FLOOD CONTROL/TREAS	1021060820	06/30/2021	78.05	RF.CLA38E20.2-3 - CENG	2021	AP Manual - Doc 1522010568
REGIONAL FLOOD CONTROL/TREAS	1922001518	08/17/2021	(78.05)	RF.CLA38E20.2-3 - CENG	2022	AP Manual - Doc 1522010568
REGIONAL FLOOD CONTROL/TREAS	1122001480	06/30/2022	1,232.35	RF.CLA38E20.2-3 - CENG	2022	AP Manual - Doc 1523002396
REGIONAL FLOOD CONTROL/TREAS	1123000054	07/21/2022	(1,232.35)	RF.CLA38E20.2-3 - CENG	2023	AP Manual - Doc 1523002396
REGIONAL FLOOD CONTROL/TREAS	1122001600	06/30/2022	2,954.21	RF.CLA38E20.2-3 - CENG	2022	AP Manual - Doc 1523021659
REGIONAL FLOOD CONTROL/TREAS	1123000306	08/31/2022	(2,954.21)	RF.CLA38E20.2-3 - CENG	2023	AP Manual - Doc 1523021659
PUBLIC WORKS/CC TREAS	1523021659	08/23/2022	2,954.21	RF.CLA38E20.2-3 - CENG	2023	Kleinfelder; 3123011511/FY22
PUBLIC WORKS/CC TREAS	1522010568	08/03/2021	78.05	RF.CLA38E20.2-3 - CENG	2022	Kleinfelder/3122003189;FY21-12
PUBLIC WORKS/CC TREAS	1522026013	09/17/2021	732.83	RF.CLA38E20.2-3 - CENG	2022	Kleinfelder;3122018409
PUBLIC WORKS/CC TREAS	1522061953	12/23/2021	952.98	RF.CLA38E20.2-3 - CENG	2022	Kleinfelder; 3122052128/FY6-22
PUBLIC WORKS/CC TREAS	1522091215	03/14/2022	2,514.05	RF.CLA38E20.2-3 - CENG	2022	FY22-5 Kleinfelder 3122078835
PUBLIC WORKS/CC TREAS	1522091216	03/14/2022	907.48	RF.CLA38E20.2-3 - CENG	2022	FY22-5 Kleinfelder 3122078839
PUBLIC WORKS/CC TREAS	1522098668	03/30/2022	419.30	RF.CLA38E20.2-3 - CENG	2022	Kleinfelder; 3122086436
PUBLIC WORKS/CC TREAS	1522116868	05/12/2022	2,101.40	RF.CLA38E20.2-3 - CENG	2022	FY22-6 Kleinfelder/3122102496
PUBLIC WORKS/CC TREAS	1522116870	05/12/2022	669.55	RF.CLA38E20.2-3 - CENG	2022	FY22-8 Kleinfelder/3122102482
PUBLIC WORKS/CC TREAS	1523002396	07/01/2022	1,232.35	RF.CLA38E20.2-3 - CENG	2023	Kleinfelder; 3122125619/FY22
	WBS Total		**$12,562.20**			
REGIONAL FLOOD CONTROL/TREAS	1021060820	06/30/2021	10,707.50	RF.CLA38E20.3-1F - CONS	2021	AP Manual - Doc 1522011368
REGIONAL FLOOD CONTROL/TREAS	1922001518	08/17/2021	(10,707.50)	RF.CLA38E20.3-1F - CONS	2022	AP Manual - Doc 1522011368
REGIONAL FLOOD CONTROL/TREAS	1122001561	06/30/2022	2,381.98	RF.CLA38E20.3-1F - CONS	2022	AP Manual - Doc 1523016662
REGIONAL FLOOD CONTROL/TREAS	1123000209	08/16/2022	(2,381.98)	RF.CLA38E20.3-1F - CONS	2023	AP Manual - Doc 1523016662
REGIONAL FLOOD CONTROL/TREAS	1122001570	06/30/2022	124.20	RF.CLA38E20.3-1F - CONS	2022	AP Manual - Doc 1523017621
REGIONAL FLOOD CONTROL/TREAS	1123000220	08/22/2022	(124.20)	RF.CLA38E20.3-1F - CONS	2023	AP Manual - Doc 1523017621
REGIONAL FLOOD CONTROL/TREAS	1122001591	06/30/2022	124.20	RF.CLA38E20.3-1F - CONS	2022	AP Manual - Doc 1523022298
REGIONAL FLOOD CONTROL/TREAS	1123000300	08/30/2022	(124.20)	RF.CLA38E20.3-1F - CONS	2023	AP Manual - Doc 1523022298
PUBLIC WORKS/CC TREAS	1523026554	09/01/2022	3,026.97	RF.CLA38E20.3-1F - CONS	2023	FY23-2;J.S.&S./3123014371
PUBLIC WORKS/CC TREAS	1523030993	09/15/2022	1,712.09	RF.CLA38E20.3-1F - CONS	2023	Western States; 3123019472
PUBLIC WORKS/CC TREAS	1523032887	09/21/2022	1,196.25	RF.CLA38E20.3-1F - CONS	2023	FY23-2;Western States/3123021679
PUBLIC WORKS/CC TREAS	1523045297	10/19/2022	3,026.97	RF.CLA38E20.3-1F - CONS	2023	FY23-3;JS&S/3123032607
PUBLIC WORKS/CC TREAS	1523059003	11/17/2022	3,027.24	RF.CLA38E20.3-1F - CONS	2023	FY23-4;JS&S/3123045064
PUBLIC WORKS/CC TREAS	1523134260	05/09/2023	338,163.29	RF.CLA38E20.3-1F - CONS	2023	Western States; 3123112349/FY23
PUBLIC WORKS/CC TREAS	1524039412	08/29/2023	18,719.53	RF.CLA38E20.3-1F - CONS	2024	Western States;3124016585
PUBLIC WORKS/CC TREAS	1523022298	08/24/2022	124.20	RF.CLA38E20.3-1F - CONS	2023	FY22-12;J.S.&S./3123012287
PUBLIC WORKS/CC TREAS	1523016662	08/09/2022	2,381.98	RF.CLA38E20.3-1F - CONS	2023	western states; 3123005953/FY22
PUBLIC WORKS/CC TREAS	1523017621	08/11/2022	124.20	RF.CLA38E20.3-1F - CONS	2023	FY22-12 J.S.&S/3123006980
PUBLIC WORKS/CC TREAS	1523018431	08/15/2022	3,026.97	RF.CLA38E20.3-1F - CONS	2023	FY23-1;J.S&S/3123008147

Project Audit Report

Project: RF.CLA38E20, Duck Creek - Jones Boulevard Storm Drain

Status: Open

REGIONAL FLOOD CONTROL DISTRICT

9/9/2024

PUBLIC WORKS/CC TREAS	1522018193	08/26/2021	268,979.00	RF.CLA38E20.3-1F - CONS	2022	Western States/3122011092;FY22-1
PUBLIC WORKS/CC TREAS	1521103894	04/23/2021	9,081.18	RF.CLA38E20.3-1F - CONS	2021	JS&S; 3121089761
PUBLIC WORKS/CC TREAS	1521115119	05/21/2021	5,448.60	RF.CLA38E20.3-1F - CONS	2021	JS&S; 3121099646
PUBLIC WORKS/CC TREAS	1521118734	06/01/2021	9,081.18	RF.CLA38E20.3-1F - CONS	2021	JS&S; 3121102443
PUBLIC WORKS/CC TREAS	1522011368	08/05/2021	10,707.50	RF.CLA38E20.3-1F - CONS	2022	Western States;3122004198/FY21-12
PUBLIC WORKS/CC TREAS	1522027138	09/22/2021	526,306.36	RF.CLA38E20.3-1F - CONS	2022	Western States;3122020321/FY2201
PUBLIC WORKS/CC TREAS	1522038750	10/21/2021	746,894.37	RF.CLA38E20.3-1F - CONS	2022	Western States; 3122030607/ FY22
PUBLIC WORKS/CC TREAS	1522053895	12/02/2021	56,583.71	RF.CLA38E20.3-1F - CONS	2022	FY22-4 Western States/3122043666
PUBLIC WORKS/CC TREAS	1522061946	12/23/2021	278,899.62	RF.CLA38E20.3-1F - CONS	2022	Western States; 3122051724
PUBLIC WORKS/CC TREAS	1522073125	01/26/2022	196,477.39	RF.CLA38E20.3-1F - CONS	2022	Westers States; 3122061630/FY22-07
PUBLIC WORKS/CC TREAS	1522077580	02/07/2022	18,767.70	RF.CLA38E20.3-1F - CONS	2022	FY22-7 JS&S/3122065505
PUBLIC WORKS/CC TREAS	1522083354	02/18/2022	604.80	RF.CLA38E20.3-1F - CONS	2022	JS&S; 3122070488
PUBLIC WORKS/CC TREAS	1522084193	02/23/2022	292,307.26	RF.CLA38E20.3-1F - CONS	2022	Western States; 3122071621
PUBLIC WORKS/CC TREAS	1522090115	03/10/2022	3,026.97	RF.CLA38E20.3-1F - CONS	2022	JS&S; 3122078140
PUBLIC WORKS/CC TREAS	1522093655	03/21/2022	36,070.33	RF.CLA38E20.3-1F - CONS	2022	FY22-8 Western States/3122081695
PUBLIC WORKS/CC TREAS	1522106518	04/20/2022	224,107.28	RF.CLA38E20.3-1F - CONS	2022	FY22-9 Western States/3122094237
PUBLIC WORKS/CC TREAS	1522112517	05/03/2022	3,026.97	RF.CLA38E20.3-1F - CONS	2022	FY22-10 JS&S/3122098192
PUBLIC WORKS/CC TREAS	1522122193	05/25/2022	18,113.04	RF.CLA38E20.3-1F - CONS	2022	FY22-10 Western States/3122109230
PUBLIC WORKS/CC TREAS	1522137732	06/23/2022	35,502.54	RF.CLA38E20.3-1F - CONS	2022	Western States; 3122120634
	WBS Total		**$3,114,515.49**			
REGIONAL FLOOD CONTROL/TREAS	1121001697	06/30/2021	45,836.01	RF.CLA38E20.9 - OTHE	2021	AP Manual - Doc 1522017652
REGIONAL FLOOD CONTROL/TREAS	1122000292	08/31/2021	(45,836.01)	RF.CLA38E20.9 - OTHE	2022	AP Manual - Doc 1522017652
PUBLIC WORKS/CC TREAS	1522017652	08/25/2021	45,836.01	RF.CLA38E20.9 - OTHE	2022	CCPW/1022007980;FY21-12
	WBS Total		**$45,836.01**			
	Purchase Order Total		**$3,172,913.70**			
	Project Expense Total		**$3,172,913.70**			

Clark County Regional Flood Control District
Final Accounting Report
Report Date 10/9/2024

REGIONAL FLOOD CONTROL DISTRICT

Project: GSP01B10, Goodsprings - Phase I
Interlocal Value: $133,400.00

Funding Category	Right of Way	Predesign	Design	Construction	Construction Mgt	Environmental	Entity Costs	Other
Interlocal Funding Allocation	$57,500.00	$0.00	$75,400.00	$0.00	$0.00	$500.00	$0.00	$0.00
Amount Spent by Category	$50,866.23	$0.00	$70,240.51	$0.00	$0.00	$0.00	$0.00	$0.00
Remaining by Category	$6,633.77	$0.00	$5,159.49	$0.00	$0.00	$500.00	$0.00	$0.00

Funding / Expenditure Summary

Interlocal Agreement:	**$133,400.00**
Minus Amount Spent:	**$121,106.74**
Amount to be Returned for Future Use:	**$12,293.26**

ID Miles: GSPA0000, GSPA0005, GSPA0010, GSPA0018, GSPA0019, GSPA0020, GSPA0021, GSPA0022, GSPA0023, GSPA0024, GSPA0025, GSPA0026, GSPA0027, GSPA0029

Concur:

10-14-24
DATE

Accepted and Approved:

DATE

Project Audit Report

Project: RF.GSP01B10, Goodsprings - Phase I

Status: Open

10/9/2024

REGIONAL FLOOD CONTROL DISTRICT

Purchase Order - none

Vendor	Invoice #	Invoice Date	Amount	WBS	FY	Memo/Text
PUBLIC WORKS/CC TREAS	1517145706	06/16/2017	38,400.00	RF.GSP01B10.1-1 - ROW	2017	Chicago Title; 3017239197
	WBS Total		**$38,400.00**			
REGIONAL FLOOD CONTROL/TREAS	1119001581	06/30/2019	468.99	RF.GSP01B10.1-2 - ROW	2019	AP Manual - Doc 1520008297
REGIONAL FLOOD CONTROL/TREAS	1120000126	08/05/2019	(468.99)	RF.GSP01B10.1-2 - ROW	2020	AP Manual - Doc 1520008297
PUBLIC WORKS/CC TREAS	1515022300	08/25/2014	2,500.00	RF.GSP01B10.1-2 - ROW	2015	Valbridge Property Advisors; 3115011237
PUBLIC WORKS/CC TREAS	1515131171	05/22/2015	9,497.24	RF.GSP01B10.1-2 - ROW	2015	CCPW; 1015010128
PUBLIC WORKS/CC TREAS	1520008297	07/22/2019	468.99	RF.GSP01B10.1-2 - ROW	2020	CCPW; 1019073472
	WBS Total		**$12,466.23**			
REGIONAL FLOOD CONTROL/TREAS	1119001581	06/30/2019	5,207.65	RF.GSP01B10.2-2D - DENG	2019	AP Manual - Doc 1520008297
REGIONAL FLOOD CONTROL/TREAS	1120000126	08/05/2019	(5,207.65)	RF.GSP01B10.2-2D - DENG	2020	AP Manual - Doc 1520008297
REGIONAL FLOOD CONTROL/TREAS	1124001368	06/30/2024	41,035.53	RF.GSP01B10.2-2D - DENG	2024	AP Manual - Doc 1525021973
REGIONAL FLOOD CONTROL/TREAS	1125000179	08/14/2024	(41,035.53)	RF.GSP01B10.2-2D - DENG	2025	AP Manual - Doc 1525021973
PUBLIC WORKS/CC TREAS	1523039040	10/04/2022	4,328.36	RF.GSP01B10.2-2D - DENG	2023	CCPW; 1023017118
PUBLIC WORKS/CC TREAS	1525021973	07/31/2024	41,035.53	RF.GSP01B10.2-2D - DENG	2025	CCPW; 1024078004/FY24
PUBLIC WORKS/CC TREAS	1515131171	05/22/2015	19,668.97	RF.GSP01B10.2-2D - DENG	2015	CCPW; 1015010128
PUBLIC WORKS/CC TREAS	1520008297	07/22/2019	5,207.65	RF.GSP01B10.2-2D - DENG	2020	CCPW; 1019073472
	WBS Total		**$70,240.51**			
	Purchase Order Total		**$121,106.74**			
	Project Expense Total		**$121,106.74**			

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

REGIONAL FLOOD CONTROL DISTRICT'S POLICIES AND PROCEDURES MANUAL – 2024 ANNUAL REVIEW/UPDATE

RECOMMENDATION SUMMARY

STAFF:	Adopt amendments to the RFCD Policies and Procedures Manual 2024 annual review/update
TECHNICAL ADVISORY:	Follow staff recommendation.
CITIZENS ADVISORY:	Follow staff recommendation.

RFCD AGENDA
ITEM #09
DATE: 11/14/2024

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

REGIONAL FLOOD CONTROL DISTRICT'S POLICIES AND PROCEDURES MANUAL – 2024 ANNUAL REVIEW/UPDATE

PETITIONER:

STEVEN C. PARRISH, P.E., GENERAL MANAGER/CHIEF ENGINEER

RECOMMENDATION OF PETITIONER:

ADOPT AMENDMENTS TO THE REGIONAL FLOOD CONTROL DISRICT'S POLICIES AND PROCEDURES MANUAL – 2024 ANNUAL REVIEW/UPDATE

FISCAL IMPACT: None.

BACKGROUND:

The District Policies and Procedures Manual – Section XIII, states that the Advisory Committees will review the policies and procedures in August of each year; thereafter the amended manual will be presented to the Board for adoption. Staff has proposed changes to the following sections:

SECTION II – PROJECT DEVELOPMENT

- **Section II.B.1.a – Project Evaluation (page 16) –** Adds a Hydrographic Basin "Eldorado Valley" to the City of Henderson's planning area.
- **Section II.B.4 – Project Evaluation (page 19) –** Adds verbiage regarding compliance with Section II.C.7 to request construction funding.
- **Section II.C.1.d – Implementation of the Master Plan (pages 20-21) –** Adds a Hydrographic Basin "Eldorado Valley" to the City of Henderson's planning area.
- **Section II.C.7 – Implementation of the Master Plan (pages 24-25) –** Adds a paragraph "7 - Project Loan Program Eligibility" to clarify eligibility for this program.
- **Section II.D.3.a – Project Funding (page 25) –** Adds verbiage regarding compliance with Section II.C.7.

TAC AGENDA ITEM #07 Date: 08/29/2024	TAC AGENDA ITEM #07 Date: 09/26/2024	TAC AGENDA ITEM #08 Date: 10/31/2024	RFCD AGENDA ITEM # 09 Date: 11/14/2024
CAC AGENDA ITEM #07 Date: 08/29/2024	CAC AGENDA ITEM #07 Date: 09/30/2024	CAC AGENDA ITEM #08 Date: 11/04/2024	

- **Section II.D.5.b – Project Funding (pages 26-27) –** Adds a paragraph "b" regarding annual reimbursement payments and prioritization on the Estimated Funding Schedule (EFS).

EXHIBITS J and K

EXHIBIT J – Project Specific Loan Agenda Item and Interlocal Contract
EXHIBIT K – Reimbursement Resolution Agenda Item and Reimbursement Resolution

TAC AGENDA ITEM #07 Date: 08/29/2024	TAC AGENDA ITEM #07 Date: 09/26/2024	TAC AGENDA ITEM #08 Date: 10/31/2024	RFCD AGENDA ITEM #09 Date: 11/14/2024
CAC AGENDA ITEM #07 Date: 08/29/2024	CAC AGENDA ITEM #07 Date: 09/30/2024	CAC AGENDA ITEM #08 Date: 11/04/2024	

Respectfully submitted,

Steven C. Parrish, P.E.
General Manager/Chief Engineer

Regional Flood Control District
AGENDA ITEM DEVELOPMENT

Staff Discussion:

Date: 10/21/2024

RFCD POLICIES AND PROCEDURES MANUAL – 2024 ANNUAL REVIEW/UPDATE

The District Policies and Procedures Manual – Section XIII, states that the Advisory Committees will review the policies and procedures in August of each year; thereafter the amended manual will be presented to the Board for adoption. Staff has proposed changes to the following sections:

SECTION II – PROJECT DEVELOPMENT

- **Section II.B.1.a – Project Evaluation (page 16) –** Adds a Hydrographic Basin "Eldorado Valley" to the City of Henderson's planning area.
- **Section II.B.4 – Project Evaluation (page 19) –** Adds verbiage regarding compliance with Section II.C.7 to request construction funding.
- **Section II.C.1.d – Implementation of the Master Plan (pages 20-21) –** Adds a Hydrographic Basin "Eldorado Valley" to the City of Henderson's planning area.
- **Section II.C.7 – Implementation of the Master Plan (pages 24-25) –** Adds a paragraph "7 - Project Loan Program Eligibility" to clarify eligibility for this program.
- **Section II.D.3.a – Project Funding (page 25) –** Adds verbiage regarding compliance with Section II.C.7.
- **Section II.D.5.b – Project Funding (pages 26-27) –** Adds a paragraph "b" regarding annual reimbursement payments and prioritization on the Estimated Funding Schedule (EFS).

EXHIBITS J and K

EXHIBIT J – Project Specific Loan Agenda Item and Interlocal Contract
EXHIBIT K – Reimbursement Resolution Agenda Item and Reimbursement Resolution

Staff Recommendation:

Adopt amendments to the RFCD Policies and Procedures Manual – 2024 annual review/update.

Discussion by Technical Advisory Committee:

AGENDA #08 Date: 10/31/2024

Recommendation:

Adopt amendments to the RFCD Policies and Procedures Manual 2024 annual review/update.

Discussion by Citizens Advisory Committee:

AGENDA #08 Date: 11/04/2024

Recommendation:

Adopt amendments to the RFCD Policies and Procedures Manual 2024 annual review/update.

Staff Discussion:

Date: 09/17/2024

RFCD POLICIES AND PROCEDURES MANUAL – 2024 ANNUAL REVIEW/UPDATE

The District Policies and Procedures Manual – Section XIII, states that the Advisory Committees will review the policies and procedures in August of each year; thereafter the amended manual will be presented to the Board for adoption. Staff is currently in the process of reviewing the manual.

Staff Recommendation:

Receive a report on amendments to the RFCD Policies and Procedures Manual – 2024 annual review/update.

Discussion by Technical Advisory Committee:

AGENDA #07 Date: 09/26/2024

Recommendation:

Follow staff recommendation.

Discussion by Citizens Advisory Committee:

AGENDA #07 Date: 09/30/2024

Recommendation:

Follow staff recommendation.

Regional Flood Control District
AGENDA ITEM DEVELOPMENT

Staff Discussion:

Date: 08/19/2024

RFCD POLICIES AND PROCEDURES MANUAL – 2024 ANNUAL REVIEW/UPDATE

The District Policies and Procedures Manual – Section XIII, states that the Advisory Committees will review the policies and procedures in August of each year; thereafter the amended manual will be presented to the Board for adoption. Staff is currently in the process of reviewing the manual. In addition, the Advisory Committees may wish to review and offer comments to District staff regarding the Policies and Procedures by September 12, 2024.

Staff Recommendation:

Receive a report on amendments to the RFCD Policies and Procedures Manual – 2024 annual review/update.

Discussion by Technical Advisory Committee:

AGENDA #07 Date: 08/29/2024

Recommendation:

Follow staff recommendation.

Discussion by Citizens Advisory Committee:

AGENDA #07 Date: 08/29/2024

Recommendation:

Follow staff recommendation.

111424 Policies & Procedures-aid

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

POLICIES AND PROCEDURES MANUAL

STEVEN C. PARRISH, P.E.
GENERAL MANAGER / CHIEF ENGINEER

www.regionalflood.org

The Policies and Procedures Manual has been updated in accordance with Regional Flood Control District Board action on November 14, 2024. The Board adopted amendments to:

SECTION II – PROJECT DEVELOPMENT

- *Section II.B.1.a – Project Evaluation*
- *Section II.B.4 – Project Evaluation*
- *Section II.C.1.d – Implementation of the Master Plan*
- *Section II.C.7 – Implementation of the Master Plan*
- *Section II.D.3.a – Project Funding*
- *Section II.D.5.b – Project Funding*

EXHIBITS J and K

EXHIBIT J – Project Specific Loan Agenda Item and Interlocal Contract
EXHIBIT K – Reimbursement Resolution Agenda Item and Reimbursement Resolution

CHAPTER II. PROJECT DEVELOPMENT

The General Manager/Chief Engineer with the assistance of the entities within the District will develop and maintain a Master Plan of Flood Control Facilities. The Master Plan will set forth a comprehensive solution to flood control with the intent of improving the protection of life and property from the threat of flooding for existing and future residents of Clark County and the incorporated areas.

A. Master Plan Updates, Changes and Amendments

1. Master Plan Updates

a. The District shall conduct a detailed review of the Master Plan every five (5) years or more frequently if the Board finds that circumstances so warrant. In addition to providing the information required for annual review (Section I.G.4.(p)), the District shall:

1) Add to the plan any new information which is relevant to the plan.

2) Assess the progress toward fulfillment of the Master Plan during the five-year period.

3) Identify any major obstacles to completion of the Master Plan.

4) Recommend amendments to the Master Plan resulting from growth and development in the District.

b. If the Master Plan Update recommends a change or amendment, it will be considered for adoption before the Board and Advisory Committees in accordance with the process described in Section 2 below. Proposed updates will be submitted by the District to the Southern Nevada Regional Planning Coalition (SNRPC) to ensure conformity with the Regional Policy Plan prior to Board action.

c. If the Master Plan Update recommends no changes, it will be considered by the Advisory Committees and filed with the Board and the impacted entities.

2. Master Plan Changes and Amendments

a. The District's General Manager/Chief Engineer, or any governmental entity, may propose amendments and changes to the District's Master Plan.

b. Proposed amendments or changes shall be reviewed by the General Manager/Chief Engineer, the CAC, and the TAC to determine whether the proposal is consistent with the general principles set forth in Subsection 3 of NRS 543.590 for the Master Plan and a recommendation forwarded to the Board.

c. The entity proposing amendments or changes shall submit the proposed amendment or change for review by the Southern Nevada Regional Planning Coalition (SNRPC) in accordance with the Southern Nevada Regional Planning Act (Chapter 489, Statutes of Nevada 1999). The determination of conformity with the Plan shall be accomplished prior to Board action on the proposed amendments or changes.

d. The Board shall hold a public hearing to consider the adoption of the proposed Master Plan amendment or change.

e. The Board may adopt the proposed amendment or change to the District's Master Plan with the approval of two-thirds of the members voting.

f. If the amendment or change is adopted, the Board shall file a copy of the amendment or change with the governing body of each local government whose jurisdiction includes the hydrographic area affected by the amendment or change.

g. If the amendment is adopted unanimously by the Board, the governing body of the local government in whose jurisdiction the amendment is located shall hold a public hearing to consider the adoption of the proposed amendment as a component of its comprehensive master plan pursuant to Chapter 278 of NRS.

h. If the governing body unanimously adopts the amendment after a hearing, the amendment becomes effective and no other hearing or approval is required by any other board or commission, including those responsible for decisions relating to planning or zoning.

i. If the amendment is not adopted unanimously by the Board or by the governing body of the local government in whose jurisdiction the amendment is located, the governing body of each local entity affected shall hold a public hearing to consider the adoption of the proposed amendment as a component of its own comprehensive master plan pursuant to Chapter 278 of NRS. The amendment becomes effective upon approval by the governing body of each local entity that is affected.

B. Project Evaluation

The District staff will maintain a listing of projects proposed for funding in the next Ten-Year period. The Ten-Year Construction Program will be updated annually and must be approved by the Board after review by the TAC and CAC.

In addition to the Ten-Year Construction Program, the General Manager/Chief Engineer with assistance, cooperation, and approval of the TAC, will prepare a list of projects proposed for funding during the upcoming fiscal year (Current Year Project List). The Current Year Project List, after approval by the Board, constitutes the Capital Improvement Program for the District in the ensuing fiscal year. The Current Year Project List and the updated Ten-Year Construction Program will be presented to the Board no later than June of each year.

Board approval of the Ten-Year Construction Program and the Current Year Project List does not authorize funding of any project and does not commit the District to expending any funds.

1. The relative Project Priority, Ten Year Construction Program and Current Year Project List will be reviewed annually. Information to conduct this review will be provided by the member entities for the Hydrographic Basin as defined in the Master Plan and as grouped below:

   a. City of Henderson

      1) Pittman Wash

      2) C-1 System

      ~~2)~~3) Eldorado Valley

   b. City of Las Vegas

      1) Gowan

2) Central

3) Upper Northern Las Vegas Wash

c. City of North Las Vegas

1) Lower Northern Las Vegas Wash

2) Lower Las Vegas Wash

3) Range Wash

4) Apex

d. Clark County

1) Duck Creek/Blue Diamond

2) Tropicana/Flamingo

3) Outlying Areas

e. City of Boulder City

f. City of Mesquite

2. Upon completion of the review, the relative project priority, Ten Year Construction Program and Current Year Project List will be presented to the TAC, CAC, and Board for adoption.

3. The relative priority of Master Plan projects will be assessed in terms of the criteria listed below. A Project Priority Value will be calculated for each project within the hydrographic basin groups listed in B.1. above. Life safety issues shall be the primary consideration during evaluation of a project under criteria (a.) through (d.) which shall be weighted to recognize their utmost importance in this regard.

a. **Population Affected –** Refers to the existing population affected by the construction of the project considered. Impact includes reducing flood hazards.

b. **Assessed Land Value Impacted –** Assessed land values for developed and undeveloped land affected by the project, including all structures (public, commercial, or residential) will be reviewed.

Impact on land values related to a reduction of the flood plain area will be considered under this item.

c. **Public Perception of Need –** The project will be evaluated in terms of satisfying the public's desire to see their money spent on "worthwhile" projects and the public's perception of need.

d. **Emergency Access and Public Inconvenience –** The project will be evaluated to determine its impact on the access of emergency vehicles including police, ambulance, and fire vehicles to their respective substation, hospital, or station. The evaluation will include an assessment of the project's contribution to the development of an all-weather transportation system and accessibility to flood isolated residences, businesses, and public facilities.

e. **Cost Avoidance –** Cost avoidance includes projects which will reduce future costs, including potential damage, construction of oversized facilities, and the ability to construct. This item should also address other costs associated with lost opportunity and the risk associated with inadequate or undersized facilities.

f. **Availability of Other Funding Sources –** This includes an evaluation of the potential for funds from grants, developers, the Corps of Engineers, and other public and private interests. Additional funding sources shall include but are not limited to land donated by private developers and the Bureau of Land Management.

g. **Interrelationship to Other Projects –** Projects which score high on this criterion can function independently or are needed to complete or increase the effectiveness of the existing regional and local drainage system.

h. **Timing and Implementation –** All aspects of timing and implementation should be considered under this item including availability of right-of-way, permit review if necessary, and ability to administer and begin a project in a reasonable timeframe.

i. **Environmental Enhancement –** Evaluation of this criterion includes benefits derived from improving or mitigating the threat to public health resulting from stagnant water, erosion, raw sewage spills, and contamination of the domestic water supply. It also includes, if applicable, information on the project's enhancement of habitat, recreational opportunities, water quality and furthering the

Southern Nevada Regional Planning Coalition's (SNRPC), Southern Nevada Regional Policy Plan, including but not limited to multi-purpose use of flood control facilities.

j. **Annual Maintenance Cost –** Projects which will rank high on this criterion have a lower maintenance cost than those facilities now in existence or will reduce maintenance costs downstream.

4. The District will coordinate the development of the Ten-Year Construction Program using the Project Priority Value, Master Plan (adjusted to reflect cost increases if warranted) and design cost estimates and annual projected resources. All project phases (design, right-of-way, construction, etc.) must be programmed within a four (4) fiscal year span. When systemwide pre-design is necessary (e.g.: facility plans), it can be programmed and funded outside of the four (4) fiscal year span. An entity utilizing a loan program to finance individual projects, must comply with Section II.C.7 prior to request for construction funding.

5. The District may develop a list of projects to be funded by a specific alternate debt financing instrument. This list will be presented to the TAC, CAC, and Board for adoption when appropriate.

6. The first three years of the Ten-Year Construction Program will constitute the Current Year Project List.

7. Projected resources will be prorated for programming among the entities according to the total cost of Master Plan projects relative to the cost of projects within a hydrographic basin group shown above. Programmed resources cannot exceed projected annual available resources for each entity. Programming resources for high-cost projects may need to be delayed pending accumulation of adequate resources. Projected available resources left unprogrammed at the end of the current year will be carried over to successive years.

8. Utilizing the information provided by the Lead Entity, District staff and the TAC will evaluate the project and make recommendations to the Board. Approved projects will be placed on one of the following lists:

   a. Approved Project, Ten Year Construction Program: The project becomes a part of the Ten-Year Construction Program and is added to the list in the tenth year for funding unless otherwise approved by the Board.

b. Approved Project, Current Year Project List: The project becomes a part of the approved project list but has no relative priority within the fiscal year. District staff and the TAC will make recommendations to the Board regarding the priority within a fiscal year at the time funding is requested by the Lead Entity.

9. An entity may request amendments to the Ten-Year Construction Program at any time. General amendments can address scheduling changes and/or the need for additional funding.

a. Requests for general amendments will be reviewed by staff to determine if adequate resources are available to support a recommendation to approve. If staff determines that adequate resources are not available, the entity must revise their amendment, submit supplemental interlocal contracts to reduce funding and/or process project close outs, etc. to make resources available to support a recommendation to approve.

b. Any amendment request must include all necessary data to allow the TAC and District staff to evaluate the project.

C. Implementation of the Master Plan

1. Lead Entity Designation

a. Flood control projects often impact more than one jurisdiction. It is the intent of the District that drainage projects in general, and Master Plan projects specifically, be coordinated among the entities. Therefore, in those cases where Master Plan-approved and District funded projects have regional flood control significance impacting more than one jurisdiction, all impacted entities will be afforded opportunities to participate on the project management team. Impacted entities and the District shall have the opportunity to support the Lead Entity with their input to the following processes as they relate to the project:

1) Development of scope of services.

2) Predesign and/or design report review.

3) Plans and/or specification review.

4) Operation and maintenance of facilities.

b. The Lead Entity charged with primary project management responsibility shall be the jurisdiction in which the majority of construction lies or the jurisdiction which primarily benefits from the project.

c. Where the Lead Entity cannot be established by the entities, the District's General Manager/Chief Engineer shall determine which shall be the Lead Entity and will arbitrate regional impacts.

d. Impacted entities for projects located in the following hydrographic areas are generally defined as follows:

Hydrographic Area	Impacted Entities
Las Vegas Valley Eldorado Valley	Clark County City of Las Vegas City of North Las Vegas City of Henderson
Boulder City	City of Boulder City Clark County
Mesquite	City of Mesquite Clark County
Apex	City of North Las Vegas Clark County
Unincorporated areas of Clark County outside the Las Vegas Valley	Clark County

2. Eligibility for Funding

In order to be eligible for monies from the District funds for administration of a project, the Lead Entity must have met the following criteria:

a. Adoption by ordinance of the Uniform Regulations for the Control of Drainage (Uniform Regulations) and subsequent amendments and revisions. Any amendment to the Uniform Regulations require adoption, through ordinance, by each entity.

b. Active enforcement of the Uniform Regulations.

c. Performance of all requirements set forth by Interlocal Contract of previously funded facilities.

d. Adoption of the Hydrologic Criteria and Drainage Design Manual and subsequent amendments and revisions.

3. A project may be initiated by the Lead Entity or by the District.

4. Pre-construction and right-of-way acquisition Fund Eligibility.

In order for a project to be eligible for pre-construction and right-of-way acquisition funding, the project must:

a. Be included in the District's Master Plan.

b. Have pre-construction included in the first year of the Ten-Year Construction Program or other list approved by the Board.

c. Have right-of-way acquisition funding included within the first 3 years of the Ten-Year Construction Program.

5. Construction Fund Eligibility

Resources not committed to repayment of alternate debt financing instruments may be made available for construction of projects. In order for a project to be eligible for construction and construction management funding, the project must:

a. Be included in the first 3 years of the Ten-Year Construction Program.

b. Collection facilities one-quarter mile in length or less from a master plan facility may be considered a part of the master plan facility and can be designed, constructed, operated, and maintained in conjunction therewith.

c. Have ninety (90) percent of design complete.

d. Have all right-of-entry for construction purposes obtained or the Lead Entity satisfactorily demonstrates to the Board that it is in the process of commencing condemnation proceedings.

e. Have all temporary rights necessary for construction of the project.

f. Have all necessary local, state, and federal permits.

g. Meet all applicable environmental permitting and reporting requirements (e.g., 404 permits, Section 8 analysis, etc.).

h. Have its design formally presented to the Advisory Committees and the Board in accordance with NRS 543.580, paragraph 2. A sample project presentation agenda item is included as Exhibit A. The presentation will demonstrate that all requirements of paragraphs a – g above have been met and include:

1) A detailed project description (e.g., location, extent, design flow rates, structure size and type, volumes, capacities, special design considerations, etc.).

2) A detailed summary of costs for all phases of the project (see Section VI.B). Construction costs will be based on a detailed engineer's estimate attached as back up.

3) Identification of other funding sources. A table showing a mutually agreed upon distribution of funding among the sources will be attached as back up.

4) A projected construction schedule (award of bid date; construction start date; and duration (in months).

5) A description of right-of-way requirements. State if right-of-way has been obtained; right of entry for construction has been granted; or if no right-of-way or utility easements are required.

6) A discussion of the economic benefit of the project. The Regional Flood Control District's Board of Directors approved a region-wide benefit/cost ratio of 2:1 for District facilities on September 8, 2005. Discuss any other economic benefits of the proposed project.

7) A discussion of environmental requirements. State whether all environmental requirements have been met. List the permits/approvals and the agencies that granted them.

8) Information on possible project enhancements (e.g., recreational facilities, landscaping, and similar amenities) as authorized by NRS 543.365.

9) A vicinity map showing major streets, highlighted project alignment/location and ID/Mile labels.

10) Typical construction detail drawings.

i. Requests for resources programmed within years 2 and 3 of the Ten-Year Construction Program for right-of-way and construction may be approved if the following conditions are met:

1) Staff determines that adequate resources are available;

2) Approval of funding must not result in the delay of design funding in the first year;

3) Approval of funding must not result in the delay of programmed resources pursuant to previous Board actions (i.e.: resolutions to reimburse, entity advance funding, etc.);

4) All prerequisites for construction funding are met; and

5) Adequate design has been completed to define right-of-way requirements.

6. State law allows for other types of project delivery (e.g., construction manager at risk). If an entity chooses to pursue an alternative type of project delivery the process must comply with state law and Section II.C.5 above. At the time of consideration of construction funding, the entity will present an agenda item for approval of final prices for the project along with an agenda item for construction funding.

7. Project Loan Program Eligibility

The Board, in their sole discretion, shall determine on a case-by-case basis whether or not a project is eligible for reimbursement from the District.

a. Project specific governmental loan programs (e.g. State Revolving Funds, Corps Water Infrastructure Financing Program, etc.) acceptable to the District may be used to fund individual projects. For pre-construction and right-of-way acquisition funding the project must comply with Section II.C.4. For construction funding, the project must comply with Section II.C.5 to be eligible for District funding. Upon determination of length of loan and payment amounts, those amounts must be programmed throughout the Ten-Year Construction Program for the requesting entity for the life of the loan. These programmed amounts shall have the highest priority.

b. Loans must be obtained solely by the requesting entity without additionally being secured or cosigned by the District. An interlocal agreement and reimbursement resolution are required for reimbursement by the District. A sample Agenda Item and Interlocal Contract with Project Specific Loan are included as Exhibit J. A sample Agenda Item and Reimbursement Resolution are included as Exhibit K.

c. Should the loan not be approved for any reason, full compliance with Section II.C.5 is required.

d. The maximum cumulative annual reimbursement amount total for all entities utilizing project specific loan programs shall not exceed thirty million dollars ($30,000,000).

D. Project Funding

1. Unless otherwise determined by the Board, projects will be funded as resources become available and according to the sequence in which the respective Interlocal Contracts are approved by the Board.

2. Project approval constitutes authority to expend funds identified by the Interlocal Contract.

3. When projects meet the prerequisites for funding, staff will review pending funding requests in the following order:

   a. Loan program-initiated project funding previously approved in accordance with Section II.C.7.

   ~~a.~~b. Supplemental Interlocal Contracts to meet construction award of bid amounts, right-of-way acquisition, negotiated and/or administrative settlements and change orders.

   ~~b.~~c. Administrative items (e.g., consultant contracts).

   ~~c.~~d. Maintenance Work Program.

   ~~d.~~e. Design/Right-of-way.

   ~~e.~~f. Construction.

4. Requests received within the categories shown in Section II.D.3 above will be submitted in order of date and time of receipt.

5. When sufficient funds are not available to support a construction funding request, a priority for funding will be set by the Board. Staff will maintain a list of projects waiting for funding including an estimate of when funds may become available. This list will be known as the Estimated Funding Schedule (EFS).

   a. Projects will be placed on the EFS in the order acted upon by the Board to set priority for funding.

   b. **Annual reimbursement payments for projects funded with loan programs, as described in Section II.C.7~~.~~, will be prioritized on the EFS.**

   ~~a.~~c. In order to have a priority for funding set and be placed on the EFS a request for construction funding may be submitted prior to meeting prerequisites in II.C.5.e and II.C.5.f given duration limitations associated with them. Project presentation must clearly state which prerequisites have not been completed. All other prerequisites in II.C.5 must be met.

   ~~b.~~d. It will be the Lead Entity's responsibility to track their project(s) on the EFS in order to meet any remaining prerequisites in a timely manner. It will be the Lead Entity's responsibility to notify the District once all prerequisites have been met.

   ~~c.~~e. When funds become available, the Lead Entity will be requested to submit an Agenda Item and accompanying Interlocal Contract that the Board will consider at their next scheduled meeting. The Agenda Item must:

      1) Be submitted no later than close of business on the day prior to the date of the Technical Advisory Committee meeting; and

      2) Demonstrate all prerequisites not met at the time of the project presentation have been met.

   ~~d.~~f. If there are any changes to the scope and/or costs, the funding request must be considered by the advisory committees prior to being considered by the Board.

~~e.~~g. If the Lead Entity is not ready when funds become available, the District will go to the next project on the list for Board to consider funding at their next regularly scheduled meeting.

6. When construction projects meet the prerequisites for funding, but sufficient funds are not available to support the funding request, an entity may elect to advance funding. To be eligible for an entity advanced funding Interlocal Contract the project must be programmed in the first three (3) fiscal years of the Ten-Year Construction Program in the amount of the request.

   a. Projects that have been approved for advanced funding will be reimbursed by the District without interest, by a specific date determined by the District. This date will be two years after the programmed funding date as shown on the Ten-Year Construction Program. The District will not enter into advanced funding interlocal contracts when the agreed reimbursement date exceeds five (5) calendar years from the date the Interlocal Contract is approved. A sample Agenda Item and Interlocal Contract is attached as Exhibit H.

   b. The District will allow up to $40 million outstanding of entity advanced funding at any given time.

   c. The City or County will use its best efforts to award the bid for a project by a specific date—usually not later than 120 days after the Entity Advance Funding contract execution date.

   d. Programmed resources subject to an entity advanced funding Interlocal Contract must remain on the Ten-Year Construction Program and EFS in the fiscal year where reimbursement is planned until reimbursement occurs.

7. When construction projects meet the prerequisites for funding and the entity proposes to use District funds to implement and/or oversize master plan facilities within another public works project but sufficient funds are not available to support the funding request and the other funding source is willing and able to provide the District's share pending availability of funds, the Board may consider a resolution of intent to reimburse the other funding source in the future. In this case:

   a. The entity may enter into an agreement to reimburse the other funding source when District funds become available, but only within the current Ten-Year programming period.

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT
AGENDA ITEM

SUBJECT: INTERLOCAL CONTRACT FOR (PROJECT TITLE) UTILIZING PROJECT SPECIFIC LOAN PROGRAM
PETITIONER: (LEAD ENTITY OR PETITIONER'S NAME AND TITLE)
RECOMMENDATION OF PETITIONER: THAT THE CLARK COUNTY REGIONAL FLOOD CONTROL DISTRICT APPROVE THIS INTERLOCAL CONTRACT FOR CONSTRUCTION UTILIZING PROJECT SPECIFIC LOAN FUNDING FOR THE (PROJECT TITLE AND PROJECT NUMBER) (FOR POSSIBLE ACTION)

FISCAL IMPACT: (Including all principal and interest over the life of the loan)

	City/County	CCRFCD
Construction	$0.00	$0.00
Construction Management	$0.00	$0.00
Entity Construction Management Labor	$0.00	$0.00
Total ILC Value	$0.00	$0.00

BACKGROUND:

The (insert project title, ID Miles, and major cross streets for the project). The system consists of (list the major facilities, their length, and reach/alignment). This project will benefit the community by (describe the benefit). At this time, the (City or County) desires to obtain (or has obtained) a project specific loan to finance the project utilizing (insert agency and loan program name). This item requests approval of funding for construction for the project. A separate item is on this agenda to approve a resolution to reimburse principal and interest for the project through the term of the project specific loan.

Respectfully submitted,

TAC AGENDA ITEM # Date:	RFCD AGENDA ITEM # Date:
CAC AGENDA ITEM # Date:	

XXXXX, Director of Public Works
Lead Entity Name

EXHIBIT J
Project Specific Loan Agenda Item and Interlocal Contract

INTERLOCAL CONTRACT WITH PROJECT SPECIFIC LOAN

(PROJECT TITLE GOES HERE)

THIS INTERLOCAL CONTRACT (CONTRACT) made and entered into as of the ____ day of _____, 20___ by and between the Clark County Regional Flood Control District, hereinafter referred to as "DISTRICT", and (legal name of CITY or COUNTY) hereinafter referred to as ("CITY" or "COUNTY").

W I T N E S S E T H

WHEREAS, pursuant to Chapter 543 of the Nevada Revised Statutes, the DISTRICT may approve a project to design and construct flood control improvements, and;

WHEREAS, the flood control improvements proposed herein are the same as those generally identified in the (date of latest Master Plan Update (MPU)) Flood Control Master Plan Update as Structure(s) No.(s) _____, hereinafter referred to as "PROJECT"; and

WHEREAS, the PROJECT is identified and shown on the attached Exhibit "A"; and

WHEREAS, the PROJECT has regional flood control significance and is located in the same hydrographic area as (list all hydrographic areas).

WHEREAS, (CITY or COUNTY) has obtained a project specific loan for the PROJECT utilizing (insert agency and loan program) which is acceptable to the DISTRICT; and

WHEREAS, subject to the terms and conditions set forth herein, the DISTRICT is willing to participate in the reimbursement to the (CITY or COUNTY) of the annual principal and interest payments through the term of the CONTRACT based upon an amount set forth in a Reimbursement Resolution approved annually by the DISTRICT's Board; and

WHEREAS, the (CITY or COUNTY) has programmed resources for annual principal and interest payments through the term of the loan on the Ten Year Construction Program and will include said resources on subsequent Ten Year Construction Plans beyond the ten (10) year period as necessary.

NOW, THEREFORE, in consideration of the covenants, conditions, contracts, and promises of the parties hereto, the DISTRICT and the (CITY or COUNTY) agree to the following:

EXHIBIT J

SECTION I - SCOPE OF THE PROJECT

This INTERLOCAL CONTRACT applies to items of work eligible for inclusion in loan including (list: construction, construction management) associated with the (name of the project as shown in the title goes here). The basic improvements shall consist of flood water facilities including pipes, channels, dikes, energy dissipators, channel structures, channel access and other appurtenances as may be necessary to control floodwaters. The improvements shall be funded through DISTRICT funds as herein described. This PROJECT is further identified and shown on the attached Exhibit "A".

SECTION II - PROJECT COSTS

The DISTRICT agrees to fund PROJECT costs within the limits specified below (or insert separate statement for each phase listed in VI.B):

1. Total Construction costs including interest shall not exceed $_____.

2. Total Construction Management costs including interest shall not exceed $_____.

3. The (CITY or COUNTY) hereby acknowledges that it has obtained a loan (LOAN) to finance the construction of the PROJECT, in the total amount of $_____. Pursuant to the LOAN documents, the (CITY or COUNTY) is required to make (annual/monthly) payments, including interest and principal in the amount of $_____. (INSTALLMENTS) for a period of _____ years, commencing on _____ and ending on _____.

4. The DISTRICT is willing to participate in the payments of INSTALLMENTS for a specific amount approved annually by the DISTRICT's Board of Directors in a Reimbursement Resolution. The annual Reimbursement Resolution amount, if any, is subject to the sole determination of the DISTRICT's Board of Directors. Reimbursement payments for the INSTALLMENTS will be made by the DISTRICT directly to the (CITY or COUNTY). The (CITY or COUNTY) will be responsible for making the INSTALLMENT payments to the lender.

5. The (CITY or COUNTY) acknowledges and agrees that Reimbursement Funds received from the DISTRICT will only be used for eligible PROJECT costs.

6. The (CITY or COUNTY) understands and agrees that the DISTRICT will not participate or be a party to the LOAN for the project. It is further understood and agreed to that the DISTRICT will have no obligation whatsoever to the entity providing the LOAN to the (CITY or COUNTY). Notwithstanding any other provision herein, (CITY or COUNTY) agrees that the INSTALLMENTS are the sole responsibility of the (CITY or COUNTY).

7. The total cost of this CONTRACT to the DISTRICT shall not exceed $_____, which includes all of the items described in the paragraphs above.

8. A written request must be made to the DISTRICT and approved by the Board to reallocate funds between phases of the PROJECT. No other approval by the Lead Entity is required.

9. A written request must be made to the DISTRICT and a Supplemental Interlocal Contract must be approved by the Board to increase the total cost of the CONTRACT noted above prior to payment of any additional funds.

SECTION III - GENERAL

1. The DISTRICT may terminate this CONTRACT upon written notice to the (CITY or COUNTY), in the event the DISTRICT's Board does not allocate sufficient funds to cover the principal and interest payments required.

2. The Clark County Regional Flood Control District shall be shown on the title sheet of both the plans and the specifications as the funding agency.

3. The (CITY or COUNTY) agree to program the annual reimbursement for the PROJECT costs on the Ten-Year Construction Program in the fiscal years where reimbursement is planned until full reimbursement occurs. The DISTRICT reserves the right at its sole discretion to change the DISTRICT's Ten-Year Construction Program.

4. The (CITY or COUNTY) will use its best efforts to award the bid for this PROJECT by (insert a date—usually not later than 120 days after the contract execution date). The (CITY or COUNTY) will take all reasonable steps possible to avoid delays in the construction of DISTRICT funded projects. PROJECT delays more than four months, as measured from the award date, may be subject to a formal review by both the Technical Advisory Committee and the Board. At the review, the (CITY or COUNTY) will have an opportunity to present information relative to the delays, measures taken to avoid the delays and the likelihood of those delays continuing. The Board will make a determination, in view of the delays and limited available funding, whether PROJECT funding should continue. In the case that the Board chooses to discontinue funding, the Board may cancel any Interlocal Contract(s) associated with the PROJECT and discontinue funding for the remainder of the PROJECT. Funding already spent or appropriated by the (CITY or COUNTY) will not be required to be refunded to the DISTRICT. PROJECT funding can be reconsidered at any time when the (CITY or COUNTY) can demonstrate that the PROJECT can proceed on an acceptable schedule.

5. The (CITY or COUNTY) will comply with the Local Purchasing Act, Chapter 332 and Public Works Projects, Chapter 338, of the Nevada Revised Statutes.

6. The (CITY or COUNTY), its employees, and representatives shall at all times comply with all applicable laws, ordinances, statutes, rules, and regulations in effect at the time work is performed on the PROJECT.

7. The (CITY or COUNTY) will require appropriate financial security for the construction of the PROJECT.

8. The (CITY or COUNTY) shall provide all impacted entities and the DISTRICT with the opportunity to provide the (CITY or COUNTY) with input relative to the following processes: scope of services development; consultant selection; design, construction and maintenance review; and monitoring of the effectiveness and impacts of facilities on flood flows.

9. Applicable portions of the current editions of the Clark County Regional Flood Control District Policies and Procedures, the Hydrologic Criteria and Drainage Design Manual, and Uniform Regulations for the Control of Drainage adopted by the DISTRICT will apply in developing this PROJECT unless specifically superseded by this CONTRACT.

10. Purchases of right-of-way in excess of that actually needed for construction will not be allowed unless a comparison between the cost of excess acquisition and needed acquisition, including damages, indicates that benefits from such a transaction would result. Title to residual property will be vested in the name of the (CITY or COUNTY). Revenues derived from the sale of these properties, less the cost of the sale of these properties, will be forwarded to the DISTRICT.

11. Administrative settlements and acceptance of counter offers involving right-of-way may only be made following a review and approval by the DISTRICT.

12. Accurate documentation of all work performed, and payments made will be maintained by the (CITY or COUNTY) in accordance with applicable state laws and retention policies of the (CITY or COUNTY).

13. The DISTRICT reserves the right to review and/or audit all records pertaining to all projects both during and after PROJECT completion.

14. Up to the limits set forth in NRS Chapter 41, the (CITY or COUNTY) will indemnify and defend the DISTRICT against and from any and all claims and demands of whatsoever nature which arises out of allegations of negligence or misconduct of (CITY or COUNTY) officers, employees or agents, related to or under this CONTRACT which results from injury to or death of any persons whomsoever, or against and from damage to or loss or destruction of property.

15. Any costs found to be improperly allocated to this PROJECT will be refunded by the (CITY or COUNTY) to the DISTRICT.

16. The items covered in SECTION II – PROJECT COSTS must be completed to the satisfaction of the DISTRICT prior to (date of completion of project). The DISTRICT may, at any time thereafter, grant extensions or terminate this CONTRACT after thirty (30) days' notice.

17. This CONTRACT may be executed in multiple counterparts, each of which shall be deemed an original CONTRACT and each of which shall constitute one and the same CONTRACT. The counterparts of this CONTRACT may be executed and delivered by facsimile or other electronic signature (including portable document format) by either of the parties and the receiving party may rely on the receipt of such document so executed and delivered electronically or by facsimile as if the original had been received.

18. This CONTRACT shall be in full force and effect from _____ to _____, unless otherwise terminated earlier. The DISTRICT may terminate this CONTRACT at any time upon giving thirty (30) days written notice to the (CITY or COUNTY).

19. It is not intended by this CONTRACT, and nothing contained in this CONTRACT, shall create any partnership, joint venture, guarantee, oblige, or any other arrangement between the DISTRICT and (CITY or COUNTY). No term or provision of this CONTRACT is intended to benefit any person, partnership, corporation, or other entity not a party to this CONTRACT, including without limitation, any lender or broker, and no such other person, partnership, or entity shall have any rights or causes of action hereunder against the DISTRICT.

20. All of thc DISTRICT'S financial obligations under this agreement are subject to statutory requirements including, but not limited to, NRS 354.626 and subparagraphs a and b below:

    a. Notwithstanding the monetary obligations of this CONTRACT, the total amount of the DISTRICT'S payment obligations hereunder for any fiscal year shall not exceed the amounts that the DISTRICT has appropriated as set forth in this CONTRACT.

    b. Notwithstanding the monetary obligations of this CONTRACT, the DISTRICT'S liability and payment obligations shall be extinguished for the particular year in which the DISTRICT'S governing body fails to appropriate monies for the year for the payment of all amounts which will become due.

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21. This INTERLOCAL CONTRACT, including any rights or obligations hereunder, may not be assigned and/or transferred to any person, partnership, corporation, or other entity including any lender or broker.

Date of District Action: REGIONAL FLOOD CONTROL DISTRICT

BY: _____
(Insert Chair's Name), Chair

ATTEST: _____

_____
(Insert Board Secretary's Name)
Secretary

Approved as to Form:

BY: _____
(Insert District Attorney or Legal Counsel Name)
District Attorney or Legal Counsel Name

****

Date of Council Action: (CITY or COUNTY) OF _____
(or Commission Action)

BY: _____
(Mayor/Board Chair's Name), Title

ATTEST: _____

_____
(Insert Name), (City or County Clerk)

EXHIBIT J

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT
AGENDA ITEM

SUBJECT: REIMBURSEMENT RESOLUTION (PROJECT TITLE - USE TITLE AS APPROVED ON THE INTERLOCAL CONTRACT)
PETITIONER: (LEAD ENTITY OR PETITIONER'S NAME AND TITLE)
RECOMMENDATION OF PETITIONER: THAT THE CLARK COUNTY REGIONAL FLOOD CONTROL DISTRICT APPROVE THIS REIMBURSEMENT RESOLUTION FOR FUNDING THE INTERLOCAL CONTRACT FOR CONSTRUCTION FOR THE (PROJECT TITLE) (FOR POSSIBLE ACTION)

FISCAL IMPACT: None with this action.

BACKGROUND:

The (insert project title, ID Miles, and major cross streets for the project). The system consists of (list the major facilities, their length, and reach/alignment). This project will benefit the community by (describe the benefit). At this time, the (City or County) desires to utilize (describes loan program) for this project.

Respectfully submitted,

_____
XXXXX, Director of Public Works
Lead Entity Name_____
_____

TAC AGENDA ITEM # Date:	RFCD AGENDA ITEM # Date:
CAC AGENDA ITEM # Date:	

EXHIBIT K
Reimbursement Resolution Agenda Item and Reimbursement Resolution

REIMBURSEMENT RESOLUTION NO. XX-XX

THIS REIMBURSEMENT RESOLUTION is made and entered into this _____ day of _____, 20_____, associated with the (name of the project as listed in the INTERLOCAL CONTRACT goes here).

WHEREAS, the flood control improvements proposed herein are the same as those generally identified in the (date of latest Master Plan Update (MPU)) Flood Control Master Plan Update as Structure(s) No.(s) _____, hereinafter referred to as "PROJECT"; and

WHEREAS, an INTERLOCAL CONTRACT between DISTRICT and ("CITY" or "COUNTY") was entered into for construction, construction management and other associated costs on (Insert Date of Interlocal Contract);

WHEREAS, the SCOPE OF THE PROJECT is identified in the INTERLOCAL CONTRACT; and

WHEREAS, the total cost of this PROJECT shall not exceed $_____ as authorized in the INTERLOCAL CONTRACT, which includes all the items described in the associated INTERLOCAL CONTRACT; and

WHEREAS, the (CITY OR COUNTY) has obtained a loan (LOAN) through _____, which is a loan program acceptable to the DISTRICT; and

WHEREAS, the LOAN documents require the (CITY OR COUNTY) to make payments including those for interest and principal in an amount not to exceed $_____ annually; and

WHEREAS, the DISTRICT through this Reimbursement Resolution hereby sets forth the amount the DISTRICT with reimburse the (CITY or COUNTY) for the annual LOAN repayment; and

NOW, THEREFORE, BE IT RESOLVED that the DISTRICT's Board approves REIMBURSEMENT RESOLUTION NO. XX-XX for the (name of the project as listed in the INTERLOCAL CONTRACT goes here). The DISTRICT hereby agrees to reimburse the (CITY or COUNTY) for the fiscal year _____ a monthly payment of $_____ beginning on _____ and ending on _____.

EXHIBIT K

IN WITNESS WHEREOF, the parties have caused this REIMBURSEMENT RESOLUTION to be executed the day and year first above written.

Date of District Action: REGIONAL FLOOD CONTROL DISTRICT

BY: _____
(Insert Chair's Name), Chair

ATTEST: _____

_____

_____
(Insert Board Secretary's Name)
Secretary

Approved as to Form:

BY: _____
(Insert District Attorney or Legal Counsel Name)
District Attorney or Legal Counsel Name

EXHIBIT K

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

FOURTH AMENDMENT TO THE AGREEMENT FOR PROFESSIONAL SERVICES
ARCADIS US, INC.
DEVELOPMENT OF SITE-SPECIFIC CRITERIA FOR SELENIUM IN THE LAS VEGAS WASH

RECOMMENDATION SUMMARY

STAFF: Approve.

TECHNICAL ADVISORY: Approve.

CITIZENS ADVISORY: Approve.

RFCD AGENDA
ITEM #10
DATE: 11/14/2024

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT
AGENDA ITEM

SUBJECT:

FOURTH AMENDMENT TO THE AGREEMENT FOR PROFESSIONAL SERVICES

PETITIONER:

STEVEN C. PARRISH, P.E., GENERAL MANAGER/CHIEF ENGINEER

RECOMMENDATION OF PETITIONER:

APPROVE AND AUTHORIZE THE GENERAL MANAGER TO SIGN THE FOURTH AMENDMENT TO THE AGREEMENT FOR PROFESSIONAL SERVICES BETWEEN ARCADIS US, INC. AND THE DISTRICT TO EXTEND THE COMPLETION DATE TO FUND THE DEVELOPMENT OF SITE-SPECIFIC CRITERIA FOR SELENIUM IN THE LAS VEGAS WASH (FOR POSSIBLE ACTION)

FISCAL IMPACT: None.

BACKGROUND:
In May of 2019, the NDEP published a notice of intent to revise various water quality standards for the Las Vegas Wash. The proposed standards included establishing statewide criteria for selenium based on guidance from the U.S Environmental Protection Agency (EPA). Under current conditions, portions of the Las Vegas Wash would be in non-compliance with the proposed statewide selenium criteria. The Original Agreement for Arcadis US, Inc. was approved on April 21, 2020 for services related to the development of a selenium site-specific surface water criteria for the Las Vegas Wash to cover project management activities. After discussion with various stakeholders in Southern Nevada, NDEP agreed to delay the establishment of a selenium standard for the Las Vegas Wash until December 31, 2022 or until site-specific criteria for the Las Vegas Wash can be developed.

On May 14, 2020, the Board approved an agreement between the District and the Southern Nevada Water Authority (SNWA) for the transfer of $100,000 to the District to fund the first phase of the effort to establish site-specific criteria for selenium for the Las Vegas Wash. On June 11, 2020 the

TAC AGENDA ITEM #10 Date: 10/31/2024	RFCD AGENDA ITEM #10 Date: 11/14/2024
CAC AGENDA ITEM #10 Date: 11/04/2024	

Board ratified a grant agreement between the District and NDEP for $50,000 for the development of site-specific criteria for the Las Vegas Wash. On November 12, 2020, the Board ratified a grant agreement with NDEP for an additional $15,000 to support the development of site-specific criteria for the Las Vegas Wash. On February 11, 2021, the Board approved the First Amendment to the Agreement with Arcadis US, Inc. for additional project management activities for the establishment of Selenium Site-Specific Criteria. On August 12, 2021, the Board approved the First Amendment to the Agreement with SNWA to increase funding in the amount of $114,000 to reimburse the Districtfor Arcadis US, Inc. expenditures. On September 8, 2022, the Board approved the Second Amendment to the Agreement with Arcadis US, Inc. which increased funding and extended the completion date to allow for additional studies or analysis that may be required by NDEP and/or EPA. On October 12, 2023, the Board approved the Third Amendment to the Agreement with Arcadis US, Inc., which extended the completion date.

The District is requesting that the Board approve the attached Fourth Amendment to the Agreement with Arcadis US, Inc.to extend the completion date from December 31, 2024 to June 30, 2025 and authorize the General Manager to sign the Fourth Amendment to the Agreement. The RFCD Attorney has reviewed the Fourth Amendment to the Agreement.

Respectfully Submitted,

TAC AGENDA ITEM #10 Date: 10/31/2024	RFCD AGENDA ITEM # 10 Date: 11/14/2024
CAC AGENDA ITEM #10 Date: 11/04/2024	

Steven C. Parrish, P.E.
General Manager/Chief Engineer

Regional Flood Control District
AGENDA ITEM DEVELOPMENT

Staff Discussion:

Date: 10/22/2024

FOURTH AMENDMENT TO THE AGREEMENT FOR PROFESSIONAL SERVICES
ARCADIS US INC.

In May of 2019, the NDEP published a notice of intent to revise various water quality standards for the Las Vegas Wash. The proposed standards included establishing statewide criteria for selenium based on guidance from the U.S Environmental Protection Agency (EPA). Under current conditions, portions of the Las Vegas Wash would be in non-compliance with the proposed statewide selenium criteria. The Original Agreement for Arcadis US, Inc. was approved on April 21, 2020 for services related to the development of a selenium site-specific surface water criteria for the Las Vegas Wash to cover project management activities. After discussion with various stakeholders in Southern Nevada, NDEP agreed to delay the establishment of a selenium standard for the Las Vegas Wash until December 31, 2022 or until site-specific criteria for the Las Vegas Wash can be developed.

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The District is requesting that the Board approve the attached Fourth Amendment to the Agreement with Arcadis US, Inc.to extend the completion date from December 31, 2024 to June 30, 2025 and authorize the General Manager to sign the Fourth Amendment to the Agreement. The RFCD Attorney has reviewed the Fourth Amendment to the Agreement.

Staff Recommendation:

Approve.

Discussion by Technical Advisory Committee:

AGENDA
#10 Date: 10/31/2024

Recommendation:

Approve.

Discussion by Citizens Advisory Committee:

AGENDA
#10 Date: 11/04/2024

Recommendation:

Approve.

111424 Arcadis Agreement-Amendment 4-aid

FOURTH AMENDMENT TO THE AGREEMENT FOR PROFESSIONAL SERVICES
CLARK COUNTY REGIONAL FLOOD CONTROL DISTRICT
AND
ARCADIS US, INC.
LAS VEGAS WASH SELENIUM SITE-SPECIFIC CRITERIA DEVELOPMENT

THIS FOURTH AMENDMENT TO THE AGREEMENT is made and entered into this _____ day of _____, 2024, by and between the CLARK COUNTY REGIONAL FLOOD CONTROL DISTRICT (hereinafter referred to as "DISTRICT") and Arcadis US, Inc. (hereinafter referred to as "CONSULTANT"), for services related to the development of a selenium site-specific surface water criteria for the Las Vegas Wash (hereinafter referred to as the "PROJECT").

WITNESSETH

WHEREAS, the DISTRICT desires to complete a site-specific surface water quality criteria development for selenium; and

WHEREAS, the CONSULTANT is experienced and is knowledgeable in the completion of such works; and

WHEREAS, the CONSULTANT represents that it is properly registered and qualified in accordance with the Nevada Revised Statutes and has the personnel and facilities necessary to accomplish the PROJECT within the required time; and

WHEREAS, an agreement was entered into between the DISTRICT and CONSULTANT on April 21, 2020, February 11, 2021, September 8, 2022 and October 12, 2023; and

WHEREAS, the DISTRICT requests an extension of time of performance for the PROJECT; and

WHEREAS, the parties desire to set forth the responsibilities, terms, and conditions of completing the PROJECT.

NOW, THEREFORE, in consideration of the premises and terms contained herein, the parties agree as follows:

Section V

TIME AND PERFORMANCE, paragraph E shall be changed to read as follows:

E. This AGREEMENT shall begin on April 21, 2020 and terminate on June 30, 2025 unless it is extended before the termination date with the mutual written consent of both parties or earlier terminated pursuant to Section VI.

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All other sections of the original AGREEMENT, First Amendment to the AGREEMENT, Second Amendment to the AGREEMENT and Third Amendment to the AGREEMENT shall remain unchanged.

IN WITNESS WHEREOF, the parties have caused this Fourth Amendment to the AGREEMENT to be executed the day and year first above written.

ARCADIS US, INC.

By:_____ Date: _____

****

CLARK COUNTY REGIONAL FLOOD CONTROL DISTRICT

By:_____ Date: _____
STEVEN C. PARRISH, P.E.
GENERAL MANAGER/CHIEF ENGINEER

APPROVED AS TO LEGALITY ONLY:

By:_____ Date:_____
Christopher D. Figgins
RFCD Attorney

ATTEST:

By:_____ Date:_____
Deanna Hughes
Secretary to the Board

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

REVIZE
WEB SERVICES SALES AGREEMENT TO DESIGN AND IMPLEMENT A WEBSITE FOR THE DISTRICT

RECOMMENDATION SUMMARY

STAFF:	Approve.
TECHNICAL ADVISORY:	The Technical Advisory Committee did not hear this item.
CITIZENS ADVISORY:	The Citizens Advisory Committee did not hear this item.

RFCD AGENDA
ITEM #11
DATE: 11/14/2024

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT
AGENDA ITEM

SUBJECT:

WEB SERVICES SALES AGREEMENT TO DESIGN AND IMPLEMENT A WEBSITE FOR THE DISTRICT

PETITIONER:

STEVEN C. PARRISH, P.E., GENERAL MANAGER/CHIEF ENGINEER

RECOMMENDATION OF PETITIONER:

THAT THE BOARD APPROVE AND AUTHORIZE THE GENERAL MANAGER TO SIGN THE WEB SERVICES SALES AGREEMENT (AGREEMENT) WITH REVIZE FOR WEBSITE DESIGN AND IMPLEMENTATION (FOR POSSIBLE ACTION)

FISCAL IMPACT:

$18,814.00	FY 2024-25 – Website design and implementation, support, hosting
$ 5,500.00	FY 2025-26 – Website maintenance, support, hosting
$ 5,500.00	FY 2026-27 – Website maintenance, support, hosting
$ 5,500.00	FY 2027-28 – Website maintenance, support, hosting
$ 5,500.00	FY 2028-29 – Website maintenance, support, hosting
$40,814.00	Total

BACKGROUND:

Due to the rapidly changing nature of digital communications, the District's current website requires redesign. The District would like to provide the viewing audience with a citizen focused government website compatible with modern mobile devices, which would include information relevant to the District, include items of flood control interest for all audiences, promote self-service and make the citizen journey through the website seem effortless.

The District would like to enter into an Agreement with Revize to provide their expertise in the creation of a new website design. Revize would provide their services on the new website design and implementation, ongoing software support and cyber security, unlimited technical support, customized applications and training to District staff.

RFCD AGENDA
ITEM # 11
Date: 11/14/2024

The website design and implementation one-time fee to the District to begin the process is $18,814.00. The maintenance, hosting and license fee for the first year is included in this cost. Subsequent years maintenance, hosting and licensing fees shall be budgeted in the District's annual budget request for consideration and approval by the District's Board of Directors. This agreement shall commence on November 14, 2024, and shall automatically terminate on November 14, 2029, unless otherwise terminated earlier as provided in Section 5.2 of the Agreement.

The District Attorney has reviewed the Agreement. There is sufficient funding in the FY 2024-25 budget to support this Agreement with Revize. Staff recommends approval.

Respectfully submitted,

RFCD AGENDA
ITEM # 11
Date: 11/14/2024

Steven C. Parrish, P.E.
General Manager/Chief Engineer

Regional Flood Control District
AGENDA ITEM DEVELOPMENT

Staff Discussion:

Date: 11/04/2024

WEB SERVICES SALES AGREEMENT TO DESIGN AND IMPLEMENT A WEBSITE FOR THE DISTRICT

Due to the rapidly changing nature of digital communications, the District's current website requires redesign. The District would like to provide the viewing audience with a citizen focused government website compatible with modern mobile devices, which would include information relevant to the District, include items of flood control interest for all audiences, promote self-service and make the citizen journey through the website seem effortless.

The District would like to enter into an Agreement with Revize to provide their expertise in the creation of a new website design. Revize would provide their services on the new website design and implementation, ongoing software support and cyber security, unlimited technical support, customized applications and training to District staff.

The website design and implementation one-time fee to the District to begin the process is $18,814.00. The maintenance, hosting and license fee for the first year is included in this cost. Subsequent years maintenance, hosting and licensing fees shall be budgeted in the District's annual budget request for consideration and approval by the District's Board of Directors. This agreement shall commence on November 14, 2024, and shall automatically terminate on November 14, 2029, unless otherwise terminated earlier as provided in Section 5.2 of the Agreement.

The District Attorney has reviewed the Agreement. There is sufficient funding in the FY 2024-25 budget to support this Agreement with Revize. Staff recommends approval.

Staff Recommendation:

Approve.

Discussion by Technical Advisory Committee:

AGENDA
Date:

Recommendation:

The Technical Advisory Committee did not hear this item.

Discussion by Citizens Advisory Committee:

AGENDA
Date:

Recommendation:

The Citizens Advisory Committee did not hear this item.

Revize Web Services Sales Agreement

This Sales Agreement is between Regional Flood Control District, Clark County, NV ("CLIENT") and Revize LLC, aka Revize Software Systems, ("Revize"). Federal Tax ID# 20-5000179 Date: 9-27-2024

CLIENT INFORMATION:	Regional Flood Control District, Clark County, NV	**REVIZE LLC:**
Company Name:	**Regional Flood Control District**	**Revize Software Systems**
Company Address:	**600 S. Grand Central Pkwy Suite 300**	**150 Kirts Blvd.**
Company City/State/Zip:	**Las Vegas, NV 89106-4511**	**Troy, MI 48084**
Contact Name:	**Michelle French mfrench@regionalflood.org 702-685-0017**	**248-269-9263**
Billing Dept. Contact:	**RFCD Accounts Payable AccountsPayable@regionalflood.org 702-685-0000**	
Client Website Address:	**www.regionalflood.org**	

The CLIENT agrees to purchase the following products and services provided by REVIZE. Project Timeline and Scope of Work are further defined in Exhibit A which is attached hereto and by reference incorporated herein:

Quantity	Description	Price
1	**Phase 1: Project Planning and Analysis, SOW, onetime fee:**	Included
1	**Phase 2 – Discovery & Design from Scratch, onetime fee:** • 1 mockup with up to 3 rounds of changes • Home page template and inner page design and layout. • Includes Responsive Web Design	$3,000
1	**Phase 3 & 4 – Revize Template Development, onetime fee:** • Set-up all CMS modules listed in this agreement • Integration with all 3rd party web applications	$5,000
1	**Phase 5 & 6 – Quality Assurance & Accessibility Testing**	Included
1	**Phase 7- Site Map Development and Full Content Reorganization and Migration into the new website (325 Pages, 600 Documents -approximate number on current website).** • Migration of all Documents to searchable Documents on Demand Library, example: https://clawsoncitymi.documents-on-demand.com/,	$3,314

	• To help you move stale content, Revize will not be moving over any calendar items.	
1	**Phase 8 – Beta Site Review, Full Staff Training (online), Go Live**	$1000
1	Revize Pre-Paid Annual Maintenance Fee which includes: Tech Support, CMS Updates, Cybersecurity Software & Hardware Updates, Unlimited User Training, SSL Security Certificate, Documents on Demand and Website Hosting with Unlimited GB website content storage, 500 GB Bandwidth	$5,500
1	**Grand Total**	**$18,814** $5,500/year

Payment Schedule

Payment Amount	Includes
$18,814	Year 1 Development Support, Hosting
$5,500	Year 2 Support and Hosting
$5,500	Year 3 Support and Hosting
$5,500	Year 4 Support and Hosting
$5,500	Year 5 Support and Hosting

Terms:

1. Payments: All Invoices are due upon receipt. Work begins upon execution of this agreement.
2. Revize will invoice upon completion of each phase as identified above.
3. Additional content migration, if requested, is available. Revize has made best efforts to accurately estimate all pages/documents available on client's current site for migration. If there are additional pages/documents discovered during migration, Revize will contact client with that specific information for authorization and to discuss any charges for additional migration.
4. Additional bandwidth will be made available as needed during high traffic events. Revize reserves the right to put in place mitigation measures for expected DDOS attacks
5. Governing Law and Jurisdiction. This Agreement shall be governed by, and construed under, the laws of the State of Nevada.
6. Both parties must agree in writing to any changes or additions to this Sales Agreement.
7. Client understands that project completion date is highly dependent on their timely communication with Revize. Client also agrees and understands that;

a. The primary communication tool for this project and future tech support is the Revize customer portal found at https://support.revize.com.
b. During the project, Client will respond to Revize inquiries within 48 hours of the request to avoid any delay in the project timeline.

8. Revize will provide a free redesign of the website in year 4 of the agreement. This assumes the Client agrees to five consecutive years of annual software subscription, tech support, CMS updates, and hosting.
9. Client owns design, content, and will receive all updates to the CMS for the life of the Agreement.
10. Unless otherwise agreed, Revize does not migrate irrelevant records, calendar events, news items, bid results, low quality images, or data considered non-conforming to new website layout.
11. No additional services are included unless explicitly stated in this agreement, storage is unlimited for all relevant website data
12. This agreement shall commence on November 14, 2024 and shall automatically terminate on November 14 2029 unless otherwise terminated earlier.

Enterprise Revize CMS License

As part of this agreement Revize Software Systems, LLC. provides to the Client a full Enterprise Revize CMS Software license. This software is a proprietary software built and maintained by Revize Software Systems LLC., and is intended to allow for the Client to easily update the content of their website. Client agrees that this license will only be used to maintain the websites included in this agreement. Sharing of the content management system, by the Client, with other entities not identified in this agreement is prohibited.

Revize will maintain, update, and host the Revize CMS during the agreement period. In the event that the contract is terminated, for any reason, Revize will provide the latest version of the Revize CMS to the Client. This system will then have the ability to be hosted and used by the Client as long as they wish. Revize will provide reasonable support in transferring the CMS system to the Client's decided upon hosting architecture. Reasonable support is defined as a similar level of support provided by Revize before knowledge of the decision to terminate the Agreement.

Products Client Owns Include:

- Revize CMS License
- Hosted Website
- Source Files
- All Included Revize Web Applications
- Design & Page Content

AGREED TO BY:	***CLIENT***	***REVIZE***
Signature of Authorized Person:	_____	_____
Name of Authorized Person:	_____	***Dylan Johnston***
Title of Authorized Person	_____	***Account Manager***
Date:	_____	_____

Please sign and return to: dylan@revize.com Fax 1-866-346-8880

Website Included Features:

The Following Applications & Features will be integrated into Your Website:

In addition to the Government Content Management System that enables non-technical staff to easily and quickly create/update content in the new web site, Revize provides a suite of applications and features specifically designed for municipalities. All of those apps and features are fully described in the following section. The applications and features are grouped into five categories:

- Constituent's Communication Center Apps
- Constituent's Engagement Center Apps
- Staff Productivity Apps
- Site Administration and Security Features
- Mobile Device and Accessibility Features

Constituent's Communication Center Apps

- Home Page Alert
- Document Center with Keyword Search
- FAQs with Keyword Search
- Job Posting
- Multi use Directory with Maps, Phone, Website, Email, etc.
  Example: https://www.largo.com/facilities_directory/index.php
- News Center with Facebook/Twitter Integration
- Interactive Web Forms
- Video/Photo Gallery
- Quick Link Buttons
- Revize Web Calendar
- "Share This" Social Media Flyout App
- Sliding Feature Bar
- Language Translator

Constituent's Engagement Center Apps

- Constituent Request Center with Captcha
- RSS Feed
- AI Chat – Trained on entire website

Staff Productivity Apps

- Agenda Posting Center
- Image Manager
- iCal Integration
- Link Checker
- Menu Manager
- Online Form Builder
- Staff Directory with Keyword Search
- Website Content Archiving
- Website Content Scheduling
- Interactive Fillable Forms

Site Administration and Security Features

- Audit Trail
- History Log
- URL Redirect Setup
- Roles and Permission-based Security Mode
- Secure Site Gateway
- Unique Login/Password for each Content Editor
- Google Analytics set up

Mobile Device and Accessibility Features

- ADA Compliant WCAG 2.1 AA
- ADA Accessibility Widget
- Font Size Adjustment
- Responsive Website Design (RWD)

Service Level & CMS License Agreement

1.1 Statement of Intent

The aim of this agreement is to provide a basis for close co-operation between Regional Flood Control District, Clark County, Nevada (known in this agreement as *Client*) and *Revize LLC.*, for support services to be provided by *Revize LLC.* to *Client* and, thereby ensuring a timely and efficient support service is available to *Client* end users. The objectives of this agreement are detailed in Section 1.2.

This agreement is contingent upon each party knowing and fulfilling their responsibilities and generating an environment conducive to the achievement and maintenance of targeted service levels.

1.2 Objectives of Service Level Agreements

To create an environment which is conducive to a co-operative relationship between *Revize LLC.* and *Client* to ensure the effective support of end users

To document the responsibilities of all parties taking part in the Agreement

To ensure that *Client* achieves the provision of a high quality of service for end users with the full support of *Revize LLC.*

To define the commencement of the agreement, its initial term and the provision for reviews

To define in detail the service to be delivered by *Revize LLC.* and the level of service which can be expected by *Client*, thereby reducing the risk of misunderstandings

To detail via a question list, information *Revize LLC.* requires *Client* to extract from end users prior to *Revize LLC.* involvement

To institute a formal system of objective service level monitoring ensuring that reviews of the agreement are based on factual data

To provide a common understanding of service requirements/capabilities and of the principals involved in the measurement of service levels

To provide for all parties to the Service Level Agreement a single, easily referenced document which caters for all objectives as listed above

1.3 Service Level Monitoring

The success of service level agreements depends fundamentally on the ability to measure performance comprehensively and accurately so that credible and reliable information can be provided to customers and support areas on the service provided.

Service factors must be meaningful, measurable and monitored constantly. Actual levels of service are to be compared with agreed target levels on a regular basis by both *Client* and Revize LLC. This is in reference to the agreed upon 99.99% detailed in item 2.5 of this agreement. In the event of a discrepancy between actual and targeted service levels both *Client* and Revize LLC. are expected to identify and resolve the reason(s) for any discrepancies in close co-operation.

Service level monitoring will be performed by *Client*. If *Client* suspects that response times for faults do not adhere to expected response times in table 2.2 they should provide information to Revize in response to items in 4.2

Service level monitoring and reporting is performed on response times for faults, as specified in Section 3.4 of this agreement.

Client Responsibilities

2.1 Functional Overview

The purpose of this section is to detail the *Client* responsibilities for the referral and resolution of all computer related faults and queries (supported products only) encountered by end users throughout the *Client's* contracted services with *Revize LLC.* This includes the following specific responsibilities:

- Provision of a main point of contact during *Client* business hours.
- Extracting information from end users as per *Revize LLC.* specified list of questions (detailed in section 4)
- Timely referral of faults to *Revize LLC.* as per method detailed in section 4
- Fault resolution monitoring, and production and distribution of Service Level Monitoring reports as and when required

2.2 Response Times

Table 2.2 shows the priority assigned to faults according to the perceived importance of the reported situation. The priority assignment is to refer to the initial response to the client as per Section 2.3 of this document. The support level refers to the *Client* guide for support available as illustrated in Section 2.3 of this document. *Client* agrees and understands that, in rare cases, response times may be delayed due to an overabundance of tech support requests on the part of the *Client* or Revize customers, natural disasters, acts of God, etc.

Table 2.2 - Response Priority

	Crisis	Urgent	Critical	Normal	Request For Service
Priority	Immediate	Urgent	High	Normal	Normal
Time for Response	< 1 Hour	1 Hour	4-6 Hours	24 Hours	Dependent Upon Request
Report Method	Revize Live Phone Support 248-269-9263	Revize Customer Portal	Revize Customer Portal	Revize Customer Portal	Revize Customer Portal

2.3 Client Guide for Support (Report Method Details) – Fault Matrix

Crisis:

- Crisis issues are issues that make your website completely inoperable. In this case you should call our tech support team immediately at 248-269-9263
- Example(s) include: Entire website not accessible from multiple devices/browsers

Urgent:

- Urgent issues are issues that render your system partially inoperable. These requests can be submitted to our tech support team through phone or within our customer portal www.support.revize.com
- Example(s) include: Partial portion of website not accessible from multiple devices/browsers, unapproved information on the website, or time sensitive information not available on live website.

Critical:

- Critical Issues are issues that deny you the ability to perform a core function of the system. These requests should be submitted to the customer portal www.support.revize.com
- Example(s) include: CMS not publishing to live site, perceived slow load time, content updates not appearing as intended in live site.

Normal:

- Normal issues are issues that deny usability of limited functions of the system. These requests should be submitted to the customer portal www.support.revize.com
- Example(s) include: General site irregularities, login issues, photo resizing, or image/graphic requests.

Request for Service:

- Requests for service are completed with the mindset that we do not “nickel and dime” our clients. Your annual maintenance agreement includes requests for service that you and staff may not be able to do yourselves. These types of requests include new icons, graphics, buttons, photo editing, page types, and custom applications. Revize will add in these services with no charge up to a level of reasonability beyond what is included in your contract. These requests should be submitted to the customer portal www.support.revize.com. If there is no charge, Revize will complete the changes as requested. If there is any charge, we will respond to you with alternative free options or a quote for the additional work.

2.4 Priority Level Response/Resolution Times

Table 2.2 shows the required initial telephone/portal response times for the individual priority ratings. All times indicated represent telephone response time during specified working hours of 8 a.m. to 8 p.m. Eastern Time Monday to Friday, unless otherwise indicated in this document, or otherwise agreed upon by *Client* and *Revize LLC.*.

The indicated response time represents the maximum delay between a fault/request being reported to the *Revize LLC.* and a *Revize LLC.* representative contacting the *Client* by telephone or through the customer portal. The purpose of this contact is to notify the client of the receipt of the fault/request from *Client* and provide the client with details of the proposed action to be taken in respect of the particular fault/request.

Due to the nature and variety of issues that could be reported by the client, resolution times vary dependent upon the issue itself. It is not uncommon for a perceived "quick fix" to take multiple working days, or a perceived long-term request to be completed in a matter of hours. When possible, Revize will provide an estimated time of resolution upon initial report from the client. If, after further investigation, Revize determines the expected time to significantly change, Revize will contact the client to discuss the details and new suspected time frame. In the case of a crisis/priority issues, Revize will address the issue within one hour and, if possible, provide an intermediate resolution if a longer time to assess and repair an ongoing issue is required. Crisis and Priority support will be available through our support portal and phone at all hours (24/7, 365).

2.5 Website Application Availability Monitoring

Website application availability monitoring will be performed by *Client* using software of their choice. If *Client* suspects that website availability fails to meet the agreed upon threshold of 99.99% in any one month, they agree to immediately open a support ticket in the customer portal to notify *Revize LLC.* of the issue.

Upon resolution of downtime issue, if *Client* suspects the 99.99% was not met, *Client* agrees to provide information to *Revize LLC.* which includes SCOM report and a written narrative describing any details of the perceived downtime issue. Upon *Revize LLC.* review and concurring thereof *Revize LLC.* customer will be eligible for a credit equal to the monthly portion of annual services fee as set forth in table 2.5 below. This credit would be applied to the next invoice due. The credit will not be provided if support ticket was not opened or for issues caused by *Client.*

2.5 Website Application Availability Credit Table

Table 2.5 – Website Application Availability Credit Table Website Application Availability %		Credit % for Monthly Portion of Annual Services Fee
From	**To**	
99.99%	99.50%	0%
99.49%	99.00%	10%
98.99%	95.00%	15%
94.49%	90.00%	50%
Less than 90.00%		100%

3. *Revize LLC.* Responsibilities

3.1 Functional Overview

Revize LLC. is a provider of website & computing software maintenance service and support to the *Client*.

3.2 Hours of Operation

A *Revize LLC.* representative will be available to provide support functions between the hours of 8 a.m. and 8 p.m. Monday to Friday, public holidays excepted, unless alternative arrangements have been agreed to by *Client*. The Revize Customer portal is monitored 24 hours a day. Beyond the 8 a.m. to 8 p.m. EST Revize does not guarantee response times. Response times through the customer portal officially begin at 8 a.m. EST and end at 8 p.m. EST. However, *Revize LLC.*does reserve the right to respond to requests outside of these hours.

3.3 Response Times

The *Revize LLC.* will accept the priority assigned to a fault by *Client*, as per Fault Matrix in 2.3 and Priority Assignment criteria in 4.1.

3.4 Service Level Targets

The *Revize LLC.* will respond within the time specified by the priority allocation. *Client* will issue reports as and when required to the *Revize LLC.* Support staff for the purpose of gauging *Revize LLC.* performance.

3.4 Website Application Availability

The *Revize LLC.* agrees to a live website availability threshold of 99.99% of the time in a calendar month. It is understood that *Revize LLC.*will perform routine maintenance during non-peak hours as necessary that is not factored in as part of the availability threshold. Non-peak hours are from 2:00A.M. to 6:00A.M. Eastern Standard Time. Client may request other updates/features that necessitate downtime as well. *Revize LLC.*will notify client when expected downtime is greater than 15 minutes.

4. Supported Products/ Applications/Systems

4.1 Software Support Services

Software Products Supported:

- Revize CMS
- Hosted Website
- Source Files
- All Included Revize Web Applications

Contact Details:	**Live Phone Support:**	248-269-9263
	Customer Portal:	**www.support.revize.com**
	Email (Unofficial Channel):	**Support@revize.com**

Priority Assignment Criteria:

As assigned by the *Client* fault matrix in section 2.3 of this document. This response time is to indicate the initial telephone, email, or support portal response by *Revize LLC.*, as described in Section 2.4 of this document, to the client as detailed on the *Client* Fault Report Form.

Method of Fault Referral:

- Customer Portal transmission of *Client* Fault Report Form by *Client* staff to *Revize LLC.* At support.revize.com
- Telephone contact by *Client* operator.

4.2 Information to be provided by Client for Timely Response:

- Complete description of issue
- Time estimate of when client started experiencing this issue
- Whether a change was requested recently in relation to this issue
- URL where issue is occurring (if applicable)
- Screenshot of this issue (optional)

Method of Return of Resolved Faults:

Immediately following actual resolution of each individual fault/request a *Revize LLC.* representative will notify *Client* by telephone, email, or customer portal of the completion of the fault/request. If applicable, within 48 hours of resolution *Revize LLC.* will provide *Client* with details of resolution.

Other (Details):

Revize LLC. maintains a real-time project support portal where fault issues can be reported by the *Client.* This portal can be found at support.revize.com where a user name and password will be required. This project support portal will have an updated status of the completion progress of each issue as determined by Revize.

Although each issue is updated when key objectives are met, *Client* may request an update at any time. When *Client* has issues outstanding in this portal, they will check in at least once per week to answer any follow up questions from *Revize.* If there are no outstanding issues this is not required. For a general update request, *Client* will make request notating each outstanding fault they would like an update on. *Revize* will respond with details of current status and return the report to *Client* within 72 hours of receipt of the report.

5. Revize CMS License

5.1 Enterprise Revize CMS License

As part of this agreement Revize LLC. will provide full usage access to our Enterprise Revize CMS Software, hosted in our cloud servers. This software is a proprietary software built and maintained by Revize LLC. and is intended to allow the CLIENT to easily update the content of their website. CLIENT agrees that this software access will only be used to maintain the websites included in this agreement. Sharing of the access, by the CLIENT, with other entities not identified in this agreement is prohibited.

Revize will maintain, update, and host the Revize CMS in our cloud server during the contract period. In the event that the contract is terminated, for any reason, Revize will halt CLIENT access to the Revize CMS, and will provide website content to the client, provided all payments for the entire length of the contract are fully paid. Notice of termination must be in writing and given to the non-terminating party at least 60 days prior to the effective date of termination.

As part of this agreement, Revize LLC will provide full usage access to our Enterprise Revize CMS Software, hosted in our cloud servers. This software is proprietary software built and maintained by Revize LLC. and is intended to allow the CLIENT to easily update the content of their website. CLIENT agrees that this software access will only be used to maintain the websites included in this agreement. Sharing of the access, by the CLIENT, with other entities not identified in this agreement is prohibited. Revize will maintain, update, and host the Revize CMS in our cloud server during the agreement period.

5.2 Termination of Agreement

Client may terminate this agreement at any time upon written notification to Revize. In the event that the agreement is terminated for any reason, Revize will cease providing services under the agreement, halt Client access to the Revize CMS, and will provide website content to the client. Client shall pay Revize for services performed up to the time of the receipt of the written notification to terminate. Notice of termination must be in writing and given at least ten (10) calendar days prior to the effective date of termination. Notice of termination shall be sent to:

Revize Websites Account Receivable
151 Kirts Blvd. suite B
Troy, MI 48084
248-928-8053
accounts@revize.com

Exhibit A

Project Timeline

Phase	Duration
Phase 1: Kickoff Meeting and Discovery (project planning/analysis)	3 Weeks
Phase 2: Design Mockups/Wireframes	5 Weeks
Phase 3 and 4: Revize Template Development & CMS Integration	4 Weeks
Phase 5 & 6: Quality Assurance, Accessibility, & Custom Development	3 Weeks
Phase 7: Site Map Development and Content Migration	2 Weeks
Phase 8: Core Content Editing Training, Beta Site Review, Full Staff Training, and Go Live	3 Weeks
Go-Live (Average) 19-26 Weeks	

Project Phases

Revize Website Scope of Work:

Phase 1: Kickoff Meeting and Discovery (project planning/analysis)

Revize:

- Revize will conduct a website design kickoff meeting with the client.
- Site mapping process overview
- Water Agency website best practices discussed.
- After the meeting, Revize will provide a detailed project plan that assesses key findings and details.

Client:

- Before kickoff meeting client is required to register in Revize project portal, complete design questionnaire, upload at least 8 preliminary photos, and provide Revize with a kickoff meeting schedule (date/time).
- Client representative will be asked to participate in a follow-up meeting to review the project plan

Revize Website Scope of Work:

Phase 2: Design Mockups/Wireframes

Revize:

- Within (5) five weeks of the kick-off meeting Revize will provide (1) one custom homepage mockup and (1) basic interior page mockup.
- As deemed appropriate by Revize, additional wireframes may be delivered to provide a view of custom functionality or other areas of the site that are of particular importance. (Intended to focus development efforts later in the project.)
- Revize will provide revisions to each mockup based on the feedback received from the client.
- There will be a limit of up to (3) three sets of revisions Revize will provide to each mockup.
- Web/phone meetings may be necessary between each round of mockups/wireframes

Client:

- Within (3) three business days of acceptance of the first mockup, the client shall provide design feedback/change requests to Revize through the customer portal in a single list. Feedback should be what the client website committee agrees to together. Any lists that have requests that compete with one another may result in delays.
- Revize will return an updated mockup based on that feedback to the client. Delivery time is dependent upon amount and specifics of feedback. Large lists of feedback may take longer. Depending on the number of rounds, this process can cause delays to the timeline.
- When the client considers the mockups final, they will indicate their approval in the Revize project portal
- Based on previous sitemap process overview, Client will decide whether they would like to create a sitemap or whether they would like Revize to create the sitemap. The sitemap should be provided in an excel or word format. Existing pages that client wants to be rebuilt in the new site should be linked with the correct URL and any notes for functionality of the new page. New pages should include a page name and brief description of the page functionality (e.g., freeform page style, staff directory, document center, etc.)

(Next steps cannot begin until main client homepage mockup is approved.)

Phase 3 begins on next page

Revize Website Scope of Work:

Phase 3 and 4: Revize Template Development & CMS Integration

Revize:

- Mockups will be developed into HTML pages making them clickable and resizable.
- Following HTML Development, Revize will add in the Revize Content Management System which makes the website easily editable.
- Integration of any 3rd party software will begin during this phase

Client:

- There are zero major tasks assigned to the client at this stage of the project, but this is an ideal point of the project to be working on a final sitemap and begin writing any new content. Content can be written in MS-Word and provided to Revize. Or, added by the client directly into the beta website after phase 7.

Phase 5 & 6: Quality Assurance, Accessibility, & Custom Development

Revize:

- Revize will review all developed assets for functionality. The development team will review functionality, style sheet, and formatting checking for errors and verifying that site matches approved design mockups.
- Any custom needs identified earlier in the project will be executed during this phase and tested for quality assurance.
- ADA programming and beta site review with the client

Client:

- Much like phase 4, phase 5 does not require much involvement by the client. However, Revize may request an online web meeting to discuss the progress of particular custom development.
- The client may also be asked to review/approve changes that are suggested by Revize for accessibility reasons

Phase 7 begins on next page

Revize Website Scope of Work:

Phase 7: Site Map Development and Content Migration

Revize:

- Revize will deliver a suggested sitemap, in Excel format, for the website prior to this phase (Unless the client has chosen to create their sitemap). Client and Revize will review and provide updated versions for approval. Pages will be built out one-by-one according to this previously approved sitemap architecture. Pages that are not linked in the sitemap will be created as blank pages.
- Migration includes up to all webpages, documents, and new content up to the relevant amount on the current website.

Client:

- To avoid delays, the client should plan to approve a sitemap before this phase.
- Any new content that the client would like Revize to add into the website should be provided either directly from the old website, or in an MS-Word like format. Otherwise, the client will have the ability to add new content before go live.
- After migration, the beta site will be provided with built out pages and content for review.

Revize Website Scope of Work:

Phase 8: Core Content Editing Training, Beta Site Review, Full Staff Training, and Go Live

Revize:

- Revize will conduct a review of the beta site followed by a core team training (smaller group).
- After the beta site review, the client may request tweaks to the functionality of the website.
- Revize will conduct a separate full staff training for all CMS editors on-site in a classroom style setting.
- The training schedule will include editor training, and administrator training with a question-and-answer period.
- Results of the user experience testing will be provided to the client for review.
- Any change requests will be reviewed by Revize for feasibility and scope conformance before they are completed.
- Revize will conduct meeting with client IT department before go live to discuss the process and establish pre-go-live checklist (e.g. SSL certificates, redirects, subdomains, etc.)
- Retraining is available any time after Go Live.

Client:

- Through the project portal, the client should provide a date and time to conduct beta site review and training.
- After training, the client will complete any final content polishing. This may include adding in different header photos, post migration content, or basic tweaks.
- The client may also request functional tweaks to the site based on their review or results of UX testing
- The client should provide a list of pre-go-live questions to Revize for review and discussion.
- When ready for the site to be pushed live, the client will make a request in the project portal at least 48 hours before desired go-live time. Revize will provide the go-live instructions before that time.

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

HOBBS ONG & ASSOCIATES AND PFM FINANCIAL ADVISORS, LLC
MUNICIPAL ADVISOR SERVICES
FIRST OPTIONAL ONE-YEAR EXTENSION

RECOMMENDATION SUMMARY

STAFF:	Approve.
TECHNICAL ADVISORY:	The Technical Advisory Committee did not hear this item.
CITIZENS ADVISORY:	The Citizens Advisory Committee did not hear this item.

RFCD AGENDA
ITEM #12
DATE: 11/14/2024

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:
MUNICIPAL ADVISOR SERVICES
FIRST OPTIONAL ONE-YEAR EXTENSION

PETITIONER:
STEVEN C. PARRISH, P.E., GENERAL MANAGER/CHIEF ENGINEER

RECOMMENDATION OF PETITIONER:
THAT THE BOARD APPROVE THE FIRST OPTIONAL ONE-YEAR EXTENSION TO THE CONTRACT TO PROVIDE MUNICIPAL ADVISOR SERVICES WITH HOBBS ONG & ASSOCIATES AND PFM FINANCIAL ADVISORS, LLC FOR THE PERIOD COVERING JANUARY 1, 2025, THROUGH DECEMBER 31, 2025 AND AUTHORIZE THE GENERAL MANAGER TO SIGN THE EXTENSION LETTER (FOR POSSIBLE ACTION)

FISCAL IMPACT: None by this action.

BACKGROUND:

On February 10, 2022, the District's Board of Directors approved a Municipal Advisor Services Contract (MASC), as a joint venture, with Hobbs Ong & Associates and PFM Financial Advisors, LLC to provide advisory services. Pursuant to Section I – Term Of Contract, states in part, an option to renew for two (2), one-year periods, subject to the provision of Section II within the MASC.

At this time, the District is requesting approval from the District Board to exercise the first optional one-year extension and authorize the General Manager to sign and provide the Consultant with a written letter exercising the first optional one-year extension for the period covered January 1, 2025, through December 31, 2025. The terms and conditions will continue to be those set forth in the originally approved MASC.

The RFCD Attorney has reviewed the Extension Letter. Staff recommends that the Board approve the first optional one-year extension for Municipal Advisor Services.

Respectfully submitted,

RFCD AGENDA
ITEM #12
Date: 11/14/2024

Steven C. Parrish, P.E.
General Manager/Chief Engineer

Regional Flood Control District
AGENDA ITEM DEVELOPMENT

Staff Discussion:

Date: 11/04/2024

MUNICIPAL ADVISOR SERVICES
FIRST OPTIONAL ONE-YEAR EXTENSION

On February 10, 2022, the District's Board of Directors approved a Municipal Advisor Services Contract (MASC), as a joint venture, with Hobbs Ong & Associates and PFM Financial Advisors, LLC to provide advisory services. Pursuant to Section I – Term Of Contract, states in part, an option to renew for two (2), one-year periods, subject to the provision of Section II within the MASC.

At this time, the District is requesting approval from the District Board to exercise the first optional one-year extension and authorize the General Manager to sign and provide the Consultant with a written letter exercising the first optional one-year extension for the period covered January 1, 2025, through December 31, 2025. The terms and conditions will continue to be those set forth in the originally approved MASC.

The RFCD Attorney has reviewed the Extension Letter. Staff recommends that the Board approve the first optional one-year extension for Municipal Advisor Services.

Staff Recommendation:

Approve.

Discussion by Technical Advisory Committee:

AGENDA
Date:

Recommendation:

The Technical Advisory Committee did not hear this item.

Discussion by Citizens Advisory Committee:

AGENDA
Date:

Recommendation:

The Citizens Advisory Committee did not hear this item.

REGIONAL FLOOD CONTROL DISTRICT

November 14, 2024

Guy Hobbs
Hobbs Ong & Associates, Inc.
6385 South Rainbow Boulevard, Suite 105
Las Vegas, NV 89118

RE: First Optional one-year extension to the Municipal Advisor Services Contract for the period covered of January 1, 2025, through December 31, 2025

On February 10, 2022, the District's Board of Directors approved a Municipal Advisor Services Contract (MASC), as a joint venture, with Hobbs Ong & Associates and PFM Financial Advisors, LLC to provide advisory services. Pursuant to Section I – Term Of Contract, states in part, an option to renew for two (2), one-year periods, subject to the provision of Section II within the MASC.

Pursuant to the MASC, the District's Board of Directors, on November 14, 2024, approved an item authorizing the General Manager to provide the consultant with a written letter exercising the first optional one-year extension for the period covered January 1, 2025, through December 31, 2025. The terms and conditions will continue to be those set forth in the originally approved MASC.

Thank you,

_____
Steven C. Parrish, P.E.
General Manager/Chief Engineer

SCP:dmh

111424 Municipal Advisor-Extension Letter

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

AMENDMENT TO THE INTERLOCAL AGREEMENT ADOPTING AN AMENDED SELF-FUNDED GROUP MEDICAL AND DENTAL BENEFITS EXCLUSIVE PROVIDER ORGANIZATION (EPO) PLAN

RECOMMENDATION SUMMARY

STAFF: Approve and authorize the Chair to sign an amendment to the Self-Funded Group Medical and Dental Benefits Exclusive Provider Organization (EPO) Plan among Clark County, Clark County Water Reclamation District, University Medical Center of Southern Nevada, Las Vegas Convention and Visitors Authority, Las Vegas Valley Water District, Clark County Regional Flood Control District, Regional Transportation Commission of Southern Nevada, Southern Nevada Health District, Henderson District Public Libraries, Mount Charleston Fire Protection District, Las Vegas Metropolitan Police Department, Moapa Valley Fire Protection District and Eighth Judicial District Court adopting an amended Self-Funded Group Medical and Dental Benefits Plan, effective January 1, 2025.

TECHNICAL ADVISORY: The Technical Advisory Committee did not hear this item.

CITIZENS ADVISORY: The Citizens Advisory Committee did not hear this item.

RFCD AGENDA
ITEM #13
DATE: 11/14/2024

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT
AGENDA ITEM

SUBJECT:

SELF-FUNDED GROUP MEDICAL AND DENTAL BENEFITS EXCLUSIVE PROVIDER ORGANIZATION (EPO) PLAN

PETITIONER:

STEVEN C. PARRISH, P.E., GENERAL MANAGER/CHIEF ENGINEER

RECOMMENDATION OF PETITIONER:

THAT THE BOARD APPROVE AND AUTHORIZE THE CHAIR TO SIGN AN AMENDMENT TO THE SELF-FUNDED GROUP MEDICAL AND DENTAL BENEFITS EXCLUSIVE PROVIDER ORGANIZATION (EPO) PLAN AMONG CLARK COUNTY, CLARK COUNTY WATER RECLAMATION DISTRICT, UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA, LAS VEGAS CONVENTION AND VISITORS AUTHORITY, LAS VEGAS VALLEY WATER DISTRICT, CLARK COUNTY REGIONAL FLOOD CONTROL DISTRICT, REGIONAL TRANSPORTATION COMMISSION OF SOUTHERN NEVADA, SOUTHERN NEVADA HEALTH DISTRICT, HENDERSON DISTRICT PUBLIC LIBRARIES, MOUNT CHARLESTON FIRE PROTECTION DISTRICT, LAS VEGAS METROPOLITAN POLICE DEPARTMENT, MOAPA VALLEY FIRE PROTECTION DISTRICT AND EIGHTH JUDICIAL DISTRICT COURT ADOPTING AN AMENDED SELF-FUNDED GROUP MEDICAL AND DENTAL BENEFITS EPO PLAN, EFFECTIVE, JANUARY 1, 2025 (FOR POSSIBLE ACTION)

FISCAL IMPACT:
The FY 2024-25 budget includes sufficient funds for the Self-Funded Group Medical and Dental Benefits EPO Plan.

BACKGROUND:
Clark County established a Self-Funded Group Medical and Dental Benefits program in 1984 to provide group medical and dental benefits to the employees of Clark County and affiliated entities. The program consists of a Preferred Provider Organization (PPO) plan and an Exclusive Provider Organization (EPO) plan. Annually, the Plan is put before the Regional Flood Control District's Board for approval.

Following are the proposed modifications for the upcoming Plan Year, effective January 1, 2025:

- The addition of a $30 specialist copay for University Medical Center of Southern Nevada outpatient clinics.
- The removal of a fourth-tier pharmacy benefit for GLP-1-FSA approved weight loss medication(s).

RFCD AGENDA
ITEM # 13
Date: 11/14/2024

- The clarification of a benefit rule pertaining to the child of a surviving spouse.
- The change of the effective date of employee coverage from 60 days to 45 days.
- Broadening the coverage for speech therapy to include other types of communication disorders.
- The replacement of UMR CARE with Care Management.
- The addition of Alternative/Complementary Treatment to the Glossary of Terms.

The amended Plan has been discussed with represented members, as required by governing bargaining agreements. The Clark County Board of County Commissioners approved this item at their October 15, 2024, Board meeting. Staff recommends approval.

Respectfully submitted,

RFCD AGENDA
ITEM #13
Date: 11/14/2024

Steven C. Parrish, P.E.
General Manager/Chief Engineer

CLARK COUNTY
EXCLUSIVE PROVIDER ORGANIZATION (EPO) PLAN

Health and Dental Benefit Summary Plan Description
7670-00-414937
7670-05-414937
7670-02-414937

Benefit Plan(s) 003, 004

Revised 01-01-2025

BENEFITS ADMINISTERED BY

UMR℠

A UnitedHealthcare Company

Table of Contents

CLARK COUNTY EPO

GROUP HEALTH BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on benefits available under this Plan as well as with information on a Covered Person's rights and obligations under the CLARK COUNTY EPO, Group Health Benefit Plan (the "Plan"). You are a valued Employee of CLARK COUNTY EPO, and Your employer is pleased to sponsor this Plan that may assist in Your health care needs. Please read this document carefully and contact Your Health Benefits Department if you have questions or require further assistance.

CLARK COUNTY, NEVADA is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of an independent Third-Party Administrators to process claims and handle other duties for this self-funded Plan. The Third-Party Administrators for this Plan are UMR, Inc. (hereinafter "UMR") for medical claims, and Navitus Health Solutions for pharmacy claims. The Third-Party Administrators do not assume liability for benefits payable under this Plan, since they are solely claims-paying agents for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, out-of-pocket amounts, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits.

Some of the terms used in this document begin with capital letters, even though such terms normally would not be capitalized. These terms have special meaning under the Plan. Most capitalized terms are listed in the Glossary of Terms, but some are defined within the provisions in which they are used. Becoming familiar with the terms defined in the Glossary of Terms will help You to better understand the provisions of this Plan.

Each individual covered under this Plan will be receiving an identification card that he or she may present to providers whenever he or she receives services. On the back of this card are phone numbers to call in case of questions or problems.

This document contains information on the benefits and limitations of the Plan and will serve as both the Summary Plan Description (SPD) and Plan document. Therefore, it will be referred to as both the SPD and the Plan document.

This document became effective on **January 1, 2025**

.

PLAN INFORMATION

Plan Name	CLARK COUNTY EXCLUSIVE PROVIDER ORGANIZATION (EPO) GROUP HEALTH BENEFIT PLAN
Name And Address Of Employer	CLARK COUNTY, NEVADA 500 S GRAND CENTRAL PKWY LAS VEGAS NV 89155
Name, Address, And Phone Number Of Plan Administrator	CLARK COUNTY, NEVADA 500 S GRAND CENTRAL PKWY LAS VEGAS NV 89155 702-455-4544
Named Fiduciary	CLARK COUNTY, NEVADA
Claims Appeal Fiduciary For Medical Claims	UMR
Employer Identification Number Assigned By The IRS	88-6000028
Type Of Benefit Plan Provided	Self-Funded Health and Welfare Plan providing group health benefits.
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for medical claims.
Name And Address Of Agent For Service Of Legal Process	KIMBERLY BUCHANAN CLARK COUNTY, NEVADA 500 S GRAND CENTRAL PKWY /CHIEF DEPUTY DISTRICT ATTORNEY LAS VEGAS NV 89155
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
Compliance	It is intended that this Plan comply with all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law will be deemed controlling, and any conflicting part of this Plan will be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator will perform its duties as the Plan Administrator and in its sole discretion, will determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator will have full and sole discretionary authority to interpret all Plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator will be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third-Party Administrators for this Plan. Any interpretation, determination, or other action of the Plan Administrator or the Third-Party Administrators will be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third-Party Administrators will be based only on such evidence presented to or considered by the Plan Administrator or the Third-Party Administrators at the time they made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third-Party Administrators make, in their sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) 003, 004

All health benefits shown on this Schedule of Benefits are subject to the following: Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses and Maximums section of this SPD for more details.

Benefits listed in this Schedule of Benefits are subject to all provisions of the Plan, including any benefit determination based on an evaluation of medical facts and covered benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Care Management section of this SPD for a description of these services and prior authorization procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions to the in-network or out-of-network classifications.

If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, it is a combined Maximum Benefit for services that the Covered Person receives from all in-network and out-of-network providers and facilities.

	UNIVERSITY MEDICAL CENTER/SHO	IN-NETWORK AND OOA SHO/ UHC CP	OUT-OF-NETWORK
Annual Total Out-Of-Pocket Maximum Excluding The Prescription Benefit Out-Of-Pocket Maximum: • Per Person • Per Family – Individual Embedded Out-Of-Pocket Maximum ***Note: Embedded Out-Of-Pocket Maximum Means That If You Have Family Coverage, Any Combination Of Covered Family Members May Help Meet The Family Out-Of-Pocket Maximum; However, No One Person Will Pay More Than His Or Her Embedded Individual Out-Of-Pocket Maximum Amount.***	 $3,750 $7,750 $3,750	 $3,750 $7,750 $3,750	
Ambulance Transportation: **Ground:** • Co-pay Per Trip (Waived If Patient Is Admitted As Inpatient) **Air:** • Co-pay Per Trip (Waived If Patient Is Admitted As Inpatient) ***Note: SHO Non-Emergency Arranged Transfers Are Covered At 100%.***	No Benefit	 $50 $50	

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
Anti-Cancer Drug Therapy, Non-Cancer Related Drug Therapy Or Other Medically Necessary Therapeutic Drug Services: • Co-pay Per Day ***Note: Co-pay Is In Addition To The Physician's Office Visit Co-pay / Cost Share.***	$10	$10	No Benefit
Autism Services - Refer To The Covered Medical Benefits Section For Details: **Autism Services:** **ABA Therapy:** • Co-pay Per Visit	100% Covered $10	100% Covered $10	No Benefit
Dialysis: • Co-pay Per Day ***Note: Co-pay Is In Addition To The Physician's Office Visit Co-pay / Cost Share.***	$10 (University Medical Center)	$10 (Fresenius)	No Benefit
Durable Medical Equipment: • Maximum Benefit Every 3 Years **Breast Prostheses:** • Maximum Benefit Per Calendar Year **Camisoles:** • Maximum Benefit Per Calendar Year **Compression Stockings:** • Maximum Benefit Per Calendar Year ***Note: One Pair Equals Two Units, One Limb Equals One Unit And Compression Panty Hose Equals One Unit.*** **Insulin Pumps And Diabetic Equipment:** • Co-pay Per Device	No Benefit	1 Purchase Of A Type Of Durable Medical Equipment Including Repair And Replacement 100% Covered 1 Prosthesis Per Breast 100% Covered 2 Camisoles 100% Covered 6 Pairs 100% Covered $20	No Benefit

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
Emergency Services / Treatment:			
Urgent Care:			
• Co-pay Per Visit	$20 (UMC Quick Care Only)	$20	
Walk-In Retail Health Clinics:			No Benefit
• Co-pay Per Visit	$10	$20	
Emergency Room Only:			
• Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hour(s))	$500	$500	
Emergency Physicians Only:	100% Covered	100% Covered	
Extended Care Facility Benefits, Such As Skilled Nursing, Convalescent, Or Subacute Facility:			No Benefit
• Co-pay Per Admission (Waived If Admitted From An Acute Care Facility)	Not Applicable	$250	
• Maximum Days Per Calendar Year	100 Days		
Gender Transition: ***Note: Also, Member Must Have Been Confirmed With Gender Dysphoria And Actively Participating In A Recognized Gender Identity Treatment Program.***	100% Covered After All Applicable Copayments		No Benefit
Hearing Services:			No Benefit
Exams, Tests:	Covered	Covered	
Hearing Aids:	No Benefit		
• Maximum Benefit Every 3 Years		$3,000	
Implantable Hearing Devices:	100% Covered	100% Covered	
Home Health Care Benefits: ***Note: A Home Health Care Visit Will Be Considered A Periodic Visit By A Nurse, Qualified Therapist, Or Qualified Dietician, As The Case May Be, Or Up To Four Hours Of Home Health Care Services.***	No Benefit	100% Covered	No Benefit

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
Hospice Care Benefits:			No Benefit
Inpatient Hospice Services Only:			
• Co-pay Per Day	Not Applicable	$350	
• Maximum Co-pay Per Admission	Not Applicable	$1,750	
	100% Covered		
Inpatient Hospice Physician Charges Only:			
•	100% Covered	100% Covered	
Outpatient Hospice Services / Outpatient Hospice Physician Charges:	No Benefit	100% Covered	
Bereavement Counseling:			
• Co-pay Per Visit	$10	$20	
• Maximum Benefit Per Calendar Year	5 Sessions		
Note: Limit Applies To Group Therapy Sessions. Group Therapy Is The Only Covered Benefit Under Bereavement Counseling.			
Inpatient Respite Care:			
• Maximum Benefit Including Outpatient Respite Care	5 Inpatient Days Or 5 Outpatient Visits Per 90 Days Of Home Hospice Care		
	100% Covered	100% Covered	
Outpatient Respite Care:	No Benefit		
Included In Inpatient Respite Care Maximum			
• Co-pay Per Visit		$10	
Hospital Services:			No Benefit
Pre-Admission Testing:	100% Covered	100% Covered	
Inpatient Services Only; Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:			
• Co-pay Per Day	Not Applicable	$350	
• Maximum Co-pay Per Admission	Not Applicable	$1,750	
	100% Covered		
Inpatient Physician Charges Only:	100% Covered	100% Covered	
Inpatient Rehabilitation (Specifically Physical Therapy / Occupational Therapy / Speech Therapy):	100% Covered	100% Covered	

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
Outpatient Services / Outpatient Physician Charges:	100% Covered	100% Covered	No Benefit
Outpatient Advanced Imaging Charges: • Co-pay Per Test Or Procedure	Not Applicable 100% Covered	$10	
Outpatient Lab And X-Ray Charges: • Co-pay Per Visit	Not Applicable 100% Covered	$5	
Outpatient Surgery Only: • Co-pay Per Visit	Not Applicable 100% Covered	$250	
Outpatient Surgeon Charges Only:	100% Covered	100% Covered	
Note: Any Co-pay / Cost Share Is In Addition To Any Physician Office Visit Co-pay / Cost Share.			
Ambulatory Surgery - Facility Charges Only: • Co-pay Per Visit	No Benefit	$75	
Ambulatory Surgery - Physician Charges Only: • Co-pay Per Visit	No Benefit	$40	
Note: Any Co-pay / Cost Share Is In Addition To Any Physician Office Visit Co-pay / Cost Share.			
Physician Clinic Visits In An Outpatient Hospital Setting - Facility Claim:	100% Covered	100% Covered	
Physician Clinic Visits In An Outpatient Hospital Setting - Physician Claim: • Co-pay Per Visit - Primary Care Physician • Co-pay Per Visit - Specialist	$10 $30	$20 $40	
Physician Clinic Visits In An Outpatient Hospital Setting - Physician Claim For Allergy Testing, Serum And Injections (Must Be Performed By An Allergist), And Advanced Imaging (CT, MRI, PET): • Co-pay Per Visit	$10	$10	
Note: All Co-pays Are In Addition To The Physician Office Visit Co-pay / Cost Share. Allergy Testing, Serum And Injections Not Performed By An Allergist Are Not Covered.			

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
Infant Formula: • Maximum Benefit Per Calendar Year ***Note: Any Additional Therapeutic Supplies Would Require Prior Authorization.***	1 Thirty-Day Therapeutic Supply For Up To 4 Times 100% Covered	100% Covered	No Benefit
Infertility Treatment: **Office Visit Evaluation:** • Co-pay Per Visit **Artificial Insemination Services:** • Maximum Benefit Per Lifetime On All County Plans **All Other Infertility Services:**	Not Applicable 100% Covered 6 Cycles 100% Covered 100% Covered	$20 100% Covered 100% Covered	No Benefit
Manipulations: • Co-pay Per Visit • Maximum Visits Per Calendar Year ***Note: Prior Authorization Is Required For Additional Visits.***	No Benefit	$20 20 Visits	No Benefit
Mental Health, Substance Use Disorder, And Chemical Dependency Benefits: **Inpatient Services Only:** • Co-pay Per Day • Maximum Co-pay Per Admission **Inpatient Physician Charges Only:** **Residential Services Only:** • Co-pay Per Admission (Waived If Admitted From An Acute Care Facility) **Residential Physician Charges Only:** **Outpatient Or Partial Hospitalization Services And Physician Charges:** **Office Visit:** • Co-pay Per Visit	Not Applicable Not Applicable 100% Covered 100% Covered No Benefit No Benefit 100% Covered No Benefit	$350 $1,750 100% Covered $250 100% Covered 100% Covered $20	No Benefit

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
Morbid Obesity Treatment:	100% Covered After All Applicable Copayments		No Benefit
Bariatric Surgery: • Maximum Benefit Per Lifetime On All County Plans	1 Surgery 100% Covered After All Applicable Copayments		
Note: Complications Will Be Covered Under The Normal Medical Benefit.			
Nursery And Newborn Expenses: ***Note: Co-pay Will Be Waived For Newborn Charges, Initial Stay (Days 0-5).***	100% Covered	100% Covered	No Benefit
Nutritional Supplement:	100% Covered	100% Covered	No Benefit
Enteral Feedings: • Maximum Benefit Per Calendar Year	1 Thirty-Day Therapeutic Supply For Up To 4 Times		
Note: Any Additional Therapeutic Supplies Would Require Prior Authorization.	100% Covered	100% Covered	
Orthotic Appliances: • Co-pay Per Device • Maximum Benefit Every 3 Years	Not Applicable 1 Purchase Of A Type Of Orthotic Device Including Repair And Replacement 100% Covered	$200	No Benefit
Custom Molded Foot Orthotics: • Maximum Benefit Per Lifetime On All County Plans	$500 100% Covered	100% Covered	
Diabetic Shoes: • Maximum Benefit Per Calendar Year	1 Pair Of Shoes 100% Covered	100% Covered	
Diabetic Inserts: • Maximum Benefit Per Calendar Year	3 Pairs Of Inserts 100% Covered	100% Covered	
Note: No Prior Authorization Required If Primary Diagnosis Is Diabetes Otherwise Prior Authorization Is Required.			

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
Physician Office Visit. This Section Applies To Medical Services Billed From A Physician Office Setting: **This Section Does Not Apply To:** ➢ **Preventive / Routine Services** ➢ **Manipulation Services Billed By Any Qualifying Provider** ➢ **Dental Services Billed By Any Qualifying Provider** ➢ **Therapy Services Billed By Any Qualifying Provider** ➢ **Any Services Billed From An Outpatient Hospital Facility**			No Benefit
Primary Care Physician Visit: • Co-pay Per Visit	$10	$20	
Specialist Visit: • Co-pay Per Visit	No Benefit	$40	
The Co-pays Will Not Apply To: ➢ **Independent Lab** ➢ **Services Billed By Radiologist Or Pathologist Including Independent Radiology Facility (Freestanding Radiology Facility)**			
Physician Office Services:	100% Covered	100% Covered	No Benefit
Office Surgery: • Co-pay Per Visit - Primary Care Physician • Co-pay Per Visit - Specialist	Not Applicable Not Applicable 100% Covered	$20 $40	
Allergy Injections And Sublingual Drops: • Co-pay Per Visit ***Note: Allergy Injections Not Performed By An Allergist Are Not Covered.***	Not Applicable 100% Covered	$10	
Allergy Testing: • Co-pay Per Visit ***Note: Allergy Testing Not Performed By An Allergist Are Not Covered.***	Not Applicable 100% Covered	$10	

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
Allergy Serum: • Co-pay Per Visit ***Note: Allergy Serum Not Performed By An Allergist Are Not Covered.***	Not Applicable 100% Covered	$10	
Diagnostic X-Ray And Laboratory Tests: • Co-pay Per Visit	Not Applicable 100% Covered	$5	
Office Advanced Imaging: • Co-pay Per Visit ***Note: All Co-pays Are In Addition To The Physician Office Visit Co-pay / Cost Share.***	Not Applicable 100% Covered	$10	
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:			No Benefit
Preventive / Routine Physical Exams At Appropriate Ages:	100% Covered	100% Covered	
Immunizations: ***Note: Foreign Travel Immunizations Are Not Covered.***	100% Covered	100% Covered	
Preventive / Routine Diagnostic Tests, Lab, And X-Rays At Appropriate Ages:	100% Covered	100% Covered	
Preventive / Routine Mammograms And Breast Exams: From Age 35 To Age 40 • Maximum Exams Including 3D Mammograms For Preventive Screenings	1 Exam		
From Age 40 • Maximum Exams Per Calendar Year Including 3D Mammograms For Preventive Screenings	1 Exam		
	100% Covered	100% Covered	
3D Mammograms For Preventive Screenings: Included In Preventive / Routine Mammograms And Breast Exams Maximum	100% Covered	100% Covered	

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
3D Mammograms For Diagnosis / Treatment Of A Covered Medical Benefit:	100% Covered	100% Covered	No Benefit
Preventive / Routine Pelvic Exams And Pap Tests:			
• Maximum Exams Per Calendar Year	1 Exam		
	100% Covered	100% Covered	
Preventive / Routine PSA Tests And Prostate Exams:			
• Maximum Exams Per Calendar Year	1 Exam		
	100% Covered	100% Covered	
Preventive / Routine Screenings / Services At Appropriate Ages And Gender:	100% Covered	100% Covered	
Preventive / Routine Autism Screening: From Age 0 To 22	100% Covered	100% Covered	
Preventive / Routine Colonoscopies: From Age 45 To Age 76			
• Maximum Exams Every 10 Years	1 Exam		
	100% Covered	100% Covered	
Note: Initial Colonoscopy Paid Routine Regardless Of Diagnosis.			
Preventive / Routine Cologuard: From Age 45	100% Covered	100% Covered	
Preventive / Routine Sigmoidoscopies:			
• Maximum Exams Per Calendar Year	1 Exam		
	100% Covered	100% Covered	
Preventive / Routine Counseling For Alcohol Or Substance Use Disorder, Tobacco / Nicotine Use, Obesity, Diet, And Nutrition:	100% Covered	100% Covered	
Preventive / Routine Bone Density: From Age 60	100% Covered	100% Covered	

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
In Addition, The Following Preventive / Routine Services Are Covered For Women: ➢ **Screening For Gestational Diabetes** ➢ **Papillomavirus DNA Testing*** ➢ **Counseling For Sexually Transmitted Infections (Provided Annually)*** ➢ **Counseling For Human Immune-Deficiency Virus (Provided Annually)*** ➢ **Breastfeeding Support, Supplies, And Counseling** ➢ **Counseling For Interpersonal And Domestic Violence For Women (Provided Annually)*** ***These Services May Also Apply To Men.**	100% Covered	100% Covered	No Benefit
Prosthetic Devices: • Co-pay Per Device • Maximum Benefit Every 3 Years	Not Applicable 1 Purchase Of A Type Of Prosthetic Device Including Repair And Replacement 100% Covered	$200	No Benefit
Teladoc Services: **General Medicine:** • Co-pay Per Occurrence **Mental Health:** • Co-pay Per Occurrence ***Note: Multiple Co-pays Apply When Multiple Claims Are Billed On The Same Date Of Service.***		$10 $10	
Telehealth: • Co-pay Per Visit - Primary Care Physician • Co-pay Per Visit - Specialist **Mental Health / Substance Use Disorder Office Visit:** • Co-pay Per Visit	 $10 Not Applicable $10	 $20 $40 $10	No Benefit
Temporomandibular Joint Disorder Benefits: **Office Visit:** • Co-pay Per Visit **All Other Temporomandibular Joint Disorder Services:**	 Not Applicable 100% Covered 100% Covered	 $20 100% Covered	No Benefit

	UNIVERSITY MEDICAL CENTER / SHO	IN-NETWORK AND OOA SHO / UHC CP	OUT-OF-NETWORK
Therapeutic Radiology (Treatment Of Cancer And Other Diseases With Radiation): • Co-pay Per Day ***Note: Co-pay Is In Addition To The Physician's Office Visit Co-pay / Cost Share.***	$10	$10	No Benefit
Therapy Services: **Occupational Outpatient Hospital And Office Therapy:** • Co-pay Per Visit • Maximum Visits Per Calendar Year **Physical Outpatient Hospital And Office Therapy:** • Co-pay Per Visit • Maximum Visits Per Calendar Year **Speech Outpatient Hospital And Office Therapy:** • Co-pay Per Visit • Maximum Visits Per Calendar Year ***Note: Prior Authorization Is Required At First Visit And For Any Additional Visits After Limit Is Reached.***	 $5 30 Visits $5 30 Visits $5 30 Visits	 $5 $5 $5	No Benefit

TRANSPLANT SCHEDULE OF BENEFITS

The program for Transplant Services At Designated Transplant Facilities is:

Sierra Healthcare Options (SHO)
Optum

Transplant Services: Designated Transplant Facility **Transplant Services:** **Travel And Housing:** • Maximum Benefit Per Transplant **Lodging And Meals:** • Maximum Benefit Per Day Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	100% Covered $10,000 $200		
	UNIVERSITY MEDICAL CENTER / SHO	**IN-NETWORK AND OOA SHO / UHC CP**	**OUT-OF-NETWORK**
Transplant Services: Non-Designated Transplant Facility **Transplant Services:** **Travel And Housing:** • Maximum Benefit Per Transplant **Lodging And Meals:** • Maximum Benefit Per Day Travel And Housing At Designated Transplant Facility At Contract Effective Date/Pre-Transplant Evaluation And Up To One Year From Date Of Transplant.	100% Covered $10,000 $200	100% Covered $10,000 $200	No Benefit

OUT-OF-POCKET EXPENSES AND MAXIMUMS

CO-PAYS

A Co-pay is the amount that the Covered Person pays each time certain services are received. The Co-pay is typically a flat dollar amount and is paid at the time of service or when billed by the provider. Co-pays do not apply toward satisfaction of Deductibles. Co-pays apply toward satisfaction of in-network out-of-pocket maximums. The Co-pay and out-of-pocket maximum are shown on the Schedule of Benefits.

PLAN PARTICIPATION

Plan Participation is the Co-pay of Covered Expenses that the Covered Person is responsible for paying. The Covered Person pays this amount until the Covered Person's (or families, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is the most the Covered Person pays each year for Covered Expenses. Annual out-of-pocket maximums are shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses will be used to satisfy the Covered Person's (or families, if applicable) annual out-of-pocket maximum(s). If the Covered Person's out-of-pocket expenses in a Plan Year exceed the annual out-of-pocket maximum, the Plan pays 100% of the Covered Expenses through the end of the Plan Year.

The following will not be used to meet the out-of-pocket maximums:

- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.
- Any charges above the limits specified elsewhere in this document.
- Pharmacy Co-pays and Plan Participation amounts for Prescription benefits.
- Expenses Incurred as a result of failure to comply with prior authorization requirements.
- Any amounts over the Recognized Amount, Usual and Customary amount, Negotiated Rate, or established fee schedule that this Plan pays.

The eligible out-of-pocket expenses that the Covered Person incurs at an in-network provider will apply to the in-network total out-of-pocket maximum. The eligible out-of-pocket expenses that the Covered Person incurs at an out-of-network provider will apply to the out-of-network total out-of-pocket maximum.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles, Co-pays, or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses may not be waived by a provider under any "fee forgiveness," "not out-of-pocket," or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person's claim may be denied, and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. From time to time, the Plan may request documentation from You or Your Dependents in order to make determinations for continuing eligibility. The coverage choices that will be offered to You will be the same choices offered to other, similarly situated Employees.

WAITING PERIOD (Applies to All Other Employees)

If eligible, You must complete a Waiting Period before coverage becomes effective for You and Your Dependents. A Waiting Period is a period of time that must pass before an Employee or Dependent becomes eligible for coverage under the terms of this Plan.

You are eligible for coverage on the date listed below under the Effective Date section, upon completion of 15 calendar days of continuous employment (not to exceed 45 days) in a benefit eligible position.

The start of Your Waiting Period is the first full day of employment for the job that made You eligible for coverage under this Plan.

ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full-time 30 or more hours per week, and participants meeting the below criteria are also benefit eligible:

- Elected Officials: Individuals who are elected to county office shall be considered Employees for purposes of this Plan during the term of their elected position.
- 20-hour benefited positions at UMC (University Medical Center).

But for purposes of this Plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion:

- Leased Employees.
- Independent Contractors as defined in this Plan.
- Consultants who are paid on other than a regular wage or salary basis by the employer.
- Members of the employer's Board of Directors, owners, partners, unless engaged in the conduct of the business on a full-time, regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, which may be combined with the employer's short-term disability policy, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. Employees who meet eligibility requirements during a measurement period as required by the Affordable Care Act (ACA) regulations will be deemed to have met the eligibility requirements for the corresponding coverage period as required by the ACA regulations. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a Third-Party, whether by a court, governmental agency, or otherwise, without regard to whether or not the employer agrees to such reclassification, will change a person's eligibility for benefits.

An eligible Employee who is covered under this Plan and who retires under the employer's formal retirement plan will be eligible to continue participating in the Plan upon retirement, provided the individual continues to make the required contribution. See the Coordination of Benefits section for more information on how this Plan coordinates with Medicare coverage. Retirees may continue coverage under this Plan until death, non-payment of premium, or if they no longer meet the eligibility requirements, whichever occurs first. A surviving Spouse of a Retired Employee is eligible to remain on the plan until death or non-payment of premium provided such spouse was covered under the Plan at the time of the Retired Employee's death.

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

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

Retiree Reinstatement

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

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

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

Retiree / Dependent Reinstatement Enrollment:

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

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

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

Note: Eligible Employees and Dependents who decline to enroll in this Plan must state so in writing. In order to preserve potential special enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or health insurance policy. Proof of such plan or policy may be required upon application for special enrollment. See the Special Enrollment Provision section of this Plan.

An **eligible Dependent** includes:

- Your legal spouse, provided he or she is not covered as an Employee under this Plan. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator. An Employee's spouse who is not a United States Citizen is not eligible for coverage, unless the individual is a lawful resident actively seeking permanent residency in the United States.

- Your Domestic Partner, as long as he or she meets the definition of Domestic Partner as stated in the Glossary of Terms, and the person is not covered as an Employee under this Plan. When a person no longer meets the definition of Domestic Partner, that person no longer qualifies as Your Dependent. Anyone enrolled as a domestic partner on 12/31/2021 is considered grandfathered into the future (until noticed otherwise). NEW domestic partnerships post on 1/1/2022 will not be eligible for coverage.

- A Dependent Child until the Child reaches his or her 26th birthday. The term "**Child**" includes the following Dependents:

  - A natural biological Child;
  - A stepchild;
  - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state, or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;
  - A Child under Your (or Your spouse's) Legal Guardianship as ordered by a court. Birth to age 18 only. ;
  - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO);
  - A natural child of the covered grandfathered Domestic Partner or a Child under Your grandfathered Domestic Partner's Legal Guardianship. Employee must provide more than 50 percent of the child's support.

- A Dependent does not include the following:

  - A foster Child;
  - A grandchild;
  - A Domestic Partner;
  - A Dependent Child if the Child is covered as a Dependent of another Employee at this company;
  - The child of a surviving spouse (a dependent child was not enrolled on plan at the time of Guarantors death);
  - Any other relative or individual unless explicitly covered by this Plan.

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage. The Plan Administrator, at the administrator's discretion, may require documentation such as certified marriage certificates, grandfathered domestic partner registrations, divorce decrees, social security identification, tax returns, certified birth certificates, adoption decrees, or copies of certified court orders.

Eligibility Criteria: To be an eligible Totally Disabled Dependent Child, a Totally Disabled Dependent Child aged 26 or over must be dependent upon the Employee for more than 50 percent of his or her support and maintenance. This financial requirement does not apply to Children who are enrolled in accordance with a Qualified Medical Child Support Order because of the Employee's divorce or separation decree.

NON-DUPLICATION OF COVERAGE: Any person who is covered as an eligible Employee will not also be considered an eligible Dependent under this Plan.

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have an obligation to notify the Plan should the Dependent's eligibility status change during the Plan Year. Please notify Your Health Benefits Department regarding status changes.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
- The Dependent Child is a Dependent of an Employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a special enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 31 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of a Totally Disabled Dependent, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Continuation of Coverage section in this document.

Employees have the right to choose which eligible Dependents are covered under the Plan.

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of the following dates:

- If You apply within Your Waiting Period, Your coverage will become effective the first day of the month following the date You complete Your Waiting Period. If Your Waiting Period ends on the first day of the month, Your coverage will not begin until the first day of the following month; or **(Applies to All Other Employees)**

- If You are an Elected Official, You and Your eligible Dependents will be covered under this Plan effective on the date You take the oath of office, so long as You comply with the Plan's Enrollment Requirements within 31 days of the date the oath of office is taken; or **(Applies to Elected Officials)**

- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 45 calendar days of the event for marriage, birth or adoption and within 31 calendar days in the case of a loss of coverage.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of the following dates:

- The date Your coverage under the Plan begins if You enroll the Dependent at that time; or

- The date You acquire Your Dependent if application is made within 60 calendar days of acquiring the Dependent for marriage, birth or adoption and within 31 calendar days in the case of a loss of coverage; or

- The date set forth under the Special Enrollment Provision if Your Dependent is eligible to enroll under the Special Enrollment Provision and application is made within 60 calendar days following the event for marriage, birth or adoption and within 31 calendar days in the case of a loss of coverage; or

- The date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

Some Employers provide Employee and Dependent coverage on a non-contributory basis and do not require Employees to contribute a share of the cost of coverage. Other Employers share the cost of Employee and Dependent coverage under this Plan with the covered Employee. The level of any Employee contributions is set by the Plan Administrator, subject to the provisions of any applicable collective bargaining agreement. The Plan Administrator reserves the right to change the level of Employee contributions, also subject to the provisions of any applicable collective bargaining agreement.

ANNUAL OPEN ENROLLMENT PERIOD

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Covered Employees and covered Retirees will be able to make changes in coverage for themselves and their eligible Dependents.

(Applies to All Other Employees) Coverage Waiting Periods are waived during the annual open enrollment period for covered Employees, covered Retirees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If You and/or Your Dependent becomes covered under this Plan as a result of electing coverage during the annual open enrollment period, the following will apply:

- The employer will notify eligible Employees prior to the start of an annual open enrollment period; and

- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person’s coverage; and

- The Effective Date of coverage will be January 1 following the annual open enrollment period.

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

This Plan gives an eligible person special enrollment rights if the person experiences a loss of other health coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other, similarly situated Employees.

LOSS OF HEALTH COVERAGE

You and Your Dependents may have a special opportunity to enroll for coverage under this Plan if You experience a loss of other coverage.

In order for You to be eligible for special enrollment rights, You must meet the following conditions:

- You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan was offered; and

- You and/or Your Dependents stated in writing that You declined coverage due to coverage under another group health plan or health insurance policy; and

- The coverage under the other group health plan or health insurance policy was:

  - COBRA continuation coverage and that coverage was exhausted; or
  - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
  - Terminated and no substitute coverage was offered; or
  - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 60 calendar days following the event for marriage, birth or adoption and within 31 calendar days in the case of a loss of coverage after the date the other coverage ended.

You and/or Your Dependents were covered under a Medicaid plan or state child health plan and coverage for You or Your Dependents was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

You or Your Dependents may not enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause, such as making a fraudulent claim or an intentional misrepresentation of material fact, or

- You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

NEWLY ELIGIBLE FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

A current Employee and his or her Dependents may be eligible for a special enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependents are determined to be eligible for such assistance.

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries, and other eligible persons have special opportunities to enroll for coverage under this Plan if they experience changes in family status.

If a person becomes an eligible Dependent through marriage, attestation of a grandfathered Domestic Partnership, birth, adoption or Placement for Adoption, the Employee, spouse, and newly acquired Dependent(s) who are not already enrolled may enroll for health coverage under this Plan during a special enrollment period. The Employee must request and apply for coverage within 60 calendar days of the marriage, attestation of a grandfathered Domestic Partnership, birth, adoption, or Placement for Adoption, and within 31 calendar days in the case of a loss of coverage.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective as follows:

- In the case of marriage, on the first day of the month following the date the completed request for enrollment and supporting documentation is received by the Plan (note that eligible individuals must submit their enrollment forms prior to the Effective Dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or

- In the case of a Dependent's birth, on the date of such birth. Newborn children will automatically be covered for the first 31 days following birth. Coverage will cease beginning with the 32nd day unless the newborn child has been affirmatively enrolled as a Dependent in the plan; or

- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or

- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the first day of the month following the date the completed request for enrollment and supporting documentation is received by the Plan; or

- In the case of loss of coverage, the first day of the month following the date the completed request for enrollment and supporting documentation is received by the Plan.

RELATION TO SECTION 125 CAFETERIA PLAN

This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information.

TERMINATION

For information about continuing coverage, refer to the COBRA Continuation of Coverage section of this SPD.

EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made if You fail to make any required contribution toward the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment or at annual open enrollment periods; or
- The end of the stability period in which You became a member of a non-covered class, as determined by the employer except as follows:
    - If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave for up to the end of the six (6) calendar month period that next follows the month in which the person last worked as an Active Employee, provided the applicable Employee contribution is paid when due. Any Employee on authorized leave without pay, who fails to make premium payments as required by the Employer, will have coverage under the Group Plan terminated on the first date for which no premium payments have been paid.
    - If You are temporarily absent from work due to disability leave, the date the Employer ends the continuance.
    - If You are temporarily absent from work as a furloughed Employee, the Plan Administrator may extend Plan coverage to Employees who have been furloughed by a participating entity as a result of a decline in the economy or workload. The responsible entity shall continue to remit the full cost of the premium to the Plan for the period of time the member is furloughed. A member is eligible for continued coverage for a period not to exceed 24-months as a result of his/her furlough status. A member is considered in furlough status when he/she is in an continuous unpaid status for a specified period.
    - If You are temporarily absent from work due to active military duty, refer to USERRA under the Uniformed Services Employment and Reemployment Rights Act of 1994 section; or
- The last day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other fraudulent act related to this Plan or any other group plan.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or

The last day of the month in which Your coverage ends; or

- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state in which You reside; or

- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility and Enrollment section; or

- If Your Dependent Child qualifies for extended Dependent coverage because he or she is Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or

- The last day of the month in which Your Dependent Child no longer satisfies a required eligibility criterion listed in the Eligibility and Enrollment section; or

- The date Dependent coverage is no longer offered under this Plan; or

- The last day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment, or at annual open enrollment periods; or

- The last day of the month in which the Dependent becomes covered as an Employee under this Plan; or

- The date You or Your Dependent submits a false claim or is involved in any other fraudulent act related to this Plan or any other group plan.

RESCISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is **not** a rescission if:

- it has only a prospective effect; or
- it is attributable to non-payment of premiums or contributions; or
- it is initiated by You or Your personal representative.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You qualify for eligibility under this Plan again (are rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, Your coverage will be reinstated. If Your coverage ends due to termination of employment, leave of absence, reduction of hours, or layoff and You do not qualify for eligibility under this Plan again (are not rehired or considered to be rehired for purposes of the Affordable Care Act) within 13 weeks from the date Your coverage ended, and You did not perform any hours of service that were credited within the 13-week period, You will be treated as a new hire and will be required to meet all the requirements of a new Employee. Refer to the information on the Family and Medical Leave Act and the Uniformed Services Employment and Reemployment Rights Act for possible exceptions or contact Your Health Benefits or Personnel office.

EXTENSION OF BENEFITS

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

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

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

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

COBRA CONTINUATION OF COVERAGE

Note: UMR (the claims administrator) does not administer the benefits or services described within this provision. Please contact the benefit manager or Your employer with any questions related to this coverage or service.

Important: Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You and Your Dependents need to do to protect the right to receive it. When You become eligible for COBRA, You may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This summary provides a general notice of a Covered Person's rights under COBRA but is not intended to satisfy all the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You or Your Dependents as required.

You may have other options available to You when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, You may qualify for lower costs on Your monthly premiums and lower out-of-pocket costs. Additionally, You may qualify for a 30-day special enrollment period for another group health plan for which You are eligible (such as a spouse's plan), even if that plan generally does not accept Late Enrollees.

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits beyond the date that they might otherwise lose coverage. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event (outlined below). When a Qualifying Event causes (or will cause) a Loss of Coverage, the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage, even if You or Your Dependent is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

If You are an Employee, You will become a Qualified Beneficiary if You lose coverage under the Plan because either one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• Your employment ends for any reason other than Your gross misconduct	up to 18 months
• Your hours of employment are reduced	up to 18 months

(There are two ways in which this 18-month period of COBRA continuation coverage may be extended. See the section below entitled "The Right to Extend the Length of COBRA Continuation Coverage" for more information.)

The spouse of an Employee will become a Qualified Beneficiary if he or she loses coverage under the Plan because any one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• The Employee dies	up to 36 months
• The Employee's hours of employment are reduced	up to 18 months
• The Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
• The Employee and spouse become divorced or legally separated	up to 36 months

The Dependent Children of an Employee will become Qualified Beneficiaries if they lose coverage under the Plan because any one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• The parent-Employee dies	up to 36 months
• The parent-Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The parent-Employee's hours of employment are reduced	up to 18 months
• The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
• The parents become divorced or legally separated	up to 36 months
• The Child loses eligibility for coverage under the Plan as a Dependent	up to 36 months

Note: A spouse or a Dependent Child newly acquired through birth or adoption during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A Dependent other than a newborn or newly adopted Child who is acquired and enrolled after the original Qualifying Event is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

COBRA NOTICE PROCEDURES

THE NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

In order to be eligible to receive COBRA continuation coverage, covered Employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Employee and spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrator, whether to Your employer or to the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information (a form for notifying the COBRA Administrator is available upon request):

- The Qualified Beneficiary's name, current address, and complete phone number,
- The group number and the name of the Employee's employer,
- A description of the Qualifying Event (i.e., the life event experienced), and
- The date the Qualifying Event occurred or will occur.

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes to the addresses of family members. Keep copies of all notices You send to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your employer will give notice to the COBRA Administrator when coverage terminates due to the Employee's termination of employment or reduction in hours, the death of the Employee, or the Employee's becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days of when one of these events occurs.

EMPLOYEE OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of divorce or legal separation of the Employee and a spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar-day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would be a Loss of Coverage) due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, the covered Employee, or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that should be completed in order to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of his or her election in writing or via the online portal, if available, in order to continue group health coverage and must make the required payments when due in order to remain covered. If online election is available, You will receive instructions for online election when Your election notice is provided. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, group health coverage will be reinstated retroactively to the date coverage was lost, provided the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will become effective on the date the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and Employee contributions. This cost may also include a 2% additional fee to cover administrative expenses (or, in the case of the 11-month extension due to disability, a 50% additional fee). The cost of continuation coverage is subject to change at least once per year.

If Your employer offers annual open enrollment opportunities for active Employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope or, if online election is available, the date Your election is submitted electronically. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage. However, the Qualified Beneficiary will receive specific payment information, including due dates, when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA Administrator receives a check that is missing information or contains discrepancies regarding the information on the check (e.g., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary with information regarding what needs to be done to correct the mistake.

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

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, written notice to the COBRA Administrator is required within 30 calendar days of the date any one of the following events occurs:

- The Qualified Beneficiary marries. Refer to the Special Enrollment Provision section of this SPD for additional information regarding special enrollment rights.

- A Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment Provision section of this SPD for additional information regarding special enrollment rights.

- A final determination is made by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.

- Any Qualified Beneficiary becomes covered by another group health plan or enrolls in Medicare Part A or Part B.

Additionally, if the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information in the timeframe outlined in the request document.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- For Employees and Dependents: 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent Children will be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)

- For Dependents only: 36 months from the Qualifying Event if coverage is lost due to one of the following events:

  - The Employee's death.
  - The Employee's divorce or legal separation.
  - The former Employee's enrollment in Medicare.
  - A Dependent Child's loss of eligibility as a Dependent as defined by the Plan.

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided written notice is given to the COBRA Administrator as soon as possible, but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA, in the event that the Social Security Administration determines the Qualified Beneficiary to be disabled either before becoming eligible for, or within the first 60 days of being covered by, COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the Qualified Beneficiary has non-disabled family members who are also Qualified Beneficiaries, those non-disabled family members are also entitled to the disability extension.

The Qualified Beneficiary must give the COBRA Administrator a copy of the Social Security Administration letter of disability determination before the end of the initial 18-month period and within 60 days of the later of:

- The date of the Social Security Administration disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA.

If the Social Security Administration determines the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Events (Dependents Only): If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family who are Qualified Beneficiaries may receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent Children who are Qualified Beneficiaries if the Employee or former Employee dies, becomes entitled to Medicare (Part A, Part B, or both) or is divorced or legally separated, or if the Dependent Child loses eligibility under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event or in the case of a newborn Child being added as a result of a HIPAA special enrollment right. Dependents acquired during COBRA continuation (other than newborns and newly adopted Children) are not eligible to continue coverage as the result of a subsequent Qualifying Event. These events will lead to the extension only when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

You or Your Dependents must provide the notice of a second Qualifying Event to the COBRA Administrator within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

There may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or other group health plan coverage (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

In general, if You do not enroll in Medicare Part A or B when You are first eligible because You are still employed, after the Medicare initial enrollment period You have an eight-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of (a) the month after Your employment ends, or (b) the month after group health plan coverage based on current employment ends.

If You do not enroll in Medicare and elect COBRA continuation coverage instead, You may have to pay a Part B late enrollment penalty and You may have a gap in coverage if You decide You want Part B later. If You elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate Your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if You enroll in the other part of Medicare after the date of the election of COBRA coverage. If You are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (as the primary payer), and COBRA continuation coverage will pay second. For more information visit https://www.medicare.gov/medicare-and-you.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group health plan for any Employees. (Note that if the employer terminates the group health plan under which the Qualified Beneficiary is covered, but still maintains another group health plan for other, similarly situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same.)

- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled in Medicare.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan.

- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.

- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE

If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the Qualified Beneficiary will lose his or her special enrollment rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the Qualified Beneficiary since it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After COBRA continuation coverage is exhausted, the Qualified Beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange, in accordance with his or her HIPAA special enrollment rights.

DEFINITIONS

Qualified Beneficiary means a person covered by this group health Plan immediately before a Qualifying Event. A Qualified Beneficiary may be an Employee, the spouse of a covered Employee, or the Dependent Child of a covered Employee. This includes a Child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the Child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted Children. This also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered Employee.
- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).
- A reduction in work hours of the covered Employee.
- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)
- The covered former Employee becomes enrolled in Medicare.
- A Dependent Child no longer qualifies as a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before a Qualifying Event. Loss of Coverage includes a change in coverage terms, a change in plans, termination of coverage, partial Loss of Coverage, an increase in Employee cost, and other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after a Qualifying Event but must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA rights.

CONTINUED COVERAGE FOR DOMESTIC PARTNERS

Domestic Partners do not qualify as Qualified Beneficiaries under federal COBRA law. Therefore, under federal law, a Domestic Partner does not have the right to elect COBRA independently and separately from an eligible Employee.

However, this Plan allows grandfathered Domestic Partners to elect to continue coverage under a "COBRA-like" extension, separately and independently of eligible Employees, subject to the same terms and conditions that are outlined for Qualified Beneficiaries under COBRA when a Qualifying Event occurs.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

The Plan Administrator:
CLARK COUNTY, NEVADA
500 S GRAND CENTRAL PKWY
LAS VEGAS NV 89155

The COBRA Administrator

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in a loss of coverage. Employees on leave for military service must be treated as if they are on leaves of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leaves of absence or furloughs. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave. Reinstatement following a military leave of absence may not be subject to Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is the lesser of:

- 24 months beginning on the day that the uniformed service leave begins, or
- A period beginning on the day that the service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if giving notice is otherwise impossible or unreasonable under the circumstances.

Upon notice of intent to leave for uniformed service, Employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election of, payment for, and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Continuation of Coverage section, to the extent the COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. For periods of 31 days or longer, if an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENTLY

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will be deemed eligible for the COBRA extension only because they are not eligible for a separate, independent right of election under USERRA.

PROTECTION FROM BALANCE BILLING

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

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

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

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

ALLOWED AMOUNTS

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

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

For covered health care services that are Emergency health care services provided by an Out-of-Network provider, You are not responsible, and the Out-of-Network provider may not bill You, for amounts in excess of Your applicable Co-pay, Plan Participation, or Deductible, based on the Recognized Amount as defined in this SPD. Note: You may receive balance bills for post-stabilization services after an Emergency if Your attending Emergency Physician or treating provider determines that You can travel to an In-Network facility using non-medical or non-Emergency transportation but You choose to stay at the Out-of-Network facility, if the notice and consent requirements have been satisfied and the provider or facility acts in compliance with applicable state laws.

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

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

OUT-OF-NETWORK BENEFITS

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

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

For the purpose of this provision, the term "certain network facility" is limited to a Hospital, a Hospital Outpatient department, a critical access Hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

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

- For Emergency health care services provided by an Out-of-Network provider, the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

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

- For air Ambulance Transportation provided by an Out-of-Network provider, the allowed amount is based on one of the following, in the order listed as applicable:
  - The reimbursement rate as determined by a state All Payer Model Agreement.
  - The reimbursement rate as determined by state law.
  - The initial payment made by the claims administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
  - The amount determined by Independent Dispute Resolution (IDR).

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

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

PROVIDER NETWORK

The word **"Network"** means an organization that has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the Negotiated Rates as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Plan Participation amounts, or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing to which Network a provider belongs will help a Covered Person determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons should receive services from In-Network providers. However, this Plan does not limit a Covered Person's right to choose his or her own provider of medical care at his or her own expense if a medical expense is not a Covered Expense under this Plan or is subject to a limitation or exclusion.

To find out to which Network a provider belongs, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits:

  Clark County Nevada

- For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits.

EXCEPTIONS TO THE PROVIDER NETWORK BENEFITS

In addition to services required to be covered as specified under the Protection from Balance Billing section of this SPD, some benefits may be processed at In-Network benefit levels when provided by Out-of-Network providers. When Out-of-Network charges are covered in accordance with Network benefits, the charges may be subject to Plan limitations. The following exceptions may apply:

- Non-air Ambulance Transportation services will be payable at the In-Network level of benefits when provided by an Out-of-Network provider.
- Covered services (including Preventive Services) provided by a radiologist, anesthesiologist, certified registered nurse anesthetist, or pathologist will be payable at the In-Network level of benefits when services are provided at a Network facility even if the provider is an Out-of-Network provider.
- Covered services provided by a Physician (including surgeons and assistant surgeons only if Medically Necessary) during an Inpatient stay will be payable at the In-Network level of benefits when provided at an In-Network Hospital. The covered charge will not exceed 20% of the surgeon's allowance.
- Urgent Care services will be payable at the In-Network level of benefits when provided by an Out-of-Network provider.

CONTINUITY OF CARE

You or Your Dependents have the option of requesting extended care from Your current health care provider or facility if the provider or facility is no longer working with Your health Plan and is no longer considered In-Network.

If You meet the requirements for Continuity of Care under applicable law or Network contract, the In-Network benefit level may continue for certain medical conditions and timeframes despite the fact that these expenses are no longer considered In-Network due to provider or facility termination from the Network. In order to be eligible, You or Your Dependents generally need to be under a continuing treatment plan by a provider or facility who was a member of the participating Network and:

Undergoing a course of treatment for a serious and complex condition that is either:
An acute Illness, meaning a condition serious enough to require specialized medical care to avoid the reasonable possibility of death or permanent harm or
A chronic Illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time;
Undergoing Inpatient or institutional care;
Scheduled for non-elective surgical care, including necessary postoperative care;
Pregnant and being treated; or
Terminally ill and receiving treatment for such Illness by a provider or facility.

To obtain a Continuity of Care form that You and Your provider will need to complete for the request to be considered, call the number on the back of Your ID card or access the benefit portal.

Provider Directory Information

Each covered Employee, COBRA participant, and Child or guardian of a Child who is considered an alternate recipient under a Qualified Medical Child Support Order will automatically be given or electronically provided a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in his or her household. If a covered spouse or Dependent wants a separate provider list, he or she may make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

COVERED MEDICAL BENEFITS

This Plan provides coverage for the following covered benefits if services are authorized by a Physician or other Qualified Provider, if applicable, and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions, or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or if a plateau has been reached in terms of improvement from such services.

In addition, any diagnosis change for a covered benefit after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent International Classification of Diseases (ICD) or Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

Important: Prior authorization may be required before benefits will be considered for payment. Failure to obtain prior authorization may result in a penalty or increased out-of-pocket costs. Refer to the Care Management section of this SPD for a description of these services and prior authorization procedures.

1. **3D Mammograms,** for the diagnosis and treatment of a covered medical benefit or for preventive screenings as described under the Preventive / Routine Care benefits.

2. **Abortions:** If a Physician states in writing that the mother's life would be in danger if the fetus were to be carried to term or if the pregnancy was the result of incest or rape.

3. **Allergy Treatment,** including injections and sublingual drops, testing and serum. Allergy testing, serum and injections not performed by an allergist are not covered.

4. **Ambulance Transportation:** Emergency Ambulance Transportation by a licensed ambulance service (ground or air) to an appropriate Hospital where the required Emergency health care services can be performed.Non-Emergency Medically Necessary ground and air transportation by a vehicle designed, equipped, and used only to transport the sick and injured to the nearest medically appropriate Hospital. Medically Necessary Ambulance Transportation does not include, and this Plan will not cover, transportation that is primarily for repatriation (e.g., to return the patient to the United States) or transfer to another facility, unless appropriate medical care is not available at the facility currently treating the patient and transport is to the nearest facility able to provide appropriate medical care.

5. **Anesthetics and Their Administration.**

6. **Anti-cancer drug therapy, non-cancer related drug therapy or other Medically Necessary therapeutic drug services.**

7. **Augmentation Communication Devices** and related instruction or therapy.

8. **Autism Spectrum Disorders (ASD) Treatment.** ASD treatment may include any of the following services: diagnosis and assessment; psychological, psychiatric, and pharmaceutical (medication management) care; speech therapy, occupational therapy, and physical therapy; or Applied Behavioral Analysis (ABA) therapy.

Treatment is subject to all other Plan provisions as applicable (such as Prescription benefit coverage, behavioral/mental health coverage, and/or coverage of therapy services).

Coverage does not include services or treatment identified elsewhere in the Plan as non-covered or excluded (such as Experimental, Investigational, or Unproven treatment, custodial care, nutritional or dietary supplements, or educational services that should be provided through a school district).

9. **Breast Pumps** and related supplies. Benefits for breast pumps include the lesser cost of purchasing or renting one breast pump per pregnancy in conjunction with childbirth. Member can purchase within 30 days of delivery date. Plan does not allow for breast pumps purchased through hospital.

10. **Breast Reductions** if Medically Necessary.

11. **Breastfeeding Support, Supplies, and Counseling** in conjunction with each birth. The Plan also covers comprehensive lactation support and counseling by a trained provider during pregnancy and in the postpartum period.

12. **Cardiac Pulmonary Rehabilitation** when Medically Necessary when needed as a result of an Illness or Injury.

13. **Cardiac Rehabilitation** programs are covered when Medically Necessary, if referred by a Physician, for patients who have certain cardiac conditions.

    Covered services include:

    - Phase I cardiac rehabilitation, while the Covered Person is an Inpatient.
    - Phase II cardiac rehabilitation, while the Covered Person is in a Physician-supervised Outpatient, monitored, low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure, and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.

14. **Cataract or Aphakia Surgery** as well as surgically implanted conventional intraocular cataract lenses following such a procedure. Multifocal intraocular lenses are not allowable. Eye refractions and one set of contact lenses or glasses (frames and lenses) after cataract surgery are also covered.

15. **Circumcision** and related expenses when care and treatment meet the definition of Medical Necessity. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.

16. **Cleft Palate and Cleft Lip,** benefits will be provided for initial and staged reconstruction of cleft palate or cleft lip. Such coverage includes Medically Necessary oral surgery and pre-graft palatal expander.

17. **Contraceptives and Counseling:** All Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling.

    The following contraceptives will be processed under the medical Plan:

    - Contraceptive injections (such as Depo-Provera) and their administration regardless of purpose.
    - Contraceptive devices such as IUDs and implants, including their insertion and removal regardless of purpose.

18. **Cornea Transplants** are payable at the percentage listed under "All Other Covered Expenses" on the Schedule of Benefits.

19. **Dental Services** include:

- The care and treatment of natural teeth and gums if an Injury is sustained in an Accident (other than one occurring while eating or chewing), or for treatment of cleft palate, including implants. Treatment must be completed within 12 months of the Injury except when medical and/or dental conditions preclude completion of treatment within this time period.

➢ Examples of Covered Services, in such (accidental) instances, include:
  - ➢ Root canal therapy, post and build up.
  - ➢ Temporary crowns.
  - ➢ Temporary partial bridges.
  - ➢ Temporary and permanent fillings.
  - ➢ Pulpotomy.
  - ➢ Extraction of broken teeth.
  - ➢ Incision and drainage.
  - ➢ Tooth stabilization through splinting.

  No benefits are provided for removable dental prosthetics, dentures (partial or complete) or subsequent restoration of teeth, including permanent crowns.
- Inpatient or Outpatient Hospital charges, including professional services for X-rays, laboratory services, and anesthesia while in the Hospital, if necessary due to the patient's age of 5 years or under, due to intellectual disabilities, or because an individual has medical conditions that may cause undue medical risk.
- Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.

20. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs, diabetic shoes and nutritional counseling.

21. **Dialysis:** Charges for dialysis treatment of acute renal failure or chronic irreversible renal insufficiency for the removal of waste materials from the body, including hemodialysis and peritoneal dialysis. Coverage also includes use of equipment or supplies, unless covered through the Prescription Drug Benefits section. Charges are paid the same as for any other Illness.

22. **Durable Medical Equipment,** subject to all of the following:

- The equipment must meet the definition of Durable Medical Equipment in the Glossary of Terms. Examples include, but are not limited to, crutches, wheelchairs, Hospital-type beds, and oxygen equipment.
- The equipment must be prescribed by a Physician.
- The equipment will be provided on a rental basis when available; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied toward the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
- The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to the growth of the person or if changes to the person's medical condition require a different product, as determined by the Plan.
- If the equipment is purchased, benefits may be payable for subsequent repairs excluding batteries, or replacement only if required:
  - ➢ due to the growth or development of a Dependent Child;
  - ➢ because of a change in the Covered Person's physical condition; or
  - ➢ because of deterioration caused from normal wear and tear.

  The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered, and replacement is subject to prior approval by the Plan.

- Post-surgical bras, camisoles, breast prosthesis, compression stockings are covered.
- Insulin pumps and diabetic equipment are also covered.
- Over the counter and convenience supplies Items not covered, examples include shower chairs, toilet seats, or alcohol wipes.

23. **Emergency Room Hospital and Physician Services,** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits.

24. **Extended Care Facility Services** for both mental and physical health diagnoses. Charges will be paid under the applicable diagnostic code. The following services are covered:

    - Room and board.
    - Miscellaneous services, supplies, and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.
    -
    - **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

    - Treatment of any condition resulting from weak, strained, flat, unstable, or unbalanced feet when surgery is performed.
    - Treatment of corns, calluses, and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
    - Physician office visit for diagnosis of bunions. The Plan also covers treatment of bunions when an open cutting operation or arthroscopy is performed.

25. **Gender Transition:** Charges for services related to gender reassignment will be covered in accordance with medical necessity guidelines in accordance with Senate Bill 163 (Nevada 2023). Benefits include pre- and post-surgical hormone therapy. A candidate for gender reassignment must be confirmed with gender dysphoria in accordance with clinical guidelines.

26. **Genetic Testing or Genetic Counseling in relation to Genetic Testing** based on Medical Necessity.

    Genetic testing MUST meet the following requirements:

    The test must not be considered Experimental, Investigational, or Unproven. The test must be performed by a CLIA-certified laboratory. The test result must directly impact or influence the disease treatment of the Covered Person.

    Genetic testing must also meet at least one of the following:

    - The patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes).
    - Conventional diagnostic procedures are inconclusive.
    - The patient has risk factors or a particular family history that indicates a genetic cause.
    - The patient meets defined criteria that place him or her at high genetic risk for the condition.

27. **Hearing Services** include:

    - Exams, tests, services, and supplies to diagnose and treat a medical condition.
    - Purchase or fitting of hearing aids. Bone anchored hearing aids, used according to U.S. Food and Drug Administration (FDA) approved indications, are covered under the applicable medical/surgical benefit for a member who is not a candidate for an air-conduction hearing aid.
    - Implantable hearing devices, including semi-implantable hearing devices.

28. **Home Health Care Services:** (Refer to the Home Health Care Benefits section of this SPD.)

29. **Hospice Care Services:** Treatment given at a Hospice Care facility must be in place of a stay in a Hospital or Extended Care Facility, and may include:

- **Assessment,** which includes an assessment of the medical and social needs of the Terminally Ill person and a description of the care required to meet those needs.
- **Inpatient Care** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy, and part-time Home Health Care services.
- **Outpatient Care,** which provides or arranges for other services related to the Terminal Illness, including the services of a Physician or Qualified physical or occupational therapist or nutrition counseling services provided by or under the supervision of a Qualified dietician.
- **Respite Care** to provide temporary relief to the family or other caregivers in the case of an Emergency or to provide temporary relief from the daily demands of caring for a terminally ill person.
- **Bereavement Counseling:** services that are received by a Covered Person's Close Relative when directly connected to the Covered Person's death and the charges for which are bundled with other hospice charges. Counseling services must be provided by a Qualified social worker, Qualified pastoral counselor, Qualified psychologist, Qualified psychiatrist, or other Qualified Provider, if applicable. The services must be furnished within six months of death.

The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. However, services are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

30. **Hospital Services (Including Inpatient Services, Surgical Centers, and Inpatient Birthing Centers).** The following services are covered:

- Semi-private and private room and board services:
  - For network charges, this rate is based on the network agreement. Semi-private rate reductions may apply.
  - For non-network charges, any charge over a semi-private room charge will be a Covered Expense only if determined by the Plan to be Medically Necessary. If the Hospital has no semi-private rooms, the Plan will allow the private room rate, subject to the Protection from Balance Billing allowed amount, Usual and Customary charges, or Negotiated Rate, whichever is applicable.
- Intensive care unit room and board.
- Miscellaneous and Ancillary Services.
- Blood, blood plasma, and plasma expanders, when not available without charge.

Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

31. **Hospital Services (Outpatient).**

Observation in a Hospital room will be considered Outpatient treatment if the duration of the observation status is 72 hours or less. Observation means the use of appropriate monitoring, diagnostic testing, treatment, and assessment of patient symptoms, signs, laboratory tests, and response to therapy for the purpose of determining whether a patient will require further treatment as an Inpatient or can be discharged from the Hospital setting.

32. **Infant Formula** administered through a tube as the sole source of nutrition for the Covered Person.

33. **Infertility Treatment** to the extent required to treat or correct underlying causes of infertility, when such treatment is Medically Necessary and cures the condition of, alleviates the symptoms of, slows the harm to, or maintains the current health status of the Covered Person. Once the patient is receiving fertility treatment to achieve pregnancy, diagnostic tests and treatments are then considered part of the infertility benefit.

    Covered Infertility Treatment includes genetic testing to diagnose infertility. Covered services are limited to:

    - Laboratory studies.
    - Diagnostic procedures.
    - Artificial insemination services.

34. **Laboratory or Pathology Tests and Interpretation Charges** for covered benefits. Charges by a pathologist for interpretation of computer-generated automated laboratory test reports are not covered by the Plan.

35. **Manipulations:** Treatments for musculoskeletal conditions when Medically Necessary. Also refer to Maintenance Therapy under the General Exclusions section of this SPD.

36. **Maternity Benefits** for Covered Persons include:

    - Hospital or Birthing Center room and board.
    - Vaginal delivery or Cesarean section.
    - Non-routine prenatal care.
    - Postnatal care.
    - Diagnostic testing.
    - Abdominal operation for intrauterine pregnancy or miscarriage.
    - Outpatient Birthing Centers.
    - Midwives.
    - Amniocentesis requires medical necessity review.
    - Lactation Education covered in hospital setting.

37. **Medical Supplies** obtained outside of a medical office visit.

38. **Mental Health Treatment.** (Refer to the Mental Health Benefits section of this SPD.)

39. **Morbid Obesity Treatment** includes only the following treatments if those treatments are determined to be Medically Necessary and be appropriate for an individual's Morbid Obesity condition. Refer to the Glossary of Terms for a definition of Morbid Obesity.

    - Bariatric surgery, including, but not limited to:
        - Gastric or intestinal bypasses (Roux-en-Y, biliopancreatic bypass, and biliopancreatic diversion with duodenal switch).
        - Stomach stapling (vertical banded gastroplasty, gastric banding, and gastric stapling).
        - Lap band (laparoscopic adjustable gastric banding).
        - Gastric sleeve procedure (laparoscopic vertical gastrectomy and laparoscopic sleeve gastrectomy).
    - Charges for diagnostic services.

    This Plan does not cover diet supplements, exercise equipment or any other items listed in the General Exclusions section of this SPD. Skin removal after Morbid Obesity surgery is not covered even if found medically necessary.

40. **Nursery and Newborn Expenses, Including Circumcision,** are covered for the following Children of the covered Employee or covered spouse: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.

    Newborns covered automatically for first 31 days following birth. Coverage will cease beginning with the 32nd day unless the newborn child has been affirmatively enrolled as a dependent in the plan by completing and submitting an approved enrollment change form by the end of the 60th day following the date of birth.

41. **Nutritional Counseling.**

42. **Nutritional Supplements, Enteral Feedings, Vitamins, and Electrolytes** that are prescribed by a Physician and administered through a tube, provided they are the sole source of nutrition or are part of a chemotherapy regimen. This includes supplies related to enteral feedings (for example, feeding tubes, pumps, and other materials used to administer enteral feedings), provided the feedings are prescribed by a Physician and are the sole source of nutrition or are part of a chemotherapy regimen.

43. **Occupational Therapy.** (See Therapy Services below.)

44. **Oral Surgery** includes:

    - Excision of partially or completely impacted teeth only covered when dental benefit is exhausted.
    - Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth when such conditions require pathological examinations.
    - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
    - Reduction of fractures and dislocations of the jaw.
    - External incision and drainage of cellulitis.
    - Incision of accessory sinuses, salivary glands, or ducts.
    - Frenectomy (the cutting of the tissue in the midline of the tongue).
    - Excision of exostosis of jaws and hard palate.
    - Removal of teeth which is necessary in order to perform radiation therapy and Oral Surgical Services which treat the correction of non-dental, physiological conditions which have resulted in a severe functional impairment.

45. **Orthotic Appliances, Devices, and Casts,** including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after Injury. These devices can be used for acute Injury or to prevent Injury. Orthotic appliances and devices include custom molded shoe orthotics, supports, trusses, elastic compression stockings, and braces. Diabetic shoes are covered with prescription and related to a diabetic condition, otherwise only when an integral part of a lower body brace. Deluxe upgrades determined not to be medically necessary are not covered.

46. **Oxygen and Its Administration.**

47. **Pharmacological Medical Case Management** (medication management and lab charges).

48. **Physical Therapy.** (See Therapy Services below.)

49. **Physician Services** for covered benefits.

50. **Pre-Admission Testing** if necessary and consistent with the diagnosis and treatment of the condition for which the Covered Person is being admitted to the Hospital.

51. **Prescription Medications** that are administered or dispensed as take-home drugs as part of treatment while in the Hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility, or Skilled Nursing Facility) and that require a Physician's Prescription. Coverage does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription benefit.

52. **Preventive / Routine Care** as listed under the Schedule of Benefits.

The Plan pays benefits for Preventive Care services provided on an Outpatient basis at a Physician's office, an Alternate Facility, or a Hospital that encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes, and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
- Well-women Preventive Care visit(s) for women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The well-women visit should, where appropriate, include the following additional preventive services listed in the Health Resources and Services Administrations guidelines, as well as others referenced in the Affordable Care Act:

  - Screening for gestational diabetes;
  - Human papillomavirus (HPV) DNA testing;
  - Counseling for sexually transmitted infections;
  - Counseling and screening for human immune-deficiency virus;
  - Screening and counseling for interpersonal and domestic violence; and
  - Breast cancer genetic test counseling (BRCA) for women at high risk.

  Please visit the following links for additional information:

  https://www.healthcare.gov/preventive-care-benefits/
  https://www.healthcare.gov/preventive-care-children/
  https://www.healthcare.gov/preventive-care-women/

53. **Prosthetic Devices.** The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) that replace body parts. Benefits may be payable for subsequent repairs or replacement only if required:

- Due to the growth or development of a Dependent Child; or
- When necessary because of a change in the Covered Person's physical condition; or
- Because of deterioration caused from normal wear and tear.

The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.

Bionic, myoelectric, microprocessor-controlled, and computerized prosthetics are not covered. Deluxe upgrades determined not to be medically necessary are not covered.

54. **Qualifying Clinical Trials** as defined below, including routine patient care costs Incurred during participation in a Qualifying Clinical Trial for the treatment of:

- Cancer or other Life-Threatening Disease or Condition. For purposes of this benefit, a Life-Threatening Disease or Condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from participation in a Qualifying Clinical Trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the Qualifying Clinical Trial as defined by the researcher.

Routine patient care costs for Qualifying Clinical Trials may include:

- Covered health services (e.g., Physician charges, lab work, X-rays, professional fees, etc.) for which benefits are typically provided absent a clinical trial;
- Covered health services required solely for the administration of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered health services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational service or item as it is typically provided to the patient through the clinical trial.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other Life-Threatening Diseases or Conditions, a Qualifying Clinical Trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease or Condition and that meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

  - National Institutes of Health (NIH), including the National Cancer Institute (NCI);
  - Centers for Disease Control and Prevention (CDC);
  - Agency for Healthcare Research and Quality (AHRQ);
  - Centers for Medicare and Medicaid Services (CMS);
  - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or Veterans Administration (VA);
  - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or

- The Department of Veterans Affairs, the DOD, or the Department of Energy as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
  - It is comparable to the system of peer review of studies and investigations used by the NIH; and
  - It ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an Investigational new drug application reviewed by the U.S. Food and Drug Administration;
- The study or investigation is a drug trial that is exempt from having such an Investigational new drug application;
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant Institutional Review Boards (*IRBs*) before participants are enrolled in the trial. The Plan Sponsor may, at any time, request documentation about the trial; or
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a covered health service and is not otherwise excluded under the Plan.

55. **Radiology and Interpretation Charges.**

56. **Reconstructive Surgery** includes:

- Surgery following a mastectomy under the Women's Health and Cancer Rights Act (WHCRA). Under the WHCRA, the Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments that include all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.
- Surgery to restore a bodily function that has been impaired by a congenital Illness or anomaly, or by an Accident, or from an infection or other disease of the involved part.

57. **Respiratory Therapy.** (See Therapy Services below.)

58. **Second Surgical Opinion** if given by a board-certified Specialist in the medical field related to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

59. **Sexual Function:** Diagnostic services in connection with treatment for male or female impotence.

60. **Sleep Disorders** if Medically Necessary.

61. **Sleep Studies.**

62. **Speech Therapy.** (See Therapy Services below.)

63. **Sterilizations.**

64. **Substance Use Disorder Services.** (Refer to the Substance Use Disorder and Chemical Dependency Benefits section of this SPD.)

65. **Surgery and Assistant Surgeon Services.**

- If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the allowance for the primary procedure performed. For in-network providers, the assistant surgeon's allowable amount will be determined per the network contract.
- If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the allowance for the primary procedure; and a percentage of the allowance for the subsequent procedure(s). If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the allowance for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the allowable amount for that procedure.

66. **Telehealth.** Consultations made by a Covered Person to a Physician.

67. **Telemedicine.** (Refer to the Teladoc Services section of this SPD for more details.)

68. **Temporomandibular Joint Disorder (TMJ) Services** include:

- Diagnostic services.
- Surgical treatment of the temporomandibular joint.
- Non-surgical treatment (including intraoral devices or any other non-surgical method to alter occlusion and/or vertical dimension).

Coverage does not include orthodontic services.

69. **Therapeutic Radiology** (treatment of cancer and other diseases with radiation).

70. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

- **Occupational therapy** by a Qualified occupational therapist (OT) or other Qualified Provider, if applicable.
- **Physical therapy** by a Qualified physical therapist (PT) or other Qualified Provider, if applicable.
- **Respiratory therapy** by a Qualified respiratory therapist (RT) or other Qualified Provider, if applicable.
- **Speech therapy** necessary for the diagnosis and treatment of speech and language disorders that result in communication disabilities when performed by a Qualified speech therapist (ST) or other Qualified Provider, if applicable, including therapy for the treatment of disorders of speech, language, voice, communication, and auditory processing when such a disorder results from Injury, stroke, cancer, a Congenital Anomaly, or ~~Autism Spectrum Disorder~~ other types of communication disorders such as categorized language disorder, speech sound disorder, child-onset fluency disorder, and pragmatic communication disorder.

The Plan allows coverage for medical charges and occupational and/or physical therapy for Developmental Delays due to Accidents or Illnesses such as Bell's palsy, CVA (stroke), apraxia, cleft palate/lip, recurrent/chronic otitis media, vocal cord nodules, Down's syndrome and cerebral palsy when performed by a Qualified Provider. The Plan allows coverage for the treatment of disorders such as speech, language, voice, communication, and auditory processing when such a disorder results from Injury, stroke, cancer, or a Congenital Anomaly. The Plan will pay benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular Accident.

71. **Tobacco Addiction:** Preventive / Routine Care as required by applicable law.

72. **Transplant Services.** (Refer to the Transplant Benefits section of this SPD.)

73. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.

74. **Vision Care Services.** (Refer to Vision Care section of this SPD.)

75. **Walk-In Retail Health Clinics:** Charges associated with medical services provided at Walk-In Retail Health Clinics.

TELADOC SERVICES

Note: Teladoc Services described below are subject to state availability. Access to telephonic or video-based consultations may be restricted in some states.

This Plan has a special benefit allowing Covered Persons of all ages to receive telephone or web-based video consultations with Physicians for routine primary medical diagnoses.

Teladoc may be used:

- When immediate care is needed.
- When considering the ER or Urgent Care center for non-Emergency issues.
- When You are on vacation or on a business trip.

Teladoc can provide care for the following types of conditions:

- General medicine, including, but not limited to:
  - Colds and flu
  - Allergies
  - Bronchitis
  - Pink eye
  - Upper respiratory infections
- A refill of a recurring Prescription.
- Pediatric care.
- Non-Emergency medical assistance.

In order to obtain this benefit, a Covered Person must complete a medical history disclosure form that will serve as an electronic medical record for consulting Physicians. This form can be completed via the Teladoc website, via the call center, or via the Teladoc mobile app. Once enrolled, a Covered Person may phone 1-800-TELADOC (1-800-835-2362) and request a consultation with a Physician. A Physician will then return the Covered Person's phone call. If a Covered Person requests a web-based video consultation, the consultation will be scheduled, and an appointment reminder notification will be sent prior to the appointed time. If necessary, the Physician will write a Prescription. The Prescription will be called in to a pharmacy of the Covered Person's choice. Benefits for this service are shown in the Schedule of Benefits.

Teladoc does not guarantee that every consultation will result in a Prescription. Medications are prescribed at the Physician's discretion based on the symptoms reported at the time of the consultation. A Covered Person has 72 hours after his or her consultation to call Teladoc with any clarification questions. A member of the Teladoc clinical team will assist the Covered Person at no additional cost during this time. If a Covered Person requests another Physician consultation, he or she will be charged the Teladoc consultation fee.

Teladoc may not be used for:

- Drug Enforcement Agency (DEA) controlled Prescriptions.
- Charges for telephone or online consultations with a Physician and/or other providers who are not contracted through Teladoc.

Behavioral Health Program

The Behavioral Health Program includes access to behavioral health providers who provide behavioral health consultations to Covered Persons by telephone or video conference. The Behavioral Health Program offers Covered Persons ongoing access to behavioral diagnostic services, talk therapy, and prescription medication management, when appropriate. The behavioral health providers are selected and engaged to provide behavioral health clinical intake assessments in accordance with behavioral health protocols and guidelines that are tailored to the telehealth industry.

Behavioral Health Consultations: In order for a Covered Person to receive a behavioral health consultation under this program, the Covered Person must complete a Medical History Disclosure and an assessment that is specific to the Behavioral Health Program. This disclosure may be completed either online or by telephone with a designated Behavioral Health Program representative. In addition, the Covered Person must also agree to Teladoc's Informed Patient Consent and Release Form confirming an understanding that the behavioral health provider is not obligated to accept the Covered Person as a patient. If the Covered Person fails to complete the Medical History Disclosure, the Covered Person will not have access to the behavioral health providers through the Behavioral Health Program.

Scheduling: Teladoc will provide the Covered Person with information identifying each behavioral health provider's licensure, specialties, gender, and language, and will provide sufficient biographical information on each behavioral health provider to allow the Covered Person to choose the provider from whom he or she wishes to receive treatment. The Covered Person may schedule consultations through either Teladoc's website or the mobile platform. When scheduling a subsequent consultation, the Covered Person may choose to receive the consultation from the same provider or from a different behavioral health provider. There are no limitations on the number of behavioral health consultations a Covered Person may receive under the Behavioral Health Program.

Individual Sessions: The initial behavioral health consultation is expected to be 45 minutes in length, on average followed by subsequent psychiatric visits that will be shorter in length. At the beginning of the behavioral health consultation, the Covered Person will be required to complete a brief intake assessment before proceeding with the session. A behavioral health provider may determine that the treatment of a Covered Person's particular behavioral health issue would be managed more appropriately through in-person therapy. In such a case, the behavioral health provider will encourage the Covered Person to make an appointment for an in-person visit.

Clarifications: Unlike the consultations provided under the general medicine program, the behavioral health consultations under the Behavioral Health Program:

- Are not accessible 24 hours per day, 365 days per year. Rather, a Covered Person must schedule a behavioral health consultation with a behavioral health provider and the consultation must occur within a time period for which the behavioral health provider is scheduled to support the Behavioral Health Program.

- Are not intended to be cross-coverage consultations. Rather, the Behavioral Health Program is designed to make behavioral health providers available by telephone or video conference even when another behavioral health counselor is available to the Covered Person for an in-person visit.

- Are not intended to be provided in Emergency situations.

- Are not available for Teladoc therapy for Covered Persons under the age of 13.

- Are not available for Teladoc psychiatry for Covered Persons under the age of 18.

HOME HEALTH CARE BENEFITS

Home Health Care services are provided for patients when Medically Necessary, as determined by the Utilization Review Organization.

A Home Health Care Visit is defined as a visit by a nurse providing intermittent nurse services (each visit includes up to a 4-hour consecutive visit in a 24-hour period if Medically Necessary) or a single visit by a Qualified therapist, Qualified dietician, or other Qualified Provider, if applicable.

Information regarding Private Duty Nursing can be found elsewhere in this SPD.

Prior authorization may be required before receiving services. Please refer to the Care Management section of this SPD for more details. Covered services may include:

- Home visits instead of visits to the provider's office that do not exceed the maximum allowable under this Plan.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed 4 hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a Qualified dietician or other Qualified Provider, if applicable.
- Physical, occupational, respiratory, and speech therapy provided by or under the supervision of a Qualified therapist or other Qualified Provider, if applicable.
- Medical supplies, drugs, laboratory services, or medication prescribed by a Physician.
- Home infusion.

EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services.
- Supportive environment materials such as handrails, ramps, air conditioners, and telephones.
- Services performed by family members or volunteer workers.
- "Meals on Wheels" or similar food service.
- Separate charges for records, reports, or transportation.
- Expenses for the normal necessities of living, such as food, clothing, and household supplies.
- Legal and financial counseling services, unless otherwise covered under this Plan.

TRANSPLANT BENEFITS

Refer to the Care Management section of this SPD for prior authorization requirements

The program for Transplant Services at Designated Transplant Facilities is:

Sierra Healthcare Options (SHO)
Optum

This coverage provides You with a choice for transplant care. The Plan provides incentives to You and Your covered Dependents by giving You the option of using a Designated Transplant Facility. While the Plan does not require You to use a Designated Transplant Facility in order to receive benefits You may receive better benefits if You do so. A Designated Transplant Facility is a facility that must meet extensive criteria in the areas of patient outcomes that include patient and graft survival, patient satisfaction, Physician and program experience, program accreditations, and patient and caregiver education.

DEFINITIONS

The following terms are used for the purpose of the Transplant Benefits section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Approved Transplant Services means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician charges, organ and tissue procurement, tissue typing, and Ancillary Services.

Designated Transplant Facility means a facility that has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network or rental network with which the Plan has a contract.

Non-Designated Transplant Facility means a facility that does not have an agreement with the transplant provider network with whom the Plan has a contract. This may include a facility that is listed as a participating provider.

Organ and Tissue Acquisition/Procurement means the harvesting, preparation, transportation, and the storage of human organ and tissue that is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant includes autologous, allogeneic, and syngeneic transplant of bone marrow and peripheral and cord blood stem cells and may include chimeric antigen receptor T-cell therapy (CAR-T).

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated or Non-Designated Transplant Facility due to an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary charge, or the Plan's Negotiated Rate.

Prior authorization is required for all transplant-related services. If prior authorization is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be Medically Necessary for the medical condition for which the transplant is recommended. The medical condition must not be an individual Plan exclusion.

COVERED EXPENSES

The Plan will pay for Approved Transplant Services at a Designated or Non-Designated Transplant Facility for Organ and Tissue Acquisition/Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including a bone marrow or Stem Cell Transplant, the cost of Organ and Tissue Acquisition/Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition/Procurement. Coverage includes the cost of donor testing, blood typing, and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services for donor-related complications during the transplant period, per the transplant contract, if the recipient is a Covered Person under this Plan.

The Plan will provide donor services at a Non-Designated Transplant Facility for initial acquisition/procurement only, up to the maximum listed on the Schedule of Benefits, if any. Complications, side effects, or injuries are not covered unless the donor is a Covered Person.

Benefits are payable for the following transplant types:

- Kidney.
- Kidney/pancreas.
- Pancreas, if the transplant meets the criteria determined by care management.
- Liver.
- Heart.
- Heart/lung.
- Lung.
- Bone marrow or Stem Cell Transplant (allogeneic and autologous), which may include chimeric antigen receptor T-cell therapy (CAR-T) for certain conditions.
- Small bowel.

SECOND OPINION

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by the transplant facility, the Plan will allow him or her to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant-related services or supplies, even if a third Designated Transplant Facility accepts the Covered Person for the procedure.

ADDITIONAL PROVISIONS

TRAVEL EXPENSES (Applies to Covered Person who is a recipient)

If the Covered Person lives more than 100 miles from the transplant facility, the Plan will pay for travel and housing related to the transplant, up to the maximum listed on the Schedule of Benefits. Expenses will be paid for the Covered Person and:

- One or two parents of the Covered Person (if the Covered Person is a Dependent Child, as defined in this Plan); or
- An adult to accompany the Covered Person.

Covered travel and housing expenses include the following:

- Transportation to and from the transplant facility, including:
  - Airfare.
  - Gas/mileage.
- Lodging at or near the transplant facility, including:
  - Apartment rental.
  - Hotel rental.

  Lodging for purposes of this Plan does not include private residences.

  Lodging reimbursement that is greater than $50 per person per day may be subject to IRS codes for taxable income.

Benefits will be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the transplant facility.

TRANSPLANT EXCLUSIONS

In addition to the items listed in the General Exclusions section of this SPD, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.
- Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells, or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.
- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.
- Transplants considered Experimental, Investigational, or Unproven unless covered under a Qualifying Clinical Trial.
- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell), or allogeneic transplant (bone marrow or peripheral stem cell) for conditions that are not considered to be Medically Necessary and/or are not appropriate, based on the National Comprehensive Cancer Network (NCCN) and/or Transplant Review Guidelines.
- Expenses related to, or for, the purchase of any organ.

PRESCRIPTION DRUG BENEFITS

Administered by Navitus Health Solutions

Note: UMR (the claims administrator) does not administer the benefits or services described within this provision. Please contact the Pharmacy Benefit Manager (PBM) or Your Health Benefits Department with any questions related to this coverage or service.

Covered Drugs

Your Prescription Drug benefit provides coverage for most commonly used drugs that are Federal Legend Drugs. Federal Legend Drugs are drugs that require a label stating, "Caution: Federal law prohibits dispensing without a Prescription." Your pharmacist or the prescribing Physician can verify coverage for a drug by contacting the Pharmacy Benefit Manager (PBM) at the number on Your Prescription ID card. A complete list of covered and excluded drugs may be available on the Pharmacy Benefit Manager's website. If You are unable to access the website, Your employer will provide a copy upon request at no charge.

How to Use the Prescription Drug Card

Present Your ID card and the Prescription to a Participating Pharmacy. Then sign the pharmacist's voucher and pay the pharmacist the appropriate Co-pay amount, if applicable.

If You are without Your prescription ID card or if You are at a non-Participating Pharmacy, You may be required to pay for the Prescription and submit a claim to the PBM. Please contact the PBM or Your employer for information on how to submit a claim.

Home Delivery Drug Service

If You are using an ongoing Prescription drug, You may purchase that drug on a home delivery basis. Most drugs covered by the PBM may be purchased through the home delivery service. The home delivery drug service is most often used to purchase drugs that treat an ongoing medical condition and are taken on a regular basis.

There may be a Co-pay for home delivery Prescriptions.

Home delivery Prescriptions should be sent to the PBM. Order forms may be available on the PBM's website or from Your employer. All Prescriptions will be mailed directly to Your home.

A directory of Participating Pharmacies is available on the PBM's website. You will also be automatically provided a copy of the pharmacy directory at no charge. The pharmacy directory is a document that is separate from this SPD. The directory contains the names, addresses, and phone numbers of the pharmacies that are part of the PBM's program.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

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

Clark County EPO Plan	In-Network
Calendar Year Out-of-Pocket Maximum • Per Plan Participant • Per Family	$2,000 $4,000
Maximum Lifetime Benefit *(Except as otherwise stated)*	Unlimited
Retail (30-Day Supply)	
• Tier 1 (Mostly Generic and some lower cost Brand drugs)	$25 copay
• Tier 2 (Mostly Preferred Brand and some high cost Generic drugs)	$50 copay
• Tier 3 (Non-Preferred Brand)	$75 copay
Retail / Mail Order (90-Day Supply) *	
• Tier 1 (Mostly Generic and some lower cost Brand drugs)	$62.50 copay
• Tier 2 (Mostly Preferred Brand and some high cost Generic drugs)	$125.00 copay
• Tier 3 (Non-Preferred Brand)	$187.50 copay
• ~~Weight Loss GLP-1 FSA approved weight loss medications~~	~~25% coinsurance up to a maximum amount of $250~~ ~~$3,000 (does not accumulate to the above Prescription Out-of-Pocket Maximum~~

* **Member pays up to 2.5 times the applicable Tier Cost-Share per prescription.**

Employer Group Waiver Plan (EGWP)

The Plan Administrator offers a Medicare Employer Group Waiver Plan (EGWP) to Medicare-eligible retirees and Medicare eligible dependents covered under the Plan. The EGWP meets requirements applicable to Medicare Part D and retirees and dependents enrolled in either Medicare Part A or B or Parts A and B will be automatically enrolled in the EGWP upon becoming Medicare-eligible. The Plan Administrator will collect the Medicare premium for Part D drug plan coverage except any additional premium imposed due to exceeding the income threshold as defined by the Social Security Administration. Covered drugs will be subject to the formulary approved by the Centers for Medicare and Medicaid Services. This includes the requirement that you won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what the cost-sharing tier it's on.

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

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

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

Contact the Pharmacy Benefit Manager for more information regarding EGWP.

Note: The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides all Medicare-eligible individuals the opportunity to obtain Prescription Drug coverage through Medicare. A Medicare-eligible individual generally must pay an additional monthly premium for this coverage. In addition, electing Medicare Part D may affect Your ability to obtain Prescription coverage under this Plan. Individuals may be able to postpone enrollment in the Medicare Prescription Drug coverage if their current drug coverage is at least as good as Medicare Prescription Drug coverage. If individuals decline Medicare Prescription Drug coverage and do not have coverage at least as good as Medicare Prescription Drug coverage, they may have to pay additional monthly penalties if they change their minds and sign up later. Medicare-eligible individuals should have received notices informing them of whether or not their current Prescription Drug coverage provides benefits that are at least as good as benefits provided by the Medicare Prescription Drug coverage and explaining whether or not election of Medicare Part D will affect coverage available under this Plan. For a copy of this notice, please contact the Plan Administrator.

HEARING AID BENEFITS

This Plan includes a benefit that allows Covered Persons to access discounted hearing aids and related testing and fitting. This benefit is being offered under the Plan by UnitedHealthcare Hearing.

UnitedHealthcare Hearing provides a full range of hearing health benefits that deliver value, choice, and a positive experience.

UnitedHealthcare Hearing offers:

- Name-brand and private-labeled hearing aids from major manufacturers at discounted prices.
- Access to a network of credentialed hearing professionals at more than 5,000 locations nationwide.
- Convenient ordering with hearing aids available in person or through home delivery.

How To Use This Hearing Benefit:

- Contact UnitedHealthcare Hearing at 1-855-523-9355, between 8:00 a.m. and 8:00 p.m. Central Time Monday through Friday, or visit uhchearing.com to learn more about the ordering process and for a referral to a UnitedHealthcare Hearing provider location (if a hearing test is needed).
- Receive a hearing test by a UnitedHealthcare Hearing provider. During the appointment, You will decide if You would like to have Your hearing aids fitted in person with Your hearing provider or to have Your hearing aids delivered directly to Your home (for select hearing aid models only). A broad selection of name-brand and private-labeled hearing aids is available.
- If You choose to purchase hearing aids through the UnitedHealthcare Hearing provider, the hearing aids will be ordered by the provider and sent directly to the provider's office. You will be fitted with the hearing aid(s) by the local provider. If You choose home delivery, the hearing aids will be sent directly to Your home within 5-10 business days from the order date.

In the event that You have questions or complaints about the hearing aid products or services offered under the Plan, contact UnitedHealthcare Hearing at 1-855-523-9355 or visit uhchearing.com.

MENTAL HEALTH BENEFITS

The Plan will pay for the following Covered Expenses for services authorized by a Physician and deemed to be Medically Necessary for the treatment of a Mental Health Disorder, subject to any Deductibles, Co-pays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of Mental Health Disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a subacute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for mental health conditions. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial, and prevocational modalities. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

ADDITIONAL PROVISIONS AND BENEFITS

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for the change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

SUBSTANCE USE DISORDER AND CHEMICAL DEPENDENCY BENEFITS

The Plan will pay for the following Covered Expenses for a Covered Person, subject to any Deductibles, Co-pays if applicable, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits. Benefits are based on the Protection from Balance Billing allowed amount, the Usual and Customary amount, the maximum fee schedule, or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services means services provided at a Hospital or facility accredited by a recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency, or dual-diagnosis facility for the treatment of substance use disorders. If outside the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation of the licensing body working in that foreign country.

Residential Treatment means a subacute facility-based program that is licensed to provide "residential" treatment and delivers 24-hour-per-day, 7-day-per-week assessment and diagnostic services, as well as active behavioral health treatment for substance-related disorders. Coverage does not include facilities or programs where therapeutic services are not the primary service being provided (e.g., therapeutic boarding schools, halfway houses, and group homes).

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program generally consists of a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such a program must be a less restrictive alternative to Inpatient treatment.

Outpatient Therapy Services are covered. The services must be provided by a Qualified Provider.

ADDITIONAL PROVISIONS AND BENEFITS

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for the change. Such records must include the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.

CARE MANAGEMENT

UTILIZATION MANAGEMENT

Utilization Management is the process of evaluating whether services, supplies, or treatment is Medically Necessary and are appropriate level of care. Utilization Management can determine Medical Necessity, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Prior Authorization requirements.

PRIOR AUTHORIZATION / NOTIFICATION REQUIREMENTS

The Prior Authorization / Notification requirements detailed within this section may be deemed satisfied for certain services, providers, and/or facilities meeting specific conditions.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. Generally speaking, Physicians, facilities, and other health care professionals who access a Sierra Healthcare-Options (SHO) Provider for a service or procedure are responsible for obtaining Prior Authorization. However, the Covered Person should ensure that the provider completes all required Prior Authorizations before services are rendered. If the Covered Person is not receiving covered health care services from a Sierra Healthcare-Options (SHO) Provider, the Covered Person is responsible for ensuring that any required Prior Authorizations are completed before services are received. In that case, the Covered Person is responsible for ensuring the provider calls the phone number on the back of the Plan identification card to request Prior Authorization at least two weeks prior to a scheduled procedure in order to allow for Medical Necessity review as required by the Plan. In addition to the requirement to notify and obtain Prior Authorization of a service or procedure in advance, all admissions to a facility also require a notification within 24 hours of the admission. If the stay is accessing a Sierra Healthcare-Options (SHO) Provider, that facility must provide timely admission Notification (even if advance Notification was provided by the Physician and pre-service coverage approval is on file). If it is not a Sierra Healthcare-Options (SHO) Provider the Covered Person is responsible for ensuring the facility completes that Notification.

Special Note: A Covered Person who could reasonably expect that the absence of immediate, or Emergency, medical attention would jeopardize the life or long-term health of the individual is responsible for ensuring the provider contacts the Utilization Review Organization as soon as possible by phone or fax within 24 hours, or by the next business day if on a weekend or holiday, from the time coverage information is known. If notice is provided past the timeframe shown above, the extenuating circumstances must be communicated. The Utilization Review Organization will then review the services provided.
Note that if a Covered Person receives Prior Authorization for one facility, but then is transferred to another facility, Prior Authorization is also needed before going to the new facility, except in the case of an Emergency (see Special Notes above).

This Plan complies with the Newborns' and Mothers' Health Protection Act. Prior Authorization is not required for a Hospital or Birthing Center stay of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Prior Authorization may be required for a stay beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: Sierra Healthcare Options (SHO)

DEFINITIONS

The following terms are used for the purpose of the Care Management section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Prior Authorization / Notification is the process of determining benefit coverage prior to a service being rendered to an individual member. A determination is made based on Medical Necessity criteria for drugs, supplies, tests, procedures, and other services that are appropriate and cost-effective for the member. This member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent, and duration of stay. The Prior Authorization / Notification requirements detailed within this section may be deemed satisfied for certain services, providers, and/or facilities meeting specific conditions.

Utilization Management is the evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits Plan. This management is sometimes called "utilization review." Such assessment may be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

SERVICES REQUIRING PRIOR AUTHORIZATION

Call the Utilization Review Organization before receiving services for the following:

- Inpatient stays in Hospitals, Extended Care Facilities, or residential treatment facilities (only an option if Skilled Nursing Facility requires authorization).
- Partial hospitalizations.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment, excluding braces, any equipment purchased and rentals.
- Prosthetics and orthotics over $750.
- Qualifying Clinical Trials.
- Chemotherapy and Radiation Treatments.
- Inpatient stays in Hospitals or Birthing Centers that are longer than 48 hours following normal vaginal deliveries or 96 hours following Cesarean sections.
- Bariatric surgeries.
- Dialysis.
- Non-Emergency Ambulance Services.
- Office procedures over $750
- Outpatient Hospital Services.
- Ambulatory Surgical Facility Services (authorization not required for contracted facilities and providers).
- Inpatient and Outpatient Short-Term Rehabilitative and Habilitative Services.
- Anesthesia Services.
- Post-Cataract Surgical Services (including frames, lenses and contact lenses).
- Genetic Disease Testing Services.
- Medical Supplies (obtained outside of the office visit).
- Complex Diagnostic Imaging (MRI, CT, PET, etc.).
- Special Food Products and Enteral Formula.
- ABA Therapy.
- Enteral Supplies/food items.
- OOA and OON office consultations.
- Prosthetics and Orthotics.

- Transportation – Emergent facility to facility.
- Inpatient and Outpatient Hospice Services (including Respite Care and Bereavement Services).
- Chiropractic Care after 20 visits.
- Infertility Procedures.
- Diagnostic and Therapeutic Services (anti-cancer drug therapy, Dialysis, complex allergy, therapeutic radiology, otologic evals.
- Gender Reassignment.
- Pain Management (all POS).
- Sleep Studies (Done in the office).
- Transportation (Non-Emergent Transportation, air or ground).

PENALTIES FOR NOT OBTAINING PRIOR AUTHORIZATION

A non-Prior Authorization penalty is the amount that must be paid by a Covered Person who does not call for Prior Authorization prior to receiving certain services. A penalty may be applied to applicable claims if a Covered Person receives services but does not obtain the required Prior Authorization. Failure to obtain precertification will result in no coverage for All Related Charges (includes all ancillary services).

The phone number to call for Prior Authorization is listed on the back of the Plan identification card.

The fact that a Covered Person receives Prior Authorization from the Utilization Review Organization does not guarantee that this Plan will pay for the medical care. The Covered Person must be eligible for coverage on the date services are provided. Coverage is also subject to all provisions described in this SPD, including additional information obtained that was not available at the time of the Prior Authorization. The Prior Authorization / Notification requirements detailed within this section may be deemed satisfied for certain services, providers, and/or facilities meeting specific conditions.
Medical Director Oversight. A Care Management medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine Medical Necessity using evidence-based clinical criteria.

CARE PROVISIONS

Case Management Referrals. During the Prior Authorization review process, cases are analyzed for a number of criteria used to trigger case-to-case management for review. Care Management opportunities are identified by using system-integrated, automated, and manual trigger lists during the Prior Authorization review process. Other trigger points include the following criteria: length of stay, level of care, readmission, and utilization, as well as employer referrals or self-referrals.

Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.
Retrospective Review. Retrospective review may be conducted upon request or at the Plan's discretion, and a determination will be issued within the required timeframe of the request, unless an extension is approved. Retrospective reviews are performed according to our standard Prior Authorization policies and procedures and a final determination will be made no later than 30 days after the request for review.

MAYO CLINIC COMPLEX CARE PROGRAM

The Plan covers eligible services ("the Services") as part of the Plan's Mayo Clinic Complex Care Program, which is administered by HealthSCOPE Benefits, a UMR company. This program may provide access to Mayo Clinic for certain complex conditions.

Participation in this program is voluntary and is subject to the Plan participant's meeting Plan eligibility requirements. In order to participate in the program, the patient (or the patient's parent or legal guardian) must:

- have primary insurance coverage through the CLARK COUNTY EPO health Plan. There will be no coordination of benefits under this program with the exception of Medicare for End Stage Renal Disease (ESRD);
- agree to abide by program requirements;
- acknowledge that Mayo Clinic will receive necessary medical records prior to acceptance into the program;
- be able to safely travel for medical care and not require Emergency care at the time of travel;
- identify a designated caregiver(s). The caregiver(s) must agree to and be able to meet caregiver requirements; and
- provide the Mayo Clinic Physician with contact information for a local Physician who has agreed to manage follow-up care after the participant returns home.

Members participating in this program may receive an enhanced benefit for eligible services which may include coverage for services that would normally be excluded under this Plan, if approved through and performed at Mayo Clinic. Precertification and/or the prior authorization requirement is waived for Mayo Clinic when receiving care through the Mayo Clinic Complex Care Program.
The Plan pays covered travel expenses for the participant and a companion caregiver (or two companion caregivers if the patient is a pediatric patient) when the Services are performed at Mayo Clinic. HealthSCOPE Benefits, a UMR company, will coordinate the travel and care for the participant and companion caregiver(s).

SERVICES REQUIRING A REFERRAL

Services that may be eligible for this program include, but are not limited to:

- Acute leukemia of any type.
- Non-Hodgkin's lymphoma of any type.
- Chronic myelogenous leukemia.
- Multiple myeloma.
- Cancer of the pancreas.
- Cancer of the anus and rectum (but not including other forms of colon cancer).
- Head and neck cancers.
- Esophageal cancer.
- Stomach cancer.
- Liver and bile duct cancers.
- Brain and central nervous system tumors.
- Stage IV breast cancer with failing treatment.
- Ovarian and other gynecologic cancers other than cervical cancer.
- Failed first line therapy.
- Rare, aggressive, or complex care needs.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. **It does not, however, apply to prescription benefits.** The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim and will reduce the benefits it pays so that the total payment between the Primary Plan and the Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Foreign health care coverage.
- Medical care components of group long-term care contracts, such as skilled nursing care.
- Medical benefits under group or individual motor vehicle policies (including no-fault policies). See the order of benefit determination rules (below).
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law, not including Medicaid. See below.

However, this Plan does not coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges will not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule that will apply:

- The plan that has no coordination of benefits provision is considered primary.

- If an individual is covered under one plan as a dependent and another plan as an employee, member, or subscriber, the plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) is considered primary. This does not apply to COBRA participants. See continuation coverage below. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any employee plan beneficiary to be eligible for primary benefits from his or her employer's benefit plan.

- The plan that covers a person as a dependent is generally secondary. The plan that covers a person as a dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a dependent. See continuation coverage below. Also see the section on Medicare, below, for exceptions.

- If an individual is covered under a spouse's plan and also under his or her parent's plan, the Primary Plan is the plan that has covered the person for the longer period of time. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the plan of the parent or spouse whose birthday falls earlier in the calendar year is the Primary Plan. If the parents and/or spouse have the same birthday, the plan that has covered the parent or spouse for the longer period of time is the Primary Plan.

- If one or more plans cover the same person as a dependent child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

    If both parents have the same birthday, the plan that has covered either of the parents the longest is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.

  - If the parents are not married and reside separately, or are divorced or legally separated, (whether or not they have ever been married), the order of benefits is:

    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the non-custodial parent; and then
    - The plan of the spouse of the non-custodial parent.

- Active or Inactive Employee: If an individual is covered under one plan as an active employee (or dependent of an active employee) and is also covered under another plan as a retired or laid-off employee (or dependent of a retired or laid-off employee), the plan that covers the person as an active employee (or dependent of an active employee) will be primary. This rule does not apply if the rule in the third paragraph (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

- Continuation Coverage Under COBRA or State Law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies. (See the exception in the Medicare section.)

- Longer or Shorter Length of Coverage: The plan that has covered the person as an employee, member, subscriber, or retiree the longest is primary.

- If an active employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active employee, member, or subscriber is considered primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses may be shared equally between the plans. This Plan will not pay more than it would have paid had it been primary.

MEDICARE

If You or Your covered spouse or Dependent is also receiving benefits under Medicare, including through Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The order of benefit determination rules determine which plan will pay first (which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim and will reduce the benefits it pays so that the total payment between the Primary Plan and the Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

When Medicare is primary to this Plan and a Covered Person has not elected Medicare, this Plan will coordinate benefits using an estimate of what Medicare would have paid.

Medicare Carve-Out: If a retiree or any dependent of a retiree is eligible for Medicare Coverage and does not elect Medicare Part B, the member or dependent is subject to a penalty. If a retiree or active member/dependent becomes eligible for Medicare due to ESRD, they must also be enrolled in Medicare Part B after their 30-month coordination period, otherwise a penalty will apply. Penalty is as follows: Plan will provide coverage to the member and/or dependent at 20% of the plan allowable, either at the contracted rate or the reasonable and customary allowable when the contracted rate is not available, instead of the normal benefit payable for such service covered by the Clark County Self-Funded Plan.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally pays first under the following circumstances:
  - You continue to be actively employed by the employer and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
  - You continue to be actively employed by the employer, Your covered spouse becomes eligible for and enrolls in Medicare, and Your spouse is also covered under a retiree plan through his or her former employer. In this case, this Plan pays first for You and Your covered spouse, Medicare pays second, and the retiree plan pays last.
  - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period may also include COBRA continuation coverage or another source of coverage. At the end of the 30-month period, Medicare becomes the primary payer.
- Medicare generally pays first under the following circumstances:
  - You are no longer actively employed by an employer; and
  - You or Your spouse has Medicare coverage due to age, plus You or Your spouse also has COBRA continuation coverage through the Plan; or
  - You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first; however, COBRA may pay first for Covered Persons with ESRD until the end of the 30-month period; or

- You or Your covered spouse has retiree coverage plus Medicare coverage; or

- Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability ***before*** being diagnosed with ESRD and Medicare was previously paying as the Primary Plan, the person may continue to receive Medicare benefits on a primary basis).

- Medicare is the secondary payer when no-fault insurance, Workers' Compensation, or liability insurance is available as the primary payer.

TRICARE

If an eligible Employee is on active military duty, TRICARE is the only coverage available to that Employee. Benefits are not coordinated with the Employee's health insurance plan.

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD-PARTY ORGANIZATION

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as if it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than the Plan should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid, or from any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

The Plan has a right to subrogation and reimbursement. References to “You” or “Your” in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, Your representative(s), Your Dependents, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any Third-Party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any Third-Party for the benefits that the Plan has paid that are related to the Illness or Injury for which any Third-Party is considered responsible.

The right to reimbursement means that if it is alleged that any Third-Party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any Third-Party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor in a Workers’ Compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners’, or otherwise), Workers' Compensation coverage, other insurance carriers, or Third-Party administrators.
- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any Third-Party.
- Any person or entity that is liable for payment to You on any equitable or legal theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan’s legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any Third-Party for acts that caused benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or Injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any Third-Party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect Third-Party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any Third-Party before You receive payment from that Third-Party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible Third-Party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You, no matter how those proceeds are allocated, captioned, characterized, or classified, and regardless of the theory of recovery. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, punitive, bad faith, and any other alleged damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.

- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.

- If You receive any payment from any party allegedly arising out of Illness or Injury and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account. By participating in and accepting benefits from the Plan, You agree that:

  - Any amounts recovered by You from any Third-Party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
  - You and Your representative will be fiduciaries of the Plan with respect to such amounts; and
  - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.

- The Plan's rights to recovery will not be reduced due to Your own alleged negligence.

- By participating in and accepting benefits from the Plan, You agree to assign to the Plan any benefits, claims, or rights of recovery You have under any automobile policy (including no-fault benefits, Personal Injury Protection benefits, and/or medical payment benefits), under other coverage, or against any Third-Party, to the full extent of the benefits the Plan has paid for the Illness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, You acknowledge and recognize the Plan's right to assert, pursue, and recover on any such claim, whether or not You choose to pursue the claim, and You agree to this assignment voluntarily.

- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other Third-Party; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds, or any other recovery by You or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to the parents, guardian, or other representative of a Dependent Child who incurs an Illness or Injury caused by any Third-Party. If a parent or guardian brings a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.

- If any Third-Party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.

- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any Third-Party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect Third-Party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

- In the case of occupational Illness or Injury, the Plan's recovery rights will apply to all sums recovered, regardless of whether the Illness or Injury is deemed compensable under any Workers' Compensation or other coverage. Any award or compromise Workers' Compensation settlement, including any lump-sum settlement, will be deemed to include the Plan's interest and the Plan will be reimbursed in first priority from any such award or settlement.

GENERAL EXCLUSIONS

Exclusions, including complications from excluded items, are not considered covered benefits under this Plan and will not be considered for payment as determined by the Plan.

The Plan does not pay for expenses Incurred for the following, unless otherwise stated below or as otherwise required to be covered by the No Surprises Act. The Plan does not apply exclusions to treatment listed in the Covered Medical Benefits section based upon the source of an Injury if the Plan has information that the Injury is due to a medical condition (including physical and mental health conditions and Emergencies) or domestic violence.

1. **3D Mammograms,** unless covered elsewhere in this SPD.

2. **Abdominoplasty.**

3. **Abortions:** Unless a Physician states in writing that the mother's life would be in danger if the fetus were carried to term, or unless the pregnancy is the result of incest or rape.

4. **Acts of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

5. **Acupuncture Treatment.**

6. **Alternative / Complementary Treatment.** Refer to the Glossary of Terms for a definition of Alternative / Complementary Treatment.

7. **Appointment Missed:** An appointment the Covered Person did not attend.

8. **Aquatic Therapy.**

9. **Assistance With Activities of Daily Living.**

10. **Assistant Surgeon, Co-Surgeons, or Surgical Team Services,** unless determined to be Medically Necessary by the Plan.

11. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins or after coverage ends under this Plan.

12. **Biofeedback Services.**

13. **Blood:** Blood donor expenses.

14. **Blood Pressure Cuffs / Monitors,** unless covered elsewhere in this SPD.

15. **Breast Pumps,** unless covered elsewhere in this SPD.

16. **Cardiac Rehabilitation** beyond Phase II, including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.

17. **Claims** received later than 12 months from the date of service.

18. **Contraceptive Products and Counseling,** unless covered elsewhere in this SPD.

19. **Cosmetic Treatment**, **Cosmetic Surgery,** or any portion thereof, unless the procedure is otherwise listed as a covered benefit.

20. **Court-Ordered:** Any treatment or therapy that is court-ordered, or that is ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving-while-intoxicated conviction or other classes ordered by the court.

21. **Custodial Care** as defined in the Glossary of Terms of this SPD.

22. **Dental Services,** unless covered elsewhere in this SPD.

23. **Duplicate Services and Charges or Inappropriate Billing,** including the preparation of medical reports and itemized bills.

24. **Education:** Charges for education, special education, job training, music therapy, and recreational therapy, whether or not given in a facility providing medical or psychiatric care. This exclusion does not apply to self-management education programs for diabetics.

25. **Environmental Devices:** Environmental items such as, but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, and vacuum devices.

26. **Examinations:** Examinations for employment, insurance, licensing, or litigation purposes.

27. **Excess Charges:** Charges or the portion thereof that are in excess of the Recognized Amount, the Usual and Customary charge, the Negotiated Rate, or the fee schedule. This exclusion does not apply to payments that may be required under the No Surprises Act

28. **Experimental, Investigational, or Unproven:** Services, supplies, medicines, treatment, facilities, or equipment that the Plan determines are Experimental, Investigational, or Unproven, including administrative services associated with Experimental, Investigational, or Unproven treatment. This exclusion does not apply to Qualifying Clinical Trials as described in the Covered Medical Benefits section of this SPD.

29. **Extended Care:** Any Extended Care Facility Services that exceed the appropriate level of skill required for treatment as determined by the Plan.

30. **Family Planning:** Consultations for family planning.

31. **Fees for Medical Records.**

32. **Financial Counseling.**

33. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment, and health club memberships, or other utilization of services, supplies, equipment, or facilities in connection with weight control or bodybuilding.

34. **Foot Care (Podiatry):** Routine foot care.

35. **Foreign Coverage for Medical Care Expenses, Including Preventive Care or Elective Treatment.** Costs for repatriation from outside of the United States are also not covered.

36. **Genetic Testing or Genetic Counseling,** unless covered elsewhere in this SPD.

37. **Growth Hormones.**

38. **Home Births** and associated costs.

39. **Home Modifications:** Modifications to Your home or property, such as, but not limited to, escalators, elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts, or ramps.

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

41. **Infant Formula** not administered through a tube as the sole source of nutrition for the Covered Person.

42. **Infertility Treatment:**

    - Surgical reversal of a sterilized state that was a result of a previous surgery.

    This exclusion does not apply to services required to treat or correct underlying causes of infertility where such services cure the condition of, slow the harm to alleviate the symptoms of, or maintain the current health status of the Covered Person.

43. **Intraocular Lenses Other Than Conventional Intraocular Cataract Lenses.**

44. **Lamaze Classes** or other childbirth classes.

45. **Learning Disability:** Non-medical treatment, including, but not limited to, special education, remedial reading, school system testing, and other habilitation (such as therapies)/rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

46. **Liposuction,** unless covered elsewhere in this SPD.

47. **Maintenance Therapy** if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve a condition, or if clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

48. **Mammoplasty or Breast Augmentation,** unless covered elsewhere in this SPD.

49. **Marriage Counseling.**

50. **Massage Therapy.**

51. **Maximum Benefit.** Charges in excess of the Maximum Benefit allowed by the Plan.

52. **Military:** A military-related Illness of or Injury to a Covered Person on active military duty, unless payment is legally required.

53. **Nocturnal Enuresis Alarm.**

54. **Non-Custom-Molded Shoe Inserts.**

55. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards, or that is provided by a provider acting outside the scope of his or her license.

56. **Not Medically Necessary:** Services, supplies, treatment, facilities, or equipment that the Plan determines are not Medically Necessary. Furthermore, this Plan excludes services, supplies, treatment, facilities, or equipment that reliable scientific evidence has shown does not cure the condition, slow the degeneration/deterioration or harm attributable to the condition, alleviate the symptoms of the condition, or maintain the current health status of the Covered Person. See also Maintenance Therapy above.

57. **Nursery and Newborn Expenses** for a grandchild of a covered Employee or spouse.

58. **Nutrition Counseling,** unless covered elsewhere in this SPD.

59. **Nutritional Supplements, Enteral Feedings, Vitamins, and Electrolytes** unless covered elsewhere in this SPD.

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

61. **Orthognathic, Prognathic, and Maxillofacial Surgery.**

62. **Over-the-Counter Medication, Products, Supplies, or Devices,** unless covered elsewhere in this SPD.

63. **Palliative Foot Care.**

64. **Panniculectomy,** unless determined by the Plan to be Medically Necessary.

65. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as, but not limited to, private rooms, televisions, telephones and guest trays.

66. **Pharmacy Consultations.** Charges for or related to consultative information provided by a pharmacist regarding a Prescription order, including, but not limited to, information related to dosage instruction, drug interactions, side effects, and the like.

67. **Prescription Medication Written by a Physician:** A Covered Person with a written Physician's Prescription who obtains medication from a pharmacy should refer to the Prescription Drug Benefits section of this SPD for coverage.

68. **Preventive / Routine Care Services,** unless covered elsewhere in this SPD.

69. **Private Duty Nursing Services.**

70. **Reconstructive Surgery** when performed only to achieve a normal or nearly normal appearance, and not to correct an underlying medical condition or impairment, as determined by the Plan, unless covered elsewhere in this SPD.

71. **Return to Work / School:** Telephone or Internet consultations, or the completion of claim forms or forms necessary for a return to work or school.

72. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization, unless covered by the Plan in connection with Infertility Treatment.

73. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.

74. **Self-Administered Services** or procedures, including self-administered or self-infused medications, that can be performed by the Covered Person without the presence of medical supervision. This exclusion does not apply to medications that, due to their characteristics (as determined by the claims administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an Outpatient setting. This exclusion does not apply to hemophilia treatment centers contracted to dispense hemophilia factor medications directly to members for self-infusion.

75. **Services at No Charge or Cost:** Services for which the Covered Person would not be obligated to pay in the absence of this Plan or that are available to the Covered Person at no cost, or for which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.

76. **Services Provided By a Close Relative.** See the Glossary of Terms section of this SPD for a definition of Close Relative.

77. **Services Provided By a School.**

78. **Sex Therapy.**

79. **Sexual Function:** Non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Drug Benefits section of this SPD) in connection with treatment for male or female impotence.

80. **Standby Surgeon Charges.**

81. **Subrogation.** Charges for an Illness or Injury suffered by a Covered Person due to the action or inaction of any Third-Party if the Covered Person fails to provide information as specified in the Right of Subrogation, Reimbursement, and Offset section. See the Right of Subrogation, Reimbursement, and Offset section for more information.

82. **Surrogate Parenting and Gestational Carrier Services,** including any services or supplies provided in connection with a surrogate parent, not including pregnancy and maternity charges Incurred by a covered Employee or covered spouse acting as a surrogate parent.

83. **Taxes:** Sales taxes and shipping and handling charges, unless covered elsewhere in this SPD.

84. **Telehealth.** Consultations made by a Covered Person's treating Physician to another Physician.

85. **Tobacco Addiction:** Diagnoses, services, treatment, or supplies related to addiction to or dependency on nicotine, unless covered elsewhere in this SPD.

86. **Transportation:** Transportation services that are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.

87. **Travel:** Travel costs, unless covered elsewhere in this SPD.

88. **Vision Care,** unless covered elsewhere in this SPD. (Refer to the Vision Care Benefits section of this SPD).

89. **Vitamin B-12 Injections.**

90. **Vitamins, Minerals, and Supplements,** even if prescribed by a Physician, except for IV iron therapy that is prescribed by a Physician for Medically Necessary purposes.

91. **Vocational Services:** Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning, and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.

92. **Weekend Admissions** to Hospital confinement (admissions taking place after 3:00 pm on Fridays or before noon on Sundays) unless the admission is deemed an Emergency or is for care related to pregnancy that is expected to result in childbirth.

93. **Weight Control:** Treatment, services, or surgery for weight control**,** whether or not prescribed by a Physician or associated with an Illness, except as specifically stated for preventive counseling. This exclusion does not apply to specific services for Morbid Obesity as listed in the Covered Medical Benefits section of this SPD.

94. **Wigs (Cranial Prostheses), Toupees, Hairpieces, Hair Implants or Transplants, or Hair Weaving,** or any similar item for replacement of hair regardless of the cause of hair loss, unless covered elsewhere in this SPD.

95. **Wrong Surgeries:** Additional costs and/or care related to wrong surgeries. Wrong surgeries include, but are not limited to, surgery performed on the wrong body part, surgery performed on the wrong person, objects left in patients after surgery, etc.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

Pre-Determination

A Pre-Determination is a determination of benefits by the claim's administrator, on behalf of the Plan, prior to services being provided. Although Pre-Determinations are not required by the Plan, a Covered Person or provider may voluntarily request a Pre-Determination. A Pre-Determination informs individuals of whether, and under which circumstances, a procedure or service is generally a covered benefit under the Plan. A Covered Person or provider may wish to request a Pre-Determination before Incurring medical expenses. A Pre-Determination is not a claim and therefore may not be appealed. A Pre-Determination that a procedure or service may be covered under the Plan does not guarantee the Plan will ultimately pay the claim. All Plan terms and conditions will still be applied when determining whether a claim is payable under the Plan.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing prior authorization as required by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person or provider, when applicable, is required to obtain approval from the Plan ***before*** obtaining medical care, such as in the case of prior authorization of health care items or services that the Plan requires. If a Covered Person or provider calls the Plan for the sole purpose of learning whether or not a claim will be covered, that call is not considered a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for prior authorization. (See "Pre-Determination" above.) The fact that the Plan may grant prior authorization does not guarantee that the Plan will ultimately pay the claim.

  Note that this Plan does not require prior authorization for urgent or Emergency care claims; however, Covered Persons may be required to notify the Plan following stabilization. Please refer to the Care Management section of this SPD for more details. A condition is considered to be an urgent or Emergency care situation if a sudden and serious condition occurs such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of the patient's bodily functions would result unless immediate medical care is rendered. Examples of an urgent or Emergency care situation may include but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.

- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who may contact the Plan on the Covered Person's behalf to help with claims, appeals, or other benefit issues. A minor Dependent must have the signature of a parent or Legal Guardian in order to appoint a Third-Party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: the name of the Personal Representative, the date and duration of the appointment, and any other pertinent information. In addition, the Covered Person must agree to grant his or her Personal Representative access to his or her Protected Health Information. The Covered Person should contact the Claim Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, the Covered Person will need to send the claim to the Plan within the timelines outlined below in order to receive reimbursement. The address for submitting medical claims is on the back of the group health identification card.

A Covered Person who receives services in a country other than the United States is responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse the Covered Person for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if the paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person's/patient's ID number, name, sex, date of birth, address, and relationship to Employee
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services, or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient's account number (if applicable)
- Total billed charges
- Provider's billing name, address, and telephone number
- Provider's Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, an auto Accident, or another Accident (if applicable)
- Assignment of benefits (if applicable)

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third-Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. If Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veterans Administration Hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all the information that is necessary in order to process the claim. Claims received after the timely filing period will not be allowed.

INCORRECTLY FILED CLAIMS (Applies to Pre-Service Claims only)

If a Covered Person or Personal Representative attempts to, but does not properly, follow the Plan's procedures for requesting prior authorization, the Plan will notify the person and explain the proper procedures within five calendar days following receipt of a Pre-Service Claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Personal Representative.

HOW HEALTH BENEFITS ARE CALCULATED

When UMR receives a claim for a service that has been provided to a Covered Person, it will determine if the service is a covered benefit under this group health Plan. If the service is not a covered benefit, the claim will be denied, and the Covered Person will be responsible for paying the provider for these costs. If the service is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to the billed charges, a Negotiated Rate, or the Protection from Balance Billing allowed amount, or based on the Usual and Customary amounts, minus any Deductible, Plan Participation rate, Co-pay, or penalties that the Covered Person is responsible for paying. Refer to the Protection from Balance Billing section of this SPD for covered benefits that are payable in accordance with the Protection from Balance Billing allowed amount.

Negotiated Rate: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service, such as transplant services, Durable Medical Equipment, Extended Care Facility treatment, or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Co-pay, Deductible, Plan Participation rate, or penalties that the Covered Person is responsible for paying. If a network contract is in place, the network contract determines the Plan's Negotiated Rate.

Modifiers or Reducing Modifiers, if Medically Necessary. These terms apply to services and procedures performed on the same day and may be applied to surgical, radiological, and other diagnostic procedures. For a provider participating with a primary or secondary network, claims will be paid according to the network contract. For a provider who is not participating with a network, where no discount is applied, the industry guidelines are to allow the Usual and Customary fee allowance for the primary procedure and a percentage of the Usual and Customary fee allowance for all secondary procedures. These allowances are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

The specific reimbursement formula used will vary depending upon the Physician or facility providing the service(s) and the type of service(s) received.

Reimbursement for covered services received from providers, including Physicians or health care facilities, who are not part of Your network are determined based on one of the following:

- Fee(s) that are negotiated with the Physician or facility; or
- The amount that is usually accepted by health care providers in the same geographical area (or greater area, if necessary) for the same services, treatment, or materials based on the 100th percentile for Medicare allowable, 60% of billed charges (with approval) for non-Medicare allowable, or
- Current publicly available data reflecting the costs for health care providers providing the same or similar services, treatment, or materials adjusted for geographical differences plus a margin factor.

When covered health services are received from a non-network provider as a result of an Emergency or as arranged by Your Plan Administrator, eligible expenses are amounts negotiated by Your claims administrator or amounts permitted by law. Refer to the Protection from Balance Billing section of this SPD for more information. Please contact Your Plan Administrator if You are billed for amounts in excess of Your applicable Plan Participation, Co-pays, or Deductibles. The Plan will not pay excessive charges or amounts You are not legally obligated to pay.

See “Surgery and Assistant Surgeon Services” in the Covered Medical Benefits section for exceptions related to multiple procedures. A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

For services received from a non-network provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits. These providers charge their normal rates for services, so Covered Persons may need to pay more. Covered Persons are responsible for paying the balance of these claims after the Plan pays its portion, if any.

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person’s responsibility due to cost-sharing obligations, non-covered benefits, penalties, or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears to be correct. If You have any questions or concerns about the EOB form, call the Plan at the number listed on the EOB form or on the back of the group health identification card. The provider will receive a similar form for each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

UMR will process claims within the following timelines, although a Covered Person may voluntarily extend these timelines:

- Pre-Service Claims: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan may have an extra 15-day extension when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan may have an additional 15-day extension when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the coverage for the treatment ending or being reduced.
- Emergency and/or Urgent Care claims as defined by the Affordable Care Act: The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or Urgent Care as soon as possible, taking into account the Medical Necessity, but not later than 72 hours after the receipt of the claim by the Plan, and deference will be made to the treating Physician.

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims may be denied for any of the following reasons:

- Termination of Your employment.
- A Covered Person’s loss of eligibility for coverage under the health Plan.
- Charges are Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- A Covered Person reached the Maximum Benefit under this Plan.
- Amendment of the group health Plan.

- Termination of the group health Plan.
- The Employee, Dependent, or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Failure to comply with prior authorization requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- The Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations, or penalties.
- Application of the Protection from Balance Billing allowed amount, the Usual and Customary fee limits, the fee schedule, or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Procedures are considered Experimental, Investigational, or Unproven.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied, in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person may take to submit the claim for appeal (review).

If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental, Investigational, or Unproven treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or his or her Personal Representative may request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before taking any outside legal action.

- The Covered Person must file the appeal within 180 days of the date he or she received the EOB form from the Plan showing that the claim was denied. The Plan will assume the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- The Covered Person or his or her Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- The Covered Person may submit written comments, documents, records, and other information related to the claim to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records, and other information submitted that relates to the claim. This will include comments, documents, records, and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or his or her Personal Representative must submit a written request for a second review within 30 calendar days following the date he or she received the Plan's decision regarding the first appeal. The Plan will assume the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- The Covered Person may submit written comments, documents, records, and other pertinent information to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records, and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal and are not under the supervision of those individuals.

- If the benefit denial was based, in whole or in part, on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal and may not be supervised by the health care professional who was involved. If the Plan has consulted with medical or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. In the event of new or additional evidence, or any new rationale relied upon during the appeal process in connection with a claim that is being appealed, the Plan will automatically provide the relevant information to the Covered Person. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on his or her rights to any other benefits under the Plan. If You have any questions regarding the voluntary level of appeal, including applicable rules, a Covered Person's right to representation (i.e., to appoint a Personal Representative), or other details, please contact the Plan.

Appeals should be sent within the prescribed time period as stated above to the following address(es).

Note: Post-Service Appeal Request forms are available at www.umr.com to assist You in providing all the recommended information to ensure a full and fair review of Your Adverse Benefit Determination. You are not required to use this form.

Send Post-Service Claim Medical appeals to:
UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

Send Pre-Service Claim Medical appeals to:
UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

This Plan contracts with various companies to administer different parts of this Plan. A Covered Person who wants to appeal a decision or a claim determination that one of these companies made should send appeals directly to the company that made the decision being appealed. This includes the RIGHT TO EXTERNAL REVIEW.

Send Pharmacy appeals to:
NAVITUS HEALTH SOLUTIONS
361 INTEGRITY DR
MADISON WI 53717

TIME PERIODS FOR MAKING DECISIONS ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where the Plan is unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

URGENT CLAIM APPEALS THAT REQUIRE IMMEDIATE ACTION

A request by a Covered Person or his or her authorized representative for the review and reconsideration of coverage that requires notification or approval prior to receiving medical care may be considered an urgent claim appeal. Urgent claim appeals must meet one or both of the following criteria in order to be considered urgent in nature:

- A delay in treatment could seriously jeopardize life or health or the ability to regain maximum functionality.
- In the opinion of a Physician with knowledge of the medical condition, a delay in treatment could cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

UMR must respond to the urgent claim appeal request as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receiving the request for review.

The timelines below will apply only to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- Pre-Service Claims: Within a reasonable period of time appropriate to the medical circumstances, but no later than 30 calendar days after the Plan receives the request for review.
- Post-Service Claims: Within a reasonable period of time, but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

RIGHT TO EXTERNAL REVIEW

If, after exhausting Your internal appeals, You are not satisfied with the final determination, You may choose to participate in the external review program. This program applies only if the Adverse Benefit Determination involves:

- Clinical reasons;
- The exclusions for Experimental, Investigational, or Unproven services;
- Determinations related to Your entitlement to a reasonable alternative standard for a reward under a Wellness Program;
- Determinations related to whether the Plan has complied with non-quantitative treatment limitation provisions of Code 9812 or 54.9812 (Parity in Mental Health and Substance Use Disorder Benefits);
- Determinations related to the Plan's compliance with the following surprise billing and cost-sharing protections set forth in the No Surprises Act:
  - Whether a claim is for Emergency treatment that involves medical judgment or consideration of compliance with the cost-sharing and surprise billing protections;
  - Whether a claim for items and services was furnished by a non-network provider at a network facility;
  - Whether an individual gave informed consent to waive the protections under the No Surprises Act;

- Whether a claim for items and services is coded correctly and is consistent with the treatment actually received;
- Whether cost-sharing was appropriately calculated for claims for Ancillary Services provided by a non-network provider at a network facility; or

- Other requirements of applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure (other than a pre-determination of benefits) or the denial of payment for a service or procedure. The process is available at no charge to You after You have exhausted the appeals process identified above and You receive a decision that is unfavorable, or if UMR or Your employer fails to respond to Your appeal within the timelines stated above.

You may request an independent review of the Adverse Benefit Determination. Neither You nor UMR nor Your employer will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision. If You wish to pursue an external review, please send a written request as indicated below.

Notice of the right to external review for Pre-Service appeals should be sent to:

UHC APPEALS - UMR
PO BOX 400046
SAN ANTONIO TX 78229

Alternatively, You may fax Your request to 888-615-6584, ATTN: UMR Appeals

Notice of the right to external review for Post-Service appeals should be sent to:

UMR
EXTERNAL REVIEW APPEAL UNIT
PO BOX 8048
WAUSAU WI 54402-8048

Your written request should include: (1) Your specific request for an external review; (2) the Employee's name, address, and member ID number; (3) Your designated representative's name and address, if applicable; (4) a description of the service that was denied; and (5) any new, relevant information that was not provided during the internal appeal. You will be provided more information about the external review process at the time we receive Your request.

Any requests for an independent review must be made within 180 days of the date You receive the Adverse Benefit Determination. You or an authorized designated representative may request an independent review by contacting the toll-free number on Your ID card or by sending a written request to the address on Your ID card.

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a qualified medical care expense under the Plan. The Independent Review Organization (IRO) has been contracted by UMR and has no material affiliation or interest with UMR or Your employer. UMR will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UMR's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- All relevant medical records;
- All other documents relied upon by UMR and/or Your employer in making a decision on the case; and
- All other information or evidence that You or Your Physician has already submitted to UMR or Your employer.

If there is any information or evidence that was not previously provided and that You or Your Physician wishes to submit in support of the request, You may include this information with the request for an independent review, and UMR will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information in order to make a decision, this time period may be extended. The independent review process will be expedited if You meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide You and UMR and/or Your employer with the reviewer's decision, a description of the qualifications of the reviewer, and any other information deemed appropriate by the organization and/or required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure.

You may contact the claims administrator at the toll-free number on Your ID card for more information regarding Your external appeal rights and the independent review process.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person's coverage should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person, or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud, or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (e.g., COBRA notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. (Please note that the examples listed are not all-inclusive.)

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate claims. If someone else, such as the Covered Person's spouse or another family member, files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on his or her knowledge of the expenses Incurred, and the services rendered;
- Never allow another person to seek medical treatment under his or her identity. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. He or she should answer all questions to the best of his or her knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

In order to maintain the integrity of this Plan, each Covered Person is encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under the Family and Medical Leave Act of 1993 (FMLA), his or her employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided the following conditions are met:

- Contributions are paid; and
- The Employee has a written, approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the FMLA and any amendment; or
- The leave period required by applicable state law.

An Employee may choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken. For more information, please contact Your Health Benefits or Personnel office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree, or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy, at no charge, of the written procedures that the Plan uses when administering Qualified Medical Child Support Orders.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, the plan or issuer may pay for a shorter stay if the attending Physician (i.e., Your Physician, nurse, midwife, or physician assistant) after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce Your out-of-pocket costs, You may be required to obtain precertification. For information on precertification, contact Your plan administrator.

This group health Plan also complies with the provisions of the:

- Americans With Disabilities Act, as amended.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- Genetic Information Non-discrimination Act (GINA).

The Plan Sponsor has opted out of complying with the following federal regulations as is allowed by law for governmental or church group health plans:

- Mental Health Parity Act.

HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care, and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan will Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care, or Health Care Operations.

The Plan Sponsor will Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care, or Health Care Operations that it performs on behalf of this Plan.

This Plan agrees that it will Disclose a Covered Person's PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will Use and Disclose a Covered Person's PHI (including Electronic PHI) only for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;

- The Plan Sponsor will promptly report to this Plan any breach, or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not Use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Each Covered Person has the right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books, and records related to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of Plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees, or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Clark County Risk Management

This list includes every Employee, class of Employees, or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violation, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions, and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy, and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a person to whom the CE Discloses Protected Health Information (PHI) so that a person may carry out, assist with the performance of, or perform a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third-Party Administrators, health care clearinghouses, data processing firms, billing firms, and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse, or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Person's PHI. This includes medical records, billing records, enrollment records, Payment records, claims adjudication records, and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of six years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities related to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management, and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk related to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health condition of a Covered Person, the provision of health care, or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person, or there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan, including quality assurance, claims processing, auditing, and monitoring.

Plan Sponsor means Your employer.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic, or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend, or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the relevant facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, alternatively, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals of no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or the Third-Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy, will be excluded from any benefit consideration.

The Plan will assume that the Covered Person receives the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed to the Covered Person.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Contact Your Health Benefits or Personnel office for information regarding distribution of assets upon termination of Plan.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as, a contract of employment between any Covered Person and the employer.

GLOSSARY OF TERMS

ABA / IBI / Autism Spectrum Disorder Therapy means intensive behavioral therapy programs used to treat Autism Spectrum Disorder. These programs are often referred to as Intensive Behavioral Intervention (IBI), Early Intensive Behavioral Intervention (EIBI), or Applied Behavior Analysis (ABA). These interventions aim to reduce problem behaviors and develop alternative behaviors and skills in those with Autism Spectrum Disorder. In a typical therapy session, the Child is directed to perform an action. Successful performance of the task is rewarded with a positive reinforcer, while noncompliance or no response receives a neutral reaction from the therapist. For Children with maladaptive behaviors, plans are created to utilize the use of reinforcers to decrease problem behavior and increase more appropriate responses. Although once a component of the original Lovaas methodology, aversive consequences are no longer used. Parental involvement is considered essential to long-term treatment success; parents are taught to continue behavioral modification training when the Child is at home and may sometimes act as the primary therapist.

Accident means an unexpected, unforeseen, and unintended event that causes bodily harm or damage to the body.

Activities of Daily Living (ADL) means the following, with or without assistance: bathing, dressing, toileting, and associated personal hygiene; transferring (moving in or out of a bed, chair, wheelchair, tub, or shower); mobility; eating (getting nourishment into the body by any means other than intravenous); and continence (voluntarily maintaining control of bowel and/or bladder function, or, in the event of incontinence, maintaining a reasonable level of personal hygiene).

Acupuncture means a technique used to deliver anesthesia or analgesia, or to treat conditions of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

Advanced Imaging means the action or process of producing an image of a part of the body by radiographic techniques using high-end radiology such as MRA, MRI, CT, or PET scans and nuclear medicine.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, rescission of coverage (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time), or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Alternate Facility means a health care facility that is not a Hospital and that provides one or more of the following services on an Outpatient basis, as permitted by law:

- Surgical services;
- Emergency services; or
- Rehabilitative, laboratory, diagnostic, or therapeutic..

Alternative / Complementary Treatment means:

- Acupressure;
- Aromatherapy;
- Hypnotism;
- Massage therapy;
- Rolfing;
- Wilderness, adventure, camping, outdoor or other similar programs; or
- Art therapy, music therapy, dance therapy, animal-assisted therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health.

Ambulance Transportation means professional ground or air Ambulance Transportation provided in an Emergency situation; or when deemed Medically Necessary, which is:

- To the closest facility most able to provide the specialized treatment required;
- The most appropriate mode of transportation consistent with the well-being of You or Your Dependent.

Refer to the Protection from Balance Billing section of this SPD for the No Surprises Act requirements specific to air ambulance.

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

Birthing Center means a legally operating institution or facility that is licensed and equipped to provide immediate prenatal care, delivery services and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24-hour nursing care provided by registered nurses or certified nurse midwives.

Child (Children) means any of the following individuals with respect to an Employee: a natural biological Child; a natural child of the covered grandfathered Domestic Partner; a stepchild; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Employee's or spouse's Legal Guardianship; or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Close Relative means a member of the immediate family. Immediate family includes the Employee, spouse, mother, father, grandmother, grandfather, stepparents, step-grandparents, siblings, stepsiblings, half-siblings, Children, stepchildren, grandchildren, grandfathered Domestic Partner, Children of the grandfathered Domestic Partner.

Co-pay means the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits, if applicable.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to qualifying events.

Common-Law Marriage means a partnership whereby two adult individuals are considered married because they have lived together for a certain period of time, hold themselves to be married even without a license and a formal ceremony, and meet other applicable requirements of the state in which the Common-Law Marriage was established.

Cosmetic Treatment means medical or surgical procedures that are primarily used to improve, alter, or enhance appearance, whether or not for psychological or emotional reasons.

Covered Expenses means any expense, or portion thereof, that is Incurred as a result of receiving a covered benefit under this Plan. Details regarding Covered Expenses that are health care services subject to the federal No Surprises Act protections are provided in the Protection from Balance Billing section of this SPD.

Covered Person means an Employee, Retiree, or Dependent who is enrolled under this Plan.

Custodial Care means non-medical care given to a Covered Person, such as administering medication and assisting with personal hygiene or other Activities of Daily Living, rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do

not have the technical skills of a covered health care provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce a disability or improve the condition of a Covered Person.

Deductible means an amount of money paid once per Plan Year by the Covered Person (up to a family limit, if applicable) before any Covered Expenses are paid by the Plan. The Schedule of Benefits shows the amount of the applicable Deductible (if any), and the health care benefits to which it applies.

Dependent – see the Eligibility and Enrollment section of this SPD.

Developmental Delays means conditions that are characterized by impairment in various areas of development, such as social interaction skills, adaptive behavior, and communication skills.

Domestic Partner / Domestic Partnership means an unmarried person of the same sex with whom the covered Employee shares a committed relationship, who is jointly responsible for the other's welfare and financial obligations, who is at least 18 years of age, who is not related by blood, who maintains the same residence, and who is not married to or legally separated from anyone else.

In order for Your Domestic Partner to qualify as a Dependent, You and Your partner must complete a certification declaring that You and Your partner:

- Are in a relationship of mutual support, care, and commitment, and are responsible for each other's welfare;
- Have maintained this relationship for the past six months and intend to do so indefinitely;
- Have shared a primary residence for the past six months and intend to do so indefinitely;
- Are not married to anyone else and do not have other Domestic Partners;
- Are financially interdependent.

Durable Medical Equipment means equipment that meets all of the following criteria:

- It can withstand repeated use.
- It is primarily used to serve a medical purpose with respect to an Illness or Injury.
- It is generally not useful to a person in the absence of an Illness or Injury.
- It is appropriate for use in the Covered Person's home.

A cochlear implant is not considered Durable Medical Equipment.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as his or her Enrollment Date, as Enrollment Date is defined by the Plan.

Emergency means a serious medical condition, with acute symptoms that require immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Employee – see the Eligibility and Enrollment section of this SPD.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the date that coverage begins. **(Applies to Elected Officials)**
- For anyone who applies for coverage when first eligible, the first day of the Waiting Period. **(Applies to All Other Employees)**
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the first day coverage begins.

Experimental, Investigational, or Unproven means any drug, service, supply, care, or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational, or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials OR at least one or more large, controlled, national, multi-center, population-based studies;
- Items based on anecdotal and Unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care or treatment is considered Experimental, Investigational, or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

Extended Care Facility means a facility including, but not limited to, a skilled nursing, rehabilitation, convalescent, or subacute facility. It is an institution or a designated part of an institution that is operating pursuant to the law for such an institution and is under the full-time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: provide 24-hour-per-day service to include skilled nursing care and Medically Necessary therapies for the recovery of health or physical strength; not be a place primarily for Custodial Care; require compensation from its patients; admit patients only upon Physician orders; have an agreement to have a Physician's services available when needed; maintain adequate medical records for all patients; and have a written transfer agreement with at least one Hospital, be licensed by the state in which it operates, and provide the services to which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Gender Dysphoria means a disorder characterized by the specific diagnostic criteria classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information, among other things.

Home Health Care means a formal program of care and intermittent treatment that is: performed in the home; prescribed by a Physician; intermittent care and treatment for the recovery of health or physical strength under an established plan of care; prescribed in place of a Hospital or an Extended Care Facility stay or results in a shorter Hospital or Extended Care Facility stay; organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, nurse services means intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Home Health Care Plan means a formal, written plan made by the Covered Person's attending Physician that is evaluated on a regular basis. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the Covered Person.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for a Covered Person suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours per day, 7 days per week; is certified by Medicare as a Hospice Care Agency; and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services, medical social worker services, psychological and dietary counseling, Physician services, physical or occupational therapy, home health aide services, pharmacy services, and Durable Medical Equipment.

Hospital means a facility that:

- Is a licensed institution authorized to operate as a Hospital by the state in which it is operating; and
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- Is accredited by a recognized credentialing entity approved by CMS and/or a state or federal agency or, if outside the United States, is licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country; and
- Continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse; and
- Is not a place primarily for maintenance or Custodial Care.

For purposes of this Plan, the term "Hospital" also includes Surgical Centers and Birthing Centers licensed by the states in which they operate.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy, or complication of pregnancy. The term "Illness," when used in connection with a newborn Child, includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Incurred means the date on which a service or treatment is given, a supply is received, or a facility is used, without regard to when the service, treatment, supply, or facility is billed, charged, or paid.

Independent Contractor means someone who signs an agreement with the employer as an Independent Contractor, or an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer, and who retains control over how work is completed. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor will be made consistent with Section 530 of the Internal Revenue Code.

Infertility Treatment means services, tests, supplies, devices, or drugs that are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is performed in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams performed to prepare for induced conception; surgical reversal of a sterilized state that was a result of a previous surgery; sperm-enhancement procedures; direct attempts to cause pregnancy by any means, including, but not limited to: hormone therapy or drugs; artificial insemination; in vitro fertilization; gamete intrafallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury means a physical harm or disability to the body that is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. The term "Injury" does not include Illness or infection of a cut or wound.

Inpatient means a registered bed patient using and being charged for room and board at a Hospital. A person is not Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made. Observation in a Hospital room will be considered Inpatient treatment if the duration of the observation status exceeds 72 hours.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas, including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation, and mathematical reasoning. Specific Learning Disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling, and level of intelligence.

Legal Guardianship / Legal Guardian means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Life-Threatening Disease or Condition means a condition likely to cause death within one year of the request for treatment.

Manipulation means the act, process, or instance of manipulating a body part by manual examination and treatment, such as in the reduction of faulty structural relationships by manual means and/or the reduction of fractures or dislocations or the breaking down of adhesions.

Maximum Benefit means the maximum amount or the maximum number of days or treatments that are considered a Covered Expense by the Plan.

Medical Specialty Medications (including gene therapy and CAR-T therapy) means Prescription drugs used to treat complex, chronic, or rare medical conditions (e.g., cancer, rheumatoid arthritis, hemophilia, HIV, multiple sclerosis, inflammatory bowel disease, psoriasis, and hepatitis). Drugs in this category are typically administered by injection or infusion. Medical Specialty Medications often require special handling (e.g., refrigeration) and ongoing clinical monitoring.

Medically Necessary / Medical Necessity means health care services provided for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Injury, mental illness, substance use disorder, condition, or disease or its symptoms, that generally meet the following criteria as determined by us or our designee, within our sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice*; and
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for Your Illness, Injury, mental illness, substance use disorder, or disease or its symptoms; and
- Not mainly for Your convenience or that of Your doctor or other health care provider; and
- Is the most appropriate care, supply, or drug that can be safely provided to the member and is at least as likely as an alternative service or sequence of services to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, disease, or symptoms; and

The fact that a Physician has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment, or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment, or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion will be within our sole discretion.

UnitedHealthcare Clinical Services develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards, and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare Clinical Services and revised from time to time), are available to Covered Persons by calling UMR at the telephone number on the Plan ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.com.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act, as amended.

Mental Health Disorder means a syndrome that is present in an individual and that involves clinically significant disturbance in behavior, emotion regulation, or cognitive functioning. These disturbances are thought to reflect a dysfunction in biological, psychological, or developmental processes that are necessary for mental functioning.

Morbid Obesity means a condition in which an individual 18 years of age or older has a Body mass Index of 40 or more, or 35 or more if experiencing health conditions directly related to his or her weight, such as high blood pressure, diabetes, sleep apnea, etc.

Multiple Surgical Procedures means that more than one surgical procedure is performed during the same period of anesthesia.

Negotiated Rate means the amount that providers have contracted to accept as payment in full for Covered Expenses of the Plan.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, or too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliance means a brace, splint, cast, or other appliance that is used to support or restrain a weak or deformed part of the body, that is designed for repeated use, that is intended to treat or stabilize a Covered Person's Illness or Injury or improve function, and that is generally not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services, or supplies in a facility in which a patient is not registered as a bed patient and for whom room and board charges are not Incurred.

Palliative Foot Care means the cutting or removal of corns or calluses unless at least part of the nail root is removed or unless needed to treat a metabolic or peripheral vascular disease; the trimming of nails; other hygienic and preventive maintenance care or debridement, such as cleaning and soaking of the feet and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

Pediatric Services means services provided to individuals under the age of 19.

Physician means any of the following licensed practitioners, acting within the scope of his or her license in the state in which he or she practices, who performs services payable under this Plan: a doctor of medicine (MD), doctor of medical dentistry, including an oral surgeon (DMD), doctor of osteopathy (DO); doctor of podiatric medicine (DPM); doctor of dental surgery (DDS); doctor of chiropractic (DC); doctor of optometry (OPT). Subject to the limitations below, the term "Physician" also includes the following practitioner types: physician assistant (PA), nurse practitioner (NP), certified nurse midwife (CNM), or certified registered nurse anesthetist (CRNA), when, and only when, the practitioner is duly licensed, registered, and/or certified by the state in which he or she practices, the services being provided are within his or her scope of practice, and the services are payable under this Plan.

Placed for Adoption / Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means the CLARK COUNTY, NEVADA Group Health Benefit Plan.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means an employer who sponsors a group health plan.

Prescription means any order authorized by a medical professional for a Prescription or non-prescription drug that could be a medication or supply for the person for whom it is prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom it is prescribed. It must also identify the name, strength, quantity, and directions for use of the medication or supply prescribed.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well-being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened, except as required by applicable law. Benefits included as Preventive / Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Whether an immunization is considered Preventive / Routine is based upon the recommendation of the Centers for Disease Control and Prevention. Preventive / Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury, except as required by applicable law.

Primary Care Physician means a Physician engaged in family practice, general practice, non-specialized internal medicine (i.e., one who works out of a family practice clinic), pediatrics, obstetrics/gynecology, or the treatment of mental health/substance use disorders, or a Physician assistant / nurse practitioner regardless of specialty or practice type. Generally, these Physicians provide a broad range of services. For instance, family practitioners treat a wide variety of conditions for all family members; general practitioners provide routine medical care; internists treat routine and complex conditions in adults; and pediatric practitioners treat Children.

Private Duty Nursing (PDN) means continuous and skilled care by a registered nurse (RN) or licensed practical nurse (LPN) under the direction of a qualified practitioner for a medical condition that requires more than four continuous hours of skilled care that can be provided safely outside of an institution. It does not include care provided while confined at a Hospital, Extended Care Facility, or other Inpatient facility; care to help with Activities of Daily Living, including, but not limited to, dressing, feeding, bathing, or transferring from a bed to a chair; or Custodial Care.

Prudent Layperson means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered, and/or certified in accordance with applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

Qualified Provider means a provider duly licensed, registered, and/or certified by the state in which he or she is practicing, whose scope of practice includes the particular service or treatment being provided that is payable under this Plan.

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

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

The amount is based on either:

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

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

Note: Covered health services that use the Recognized Amount to determine Your cost-sharing may be higher or lower than if cost-sharing for these covered health services was determined based upon a Covered Expense.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic Treatment when a physical impairment exists, and the surgery restores or improves function.

Retired Employee / Retiree means a person who was employed full-time by the employer who is no longer regularly at work and who is now retired under the employer's formal retirement program.

Specialist means a Physician, or other Qualified Provider, if applicable, who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Physicians who are not considered Specialists include, but are not limited to, those specified in the definition of Primary Care Physician above.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally, does not provide Inpatient services or other accommodations; and offers the following services whenever a patient is in the center:

- It provides drug services as needed for medical operations and procedures performed;
- It provides for the physical and emotional well-being of the patients;
- It provides Emergency services;
- It has organized administration structure and maintains statistical and medical records.

Telehealth means the practice of health care delivery, diagnosis, consultation, treatment, and transfer of medical data and education using interactive audio, video, or data communications and that is billed by a Physician.

Telemedicine means the clinical services provided to patients through electronic communications utilizing a vendor.

Temporomandibular Joint Disorder (TMJ) means a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third-Party Administrator (TPA) means a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled means, as determined by the Plan in its sole discretion:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is qualified by education, training, or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.

Urgent Care means the delivery of ambulatory care in a facility dedicated to the delivery of care outside of a Hospital Emergency department, usually on an unscheduled, walk-in basis. Urgent Care centers are primarily used to treat patients who have Injuries or Illnesses that require immediate care but are not serious enough to warrant a visit to an Emergency room. Often Urgent Care centers are not open on a continuous basis, unlike a Hospital Emergency room that would be open at all times.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross-section of accurate data.

Waiting Period means the period of time that must pass before coverage becomes effective for an Employee or Dependent who is otherwise eligible to enroll under the terms of this Plan. Refer to the Eligibility and Enrollment section of this Plan to determine if a Waiting Period applies.

Walk-In Retail Health Clinics means health clinics located in retail stores, supermarkets, or pharmacies that provide a limited scope of preventive and/or clinical services to treat routine family Illnesses. Such a clinic must be operating under applicable state and local regulations and overseen by a Physician where required by law.

You / Your means the Employee.

DENTAL

Table of Contents

CLARK COUNTY, NEVADA

GROUP DENTAL BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information in English on benefits available under this Plan, as well as with information on a Covered Person's rights and obligations under the CLARK COUNTY, NEVADA Group Dental Benefit Plan (the "Plan"). You are a valued Employee of CLARK COUNTY, NEVADA, and Your employer is pleased to sponsor this Plan to provide benefits that can help meet Your dental care needs. Please read this document carefully and contact Your Health Benefits or Personnel office if You have questions or if You have difficulty translating this document.

CLARK COUNTY, NEVADA is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of an independent Third-Party Administrator, UMR, Inc. (hereinafter “UMR”) to process claims and handle other duties for this self-funded Plan. UMR, as the Third-Party Administrator, does not assume liability for benefits payable under this Plan, since it is solely a claims-paying agent for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of covered benefits through contributions, Deductibles, and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits.

Some of the terms used in this document begin with capital letters, even though it normally would not be capitalized. These terms have special meaning under the Plan. Most capitalized terms will be listed in the Glossary of Terms, but some terms are defined within the provisions in which they are used. Becoming familiar with the terms defined in the Glossary of Terms will help You to better understand the provisions of this Plan.

Each Individual covered under this Plan will be receiving an identification card that he or she may present to providers whenever he or she receives services. On the back of this card are phone numbers to call in case of questions or problems.

This document contains information on the benefits and limitations of the Plan and will serve as both the Summary Plan Description (SPD) and Plan Document. Therefore, it will be referred to as both the SPD and the Plan Document.

This document became effective on January 1, 2025.

PLAN INFORMATION

Plan Name	CLARK COUNTY, NEVADA GROUP DENTAL BENEFIT PLAN
Name And Address Of Employer	CLARK COUNTY, NEVADA 500 S GRAND CENTRAL PKWY LAS VEGAS NV 89155
Name, Address, And Phone Number Of Plan Administrator	CLARK COUNTY, NEVADA 500 S GRAND CENTRAL PKWY LAS VEGAS NV 89155 702-455-4544
Named Fiduciary	CLARK COUNTY, NEVADA
Claims Appeal Fiduciary For Dental Claims	UMR
Employer Identification Number Assigned By The IRS	88-6000028
Type Of Benefit Plan Provided	Self-funded Health and Welfare Plan providing group dental benefits.
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance. UMR provides administrative services such as claim payments for dental claims.
Name And Address Of Agent For Service Of Legal Process	KIMBERLY BUCHANAN CLARK COUNTY, NEVADA 500 S GRAND CENTRAL PKWY / CHIEF DEPUTY DISTRICT ATTORNEY LAS VEGAS NV 89155
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual’s Effective Date and runs through December 31 of the same Benefit Plan Year.
Compliance	It is intended that this Plan comply with all applicable laws. In the event of any conflict between this Plan and the applicable law, the provisions of the applicable law will be deemed controlling, and any conflicting part of this Plan will be deemed superseded to the extent of the conflict.

Discretionary Authority

The Plan Administrator will perform its duties as the Plan Administrator, and in its sole discretion, will determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator will have full and sole discretionary authority to interpret all Plan documents, including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any Plan document and any determination of fact adopted by the Plan Administrator will be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third-Party Administrators for this Plan. Any interpretation, determination, or other action of the Plan Administrator or the Third-Party Administrators will be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third-Party Administrators will be based only on such evidence presented to or considered by the Plan Administrator or the Third-Party Administrators at the time they made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third-Party Administrators make, in their sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

SCHEDULE OF BENEFITS

Benefit Plan 002

Benefits for You and Your Dependents are listed below.

This coverage provides for the use of a Preferred Provider Organization (PPO). Certain benefits are paid at different levels if the service is not provided by a Participating Provider.

SUMMARY OF BENEFITS	PPO PROVIDER (In-Network)	NON-PPO PROVIDER (Out-of-Network)
Co-Pay Per Tooth Or Unit:		No Benefit
• Crowns, Inlays, And Fixed Prosthodontics	$25	
Maximums:	**Individual**	No Benefit
• Calendar Year Benefit Maximum, Including Preventive Services And Diagnostic Services, Basic Services, Major Services, And Orthodontic Services, Dependent Children Only	$2,000	
Participation Percentage	**The Plan Pays**	
• **Preventive Services And Diagnostic Services:**	100%	No Benefit
Routine Cleanings And Fluoride Treatments. Oral Exams And Bitewing And Full-Mouth X-Rays. Refer To Covered Expenses For Any Limitations.		
• **Basic Services:**		No Benefit
Fillings, Endodontics, Periodontics (Scaling And Root Planing Only), Oral Surgery And Crowns. Refer To Covered Expenses For Any Limitations.	100%	
Periodontics (Except Scaling And Root Planing). Refer To Covered Expenses For Any Limitations.	80%	
• **Major Services:**	100%	No Benefit
Inlays, Onlays And Bridges, Dentures. Refer To Covered Expenses For Any Limitations.		
• **Orthodontic Services:**	80%	No Benefit
Orthodontic Diagnosis, Treatment, And Appliances. Refer To Covered Expenses For Any Limitations.		
Limitations And Exclusions:		
Refer To General Exclusions.	Not Payable	Not Payable

OUT-OF-POCKET EXPENSES AND MAXIMUMS

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or Usual and Customary amounts, as applicable.

ADDITIONAL OUT-OF-POCKET EXPENSES

In addition to the Deductible, if applicable, and Plan Participation percentage, the Covered Person is also responsible for the following costs:

- Co-pays.
- Any remaining charges due to the provider after the Plan's benefits are determined.
- Full charges for services that are not covered benefits under this Plan.
- Penalties, legal fees, and interest charged by a provider.
- The difference between the provider's contracted fee for the service that was actually provided and the fee for the alternate benefit that the Plan approved.

  For example, if the provider placed a resin (white) filling in Your tooth, but an amalgam (silver) filling would have been sufficient to restore the tooth, You will need to pay the difference between the cost of the resin filling and the cost of the amalgam filling.

INDIVIDUAL CALENDAR YEAR MAXIMUM BENEFIT

All Covered Expenses will count toward the Covered Person's individual dental Calendar Year Maximum Benefit that is shown on the Schedule of Benefits, as applicable.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses may not be waived by a provider under any "fee forgiveness," "not out-of-pocket," or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person's claim may be denied, and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. From time to time, the Plan may request documentation from You or Your Dependents in order to make determinations for continuing eligibility. The coverage choices that will be offered to You will be the same choices offered to other, similarly situated Employees.

WAITING PERIOD (Applies to All Other Employees)

If eligible, You must complete a Waiting Period before coverage becomes effective for You and Your Dependents. A Waiting Period is a period of time that must pass before an Employee or Dependent becomes eligible for coverage under the terms of this Plan.

You are eligible for coverage on the date listed below under the Effective Date section, upon completion of 15 calendar days of continuous employment (not to exceed 45 days) in a benefit eligible position.

The start of Your Waiting Period is the first full day of employment for the job that made You eligible for coverage under this Plan.

ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full-time 30 or more hours per week, and participants meeting the below criteria are also benefit eligible:

- Elected Officials: Individuals who are elected to county office shall be considered Employees for purposes of this Plan during the term of their elected position.
- 20-hour benefited positions at UMC (University Medical Center).

But for purposes of this Plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion:

- Leased Employees.
- Independent Contractors as defined in this Plan.
- Consultants who are paid on other than a regular wage or salary basis by the employer.
- Members of the employer's Board of Directors, owners, partners, unless engaged in the conduct of the business on a full-time, regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, which may be combined with the employer's short-term disability policy, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. Employees who meet eligibility requirements during a measurement period as required by the Affordable Care Act (ACA) regulations will be deemed to have met the eligibility requirements for the corresponding coverage period as required by the ACA regulations. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a Third-Party, whether by a court, governmental agency, or otherwise, without regard to whether or not the employer agrees to such reclassification, will change a person's eligibility for benefits.

An eligible Employee who is covered under this Plan and who retires under the employer's formal retirement plan will be eligible to continue participating in the Plan upon retirement, provided the individual continues to make the required contribution. See the Coordination of Benefits section for more information on how this Plan coordinates with Medicare coverage. Retirees may continue coverage under this Plan until death, non-payment of premium, or if they no longer meet the eligibility requirements, whichever occurs first. A surviving Spouse of a Retired Employee is eligible to remain on the plan until death or non-payment of premium provided such spouse was covered under the Plan at the time of the Retired Employee's death.

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

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

Retiree Reinstatement

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

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

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

Retiree / Dependent Reinstatement Enrollment:

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

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

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

Note: Eligible Employees and Dependents who decline to enroll in this Plan must state so in writing. In order to preserve potential special enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or health insurance policy. Proof of such plan or policy may be required upon application for special enrollment. See the Special Enrollment Provision section of this Plan.

An **eligible Dependent** includes:

- Your legal spouse, provided he or she is not covered as an Employee under this Plan. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator. An Employee's spouse who is not a United States Citizen is not eligible for coverage, unless the individual is a lawful resident actively seeking permanent residency in the United States.

- Your Domestic Partner, as long as he or she meets the definition of Domestic Partner as stated in the Glossary of Terms, and the person is not covered as an Employee under this Plan. When a person no longer meets the definition of Domestic Partner, that person no longer qualifies as Your Dependent. Anyone enrolled as a domestic partner on 12/31/2021 is considered grandfathered into the future (until noticed otherwise). NEW domestic partnerships post on 1/1/2022 will not be eligible for coverage.

- A Dependent Child until the Child reaches his or her 26th birthday. The term "**Child**" includes the following Dependents:

  - A natural biological Child;
  - A stepchild;
  - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state, or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;

  A Child under Your (or Your spouse's) Legal Guardianship as ordered by a court. A Child of a Domestic Partner or a Child under Your Domestic Partner's Legal Guardianship. Employee must provide more than 50 percent of the child's support:;

  - A Child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO);
  - A natural child of the covered grandfathered Domestic Partner.

- A Dependent does not include the following:

  - A foster Child;
  - A Child of a Domestic Partner or a Child under Your Domestic Partner's Legal Guardianship;
  - A grandchild;
  - A Domestic Partner;
  - A Dependent Child if the Child is covered as a Dependent of another Employee at this company;
  - Any other relative or individual unless explicitly covered by this Plan;
  - The child of a surviving spouse.

Note: An Employee must be covered under this Plan in order for Dependents to qualify for and obtain coverage. The Plan Administrator, at the administrator's discretion, may require documentation such as certified marriage certificates, grandfathered domestic partner registrations, divorce decrees, social security identification, tax returns, certified birth certificates, adoption decrees, or copies of certified court orders.

Eligibility Criteria: To be an eligible Totally Disabled Dependent Child, a Totally Disabled Dependent Child aged 26 or over must be dependent upon the Employee for more than 50 percent of his or her support and maintenance. This financial requirement does not apply to Children who are enrolled in accordance with a Qualified Medical Child Support Order because of the Employee's divorce or separation decree.

NON-DUPLICATION OF COVERAGE: Any person who is covered as an eligible Employee will not also be considered an eligible Dependent under this Plan.

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have an obligation to notify the Plan should the Dependent's eligibility status change during the Plan Year. Please notify Your Health Benefits Department regarding status changes.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
- The Dependent Child is a Dependent of an Employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a special enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 31 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of a Totally Disabled Dependent, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Continuation of Coverage section in this document.

Employees have the right to choose which eligible Dependents are covered under the Plan.

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of the following dates:

- If You apply within Your Waiting Period, Your coverage will become effective the first day of the month following the date You complete Your Waiting Period. If Your Waiting Period ends on the first day of the month, Your coverage will not begin until the first day of the following month; or **(Applies to All Other Employees)**

- If You are an Elected Official, You and Your eligible Dependents will be covered under this Plan effective on the date You take the oath of office, so long as You comply with the Plan's Enrollment Requirements within 31 days of the date the oath of office is taken; or **(Applies to Elected Officials)**

- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 60 calendar days of the event for marriage, birth or adoption and within 31 calendar days in the case of a loss of coverage.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of the following dates:

- The date Your coverage under the Plan begins if You enroll the Dependent at that time; or

- The date You acquire Your Dependent if application is made within 60 calendar days of acquiring the Dependent for marriage, birth or adoption and within 31 calendar days in the case of a loss of coverage; or

- The date set forth under the Special Enrollment Provision if Your Dependent is eligible to enroll under the Special Enrollment Provision and application is made within 60 calendar days following the event for marriage, birth or adoption and within 31 calendar days in the case of a loss of coverage; or

- The date specified in a Qualified Medical Child Support Order or the date the Plan Administrator determines that the order is a QMCSO.

Some Employers provide Employee and Dependent coverage on a non-contributory basis and do not require Employees to contribute a share of the cost of coverage. Other Employers share the cost of Employee and Dependent coverage under this Plan with the covered Employee. The level of any Employee contributions is set by the Plan Administrator, subject to the provisions of any applicable collective bargaining agreement. The Plan Administrator reserves the right to change the level of Employee contributions, also subject to the provisions of any applicable collective bargaining agreement.

ANNUAL OPEN ENROLLMENT PERIOD

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Covered Employees and covered Retirees will be able to make changes in coverage for themselves and their eligible Dependents.

(Applies to All Other Employees) Coverage Waiting Periods are waived during the annual open enrollment period for covered Employees, covered Retirees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

If You and/or Your Dependent becomes covered under this Plan as a result of electing coverage during the annual open enrollment period, the following will apply:

- The employer will notify eligible Employees prior to the start of an annual open enrollment period; and

- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and

- The Effective Date of coverage will be January 1 following the annual open enrollment period.

SPECIAL ENROLLMENT PROVISION

LOSS OF DENTAL COVERAGE

If You or Your Dependents lose other dental insurance or group dental coverage and are otherwise eligible under this Plan, and did not enroll when first eligible because You or Your Dependents had other dental coverage, then You or Your Dependents may enroll for dental coverage under this Plan if You meet the following conditions:

- You or Your Dependents were covered under a group dental plan or dental insurance policy at the time coverage under this Plan was first offered; and
- You or Your Dependents stated in writing that You declined coverage due to coverage under another group dental plan or dental insurance policy; and
- The coverage under the other group dental plan or dental insurance policy was:
  - Under a federal COBRA continuation provision and that coverage was exhausted; or
  - Under another type of coverage and that coverage terminated as a result of:
    - Loss of eligibility for the coverage due to legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment; or
    - The current or former employer no longer contributing toward the coverage; and
  - Not terminated due to the person's failure to pay timely premiums or for cause, such as making a fraudulent claim or an intentional misrepresentation of material fact.

You or Your Dependent must apply for coverage under this Plan no later than 60 calendar days following the event for marriage, birth or adoption and within 31 calendar days in the case of a loss of coverage after the date the other coverage ended.

You and/or Your Dependents were covered under a Medicaid plan or state child health plan and coverage for You or Your Dependents was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

NEWLY ELIGIBLE FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

A current Employee and his or her Dependents may be eligible for a special enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependents are determined to be eligible for such assistance.

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries, and other eligible persons have special opportunities to enroll for coverage under this Plan if they experience changes in family status.

If a person becomes an eligible Dependent through marriage, attestation of a grandfathered Domestic Partnership, birth, adoption, or Placement for Adoption, the Employee, spouse, and newly acquired Dependent(s) who are not already enrolled may enroll for health coverage under this Plan during a special enrollment period. The Employee must request and apply for coverage within 60 calendar days of the marriage, attestation of a grandfathered Domestic Partnership, birth, adoption, or Placement for Adoption, and within 31 calendar days in the case of a loss of coverage.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective as follows:

- In the case of marriage, on the first day of the month following the date the completed request for enrollment and supporting documentation is received by the Plan (note that eligible individuals must submit their enrollment forms prior to the Effective Dates of coverage in order for salary reductions to have preferred tax treatment from the date coverage begins); or

- In the case of a Dependent's birth, on the date of such birth. Newborn children will automatically be covered for the first 31 days following birth. Coverage will cease beginning with the 32nd day unless the newborn child has been affirmatively enrolled as a Dependent in the plan; or

- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or

- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the first day of the month following the date the completed request for enrollment and supporting documentation is received by the Plan; or

- In the case of loss of coverage, the first day of the month following the date the completed request for enrollment and supporting documentation is received by the Plan.

RELATION TO SECTION 125 CAFETERIA PLAN

This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Please refer to the employer's Section 125 Cafeteria Plan for more information.

TERMINATION

For information about continuing coverage, refer to the COBRA Continuation of Coverage section of this SPD.

EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment or at annual open enrollment periods; or
- The end of the stability period in which You became a member of a non-covered class, as determined by the employer except as follows:
    - If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave for up to the end of the six (6) calendar month period that next follows the month in which the person last worked as an Active Employee, provided the applicable Employee contribution is paid when due. Any Employee on authorized leave without pay, who fails to make premium payments as required by the Employer, will have coverage under the Group Plan terminated on the first date for which no premium payments have been paid.
    - If You are temporarily absent from work due to disability leave, the date the Employer ends the continuance.
    - If You are temporarily absent from work as a furloughed Employee, the Plan Administrator may extend Plan coverage to Employees who have been furloughed by a participating entity as a result of a decline in the economy or workload. The responsible entity shall continue to remit the full cost of the premium to the Plan for the period of time the member is furloughed. A member is eligible for continued coverage for a period not to exceed 24-months as a result of his/her furlough status. A member is considered in furlough status when he/she is in an continuous unpaid status for a specified period.
    - If You are temporarily absent from work due to active military duty, refer to USERRA under the Uniformed Services Employment and Reemployment Rights Act of 1994 section; or
- The last day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other fraudulent act related to this Plan or any other group plan.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or

  The last day of the month in which Your coverage ends; or

- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state in which You reside; or

- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility and Enrollment section; or

- If Your Dependent Child qualifies for extended Dependent coverage because he or she is Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or

- The last day of the month in which Your Dependent Child no longer satisfies a required eligibility criterion listed in the Eligibility and Enrollment Section; or

- The date Dependent coverage is no longer offered under this Plan; or

- The last day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of a change in status, because of special enrollment or at annual open enrollment periods; or

- The last day of the month in which the Dependent becomes covered as an Employee under this Plan; or

- The date You or Your Dependent submits a false claim or is involved in any fraudulent act related to this Plan or any other group plan.

EXTENSION OF BENEFITS

If coverage terminates for a Covered Person while receiving treatment for which benefits would have been paid had coverage remained in effect, dental benefits will be extended to cover dental care received within 31 days after the date of termination. This excludes orthodontia.

COBRA CONTINUATION OF COVERAGE

NOTE: UMR (the claims administrator) does not administer the benefits or services described within this provision. Please contact the benefit manager or Your employer with any questions related to this coverage or service.

Important: Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your family, and what You and Your Dependents need to do to protect the right to receive it. When You become eligible for COBRA, You may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This summary provides a general notice of a Covered Person's rights under COBRA but is not intended to satisfy all the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You or Your Dependents as required.

You may have other options available to You when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, You may qualify for lower costs on Your monthly premiums and lower out-of-pocket costs. Additionally, You may qualify for a 30-day special enrollment period for another group health plan for which You are eligible (such as a spouse's plan), even if that plan generally does not accept Late Enrollees.

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries (defined below), the right to continue their health care benefits (including dental benefits) beyond the date that they might otherwise lose coverage. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event (outlined below). When a Qualifying Event causes (or will cause) a Loss of Coverage, the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered spouse, and Your Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage, even if You or Your Dependent is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

If You are an Employee, You will become a Qualified Beneficiary if You lose coverage under the Plan because either one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• Your employment ends for any reason other than Your gross misconduct	up to 18 months
• Your hours of employment are reduced	up to 18 months

(There are two ways in which this 18-month period of COBRA continuation coverage may be extended. See the section below entitled "The Right to Extend the Length of COBRA Continuation Coverage" for more information.)

The spouse of an Employee will become a Qualified Beneficiary if he or she loses coverage under the Plan because any one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• The Employee dies	up to 36 months
• The Employee's hours of employment are reduced	up to 18 months
• The Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
• The Employee and spouse become divorced or legally separated	up to 36 months

The Dependent Children of an Employee will become Qualified Beneficiaries if they lose coverage under the Plan because any one of the following Qualifying Events happens:

Qualifying Event	Length of Continuation
• The parent-Employee dies	up to 36 months
• The parent-Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The parent-Employee's hours of employment are reduced	up to 18 months
• The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
• The parents become divorced or legally separated	up to 36 months
• The Child loses eligibility for coverage under the Plan as a Dependent	up to 36 months

Note: A spouse or a Dependent Child newly acquired through birth or adoption during a period of continuation coverage is eligible to be enrolled as a Dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A Dependent other than a newborn or newly adopted Child, who is acquired and enrolled after the original Qualifying Event is not eligible as a Qualified Beneficiary if a subsequent Qualifying Event occurs.

COBRA NOTICE PROCEDURES

THE NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

In order to be eligible to receive COBRA continuation coverage, covered Employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Employee and spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrator, whether to Your employer or to the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information (a form for notifying the COBRA Administrator is available upon request):

- The Qualified Beneficiary's name, current address, and complete phone number,
- The group number and the name of the Employee's employer,
- A description of the Qualifying Event (i.e., the life event experienced), and
- The date the Qualifying Event occurred or will occur.

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes to the addresses of family members. Keep copies of all notices You send to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your employer will give notice to the COBRA Administrator when coverage terminates due to the Employee's termination of employment or reduction in hours, the death of the Employee, or the Employee's becoming entitled to Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days of when one of these events occurs.

EMPLOYEE OBLIGATIONS TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of divorce or legal separation of the Employee and a spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar-day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would be a Loss of Coverage) due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, the covered Employee, or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE GROUP DENTAL COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that should be completed in order to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing or via the online portal, if available, in order to continue group health coverage and must make the required payments when due in order to remain covered. If online election is available, You will receive instructions for online election when Your election notice is provided. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end on the day of the Qualifying Event.

PAYMENT OF CLAIMS AND DATE COVERAGE BEGINS

No claims will be paid under this Plan for services the Qualified Beneficiary receives on or after the date coverage is lost due to a Qualifying Event. If, however, the Qualified Beneficiary has not completed a waiver and decides to elect COBRA continuation coverage within the 60-day election period, group dental coverage will be reinstated retroactively to the date coverage was lost, provided the Qualified Beneficiary makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives the completed COBRA election form and required payment.

If a Qualified Beneficiary previously waived COBRA coverage but revokes that waiver within the 60-day election period, coverage will not be retroactive to the date of the Qualifying Event but instead will become effective on the date the waiver is revoked.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and Employee contributions. This cost may also include a 2% additional fee to cover administrative expenses (or, in the case of the 11-month extension due to disability, a 50% additional fee). The cost of continuation coverage is subject to change at least once per year.

If Your employer offers annual open enrollment opportunities for active Employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope or, if online election is available, the date Your election is submitted electronically. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage. However, the Qualified Beneficiary will receive specific payment information, including due dates, when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA Administrator receives a check that is missing information or contains discrepancies regarding the information on the check (e.g., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary with information regarding what needs to be done to correct the mistake.

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

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, written notice to the COBRA Administrator is required within 30 calendar days of the date any one of the following events occurs:

- The Qualified Beneficiary marries. Refer to the Special Enrollment Provision section of this SPD for additional information regarding special enrollment rights.

- A Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment Provision section of this SPD for additional information regarding special enrollment rights.

- A final determination is made by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.

- Any Qualified Beneficiary becomes covered by another group dental plan.

Additionally, if the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information in the timeframe outlined in the request document.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- For Employees and Dependents: 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent Children will be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)

- For Dependents only: 36 months from the Qualifying Event if coverage is lost due to one of the following events:

  - The Employee's death.
  - The Employee's divorce or legal separation.
  - The former Employee's enrollment in Medicare.
  - A Dependent Child's loss of eligibility as a Dependent as defined by the Plan.

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided written notice is given to the COBRA Administrator as soon as possible, but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA, in the event that the Social Security Administration determines the Qualified Beneficiary to be disabled either before becoming eligible for, or within the first 60 days of being covered by, COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the Qualified Beneficiary has non-disabled family members who are also Qualified Beneficiaries, those non-disabled family members are also entitled to the disability extension.

The Qualified Beneficiary must give the COBRA Administrator a copy of the Social Security Administration letter of disability determination before the end of the initial 18-month period and within 60 days of the later of:

- The date of the Social Security Administration disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the original Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA.

If the Social Security Administration determines the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Events (Dependents Only): If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family who are Qualified Beneficiaries may receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent Children who are Qualified Beneficiaries if the Employee or former Employee dies, becomes entitled to Medicare (Part A, Part B, or both) or is divorced or legally separated, or if the Dependent Child loses eligibility under the Plan as a Dependent. This extension is available only if the Qualified Beneficiaries were covered under the Plan prior to the original Qualifying Event or in the case of a newborn Child being added as a result of a HIPAA special enrollment right. Dependents acquired during COBRA continuation (other than newborns and newly adopted Children) are not eligible to continue coverage as the result of a subsequent Qualifying Event. These events will lead to the extension only when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first Qualifying Event not occurred.

You or Your Dependents must provide the notice of a second Qualifying Event to the COBRA Administrator within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

COVERAGE OPTIONS OTHER THAN COBRA CONTINUATION COVERAGE

There may be other coverage options for You and Your family through the Health Insurance Marketplace, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), or other group health plan coverage (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

In general, if You do not enroll in Medicare Part A or B when You are first eligible because You are still employed, after the Medicare initial enrollment period You have an eight-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of (a) the month after Your employment ends, or (b) the month after group health plan coverage based on current employment ends.

If You do not enroll in Medicare and elect COBRA continuation coverage instead, You may have to pay a Part B late enrollment penalty and You may have a gap in coverage if You decide You want Part B later. If You elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate Your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if You enroll in the other part of Medicare after the date of the election of COBRA coverage. If You are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (as the primary payer) and COBRA continuation coverage will pay second. For more information visit https://www.medicare.gov/medicare-and-you.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group dental plan for any Employees. (Note that if the employer terminates the group dental plan under which the Qualified Beneficiary is covered, but still maintains another group dental plan for other, similarly situated Employees, the Qualified Beneficiary will be offered COBRA continuation coverage under the remaining group dental plan, although benefits and costs may not be the same.)

- The required contribution for the Qualified Beneficiary's coverage is not paid within the timeframe expressed in the COBRA regulations.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled in Medicare.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan.

- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.

- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE

If COBRA continuation coverage is elected, the continuation coverage must be maintained (by paying the cost of the coverage) for the duration of the COBRA continuation period. If the continuation coverage is not exhausted and maintained for the duration of the COBRA continuation period, the Qualified Beneficiary will lose his or her special enrollment rights. It is important to note that losing HIPAA special enrollment rights may have adverse effects for the Qualified Beneficiary since it will make it difficult to obtain coverage, whether group health coverage or insurance coverage through the individual market or the exchange. After COBRA continuation coverage is exhausted, the Qualified Beneficiary will have the option of electing other group health coverage or insurance coverage through the individual market or the exchange, in accordance with his or her HIPAA special enrollment rights.

DEFINITIONS

Qualified Beneficiary means a person covered by this group dental Plan immediately before a Qualifying Event. A Qualified Beneficiary may be an Employee, the spouse of a covered Employee, or the Dependent Child of a covered Employee. This includes a Child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the Child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted Children. This also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered Employee.
- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).
- A reduction in work hours of the covered Employee.
- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.)
- The covered former Employee becomes enrolled in Medicare.
- A Dependent Child no longer qualifies as a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before a Qualifying Event. Loss of Coverage includes a change in coverage terms, a change in plans, termination of coverage, partial Loss of Coverage, an increase in Employee cost, and other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after a Qualifying Event but must always occur within the applicable 18- or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA rights.

CONTINUED COVERAGE FOR DOMESTIC PARTNERS

Domestic Partners do not qualify as Qualified Beneficiaries under federal COBRA law. Therefore, under federal law, a Domestic Partner does not have the right to elect COBRA independently and separately from an eligible Employee.

However, this Plan allows Domestic Partners to elect to continue coverage under a "COBRA-like" extension, separately and independently of eligible Employees, subject to the same terms and conditions that are outlined for Qualified Beneficiaries under COBRA, when a Qualifying Event occurs.

IF YOU HAVE QUESTIONS

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

The Plan Administrator:
CLARK COUNTY, NEVADA
500 S GRAND CENTRAL PKWY
LAS VEGAS NV 89155

The COBRA Administrator

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in a loss of coverage. Employees on leave for military service must be treated as if they are on leaves of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leaves of absence or furloughs. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable comparable leave benefits must apply to Employees on military leave. Reinstatement following a military leave of absence may not be subject to Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) is the lesser of:

- 24 months beginning on the day that the uniformed service leave begins, or
- A period beginning on the day that the service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if giving notice is otherwise impossible or unreasonable under the circumstances.

Upon notice of intent to leave for uniformed service, Employees will be given the opportunity to elect USERRA continuation. Dependents do not have an independent right to elect USERRA coverage. Election of, payment for, and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Continuation of Coverage section, to the extent the COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. For periods of 31 days or longer, if an Employee elects to continue dental coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENTLY

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who choose to independently elect extended coverage will be deemed eligible for the COBRA extension only because they are not eligible for a separate, independent right of election under USERRA.

PROVIDER NETWORK

The word **"Network"** means an organization that has contracted with various providers to provide dental care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the Negotiated Rates as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Plan Participation amounts, or other out-of-pocket expenses. The allowable charges used in the calculation of the payable benefit to participating providers will be determined by the Negotiated Rates in the network contract. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing to which Network a provider belongs will help a Covered Person determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons should receive services from in-network providers; however, this Plan does not limit a Covered Person's right to choose his or her own provider of dental care at his or her own expense if a dental expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion.

To find out to which Network a provider belongs, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

The preferred provider organization is Sierra Dental.

PROVIDER DIRECTORY INFORMATION

Each covered Employee, COBRA participant, and Child or guardian of a Child who is considered an alternate recipient under a Qualified Medical Child Support Order will automatically be given or electronically provided a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in his or her household. If a covered spouse or Dependent wants a separate provider list, he or she may make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

Information on participating providers can also be accessed at the following website:

www.umr.com

ALTERNATE BENEFITS PROVISION

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

For example, if a regular amalgam (silver) filling is sufficient to restore a tooth, but the patient and the Dentist decide to use a resin (white) filling, the Plan will base its payment on the Usual and Customary charge or the maximum fee schedule for the amalgam filling. The patient will be responsible for paying the difference in cost.

PRE-TREATMENT ESTIMATE OF BENEFITS

One of the advantages of this dental Plan is that it enables a Covered Person to see the amount payable by the Plan prior to having the Dentist begin any extensive treatment. Through this process, Covered Persons can prevent any misunderstandings as to what is covered by the Plan. A Covered Person can accurately estimate what he or she will owe the Dentist. This procedure is known as "Pre-Treatment Estimate of Benefits." Here is how the process works:

Usually, before beginning any extensive treatment, the Covered Person will be advised as to what the Dentist intends to do. This plan of action is referred to as the Treatment Plan. The Dentist will submit the Treatment Plan to UMR prior to performing the services. UMR will then notify the Covered Person and the Dentist, in advance, regarding what benefits are payable under this Plan, and how much the Covered Person will be responsible for paying.

Obtaining a Pre-Treatment Estimate of Benefits is recommended. This feature is not mandatory; however, dental care can be expensive. A Covered Person may want to have an idea of how much this Plan will pay before agreeing to have the treatment performed.

Note: The Pre-Treatment Estimate of Benefits is not a guarantee of payment and is valid for 12 months after the notice date. Benefits are payable if coverage is in effect on the date the services are performed (subject to all Plan provisions) and if the claim is submitted to the Plan within the timely filing period. If additional procedures are performed, the claim will be reviewed in its entirety.

COVERED EXPENSES

The Plan will pay for the following Covered Expenses Incurred by a Covered Person, subject to any Deductibles, Plan Participation amounts, maximums, or limits shown on the Schedule of Benefits, and to all other provisions as stated in this SPD. Benefits are based on the Usual and Customary charge, fee schedule, or Negotiated Rate. Any procedure that is not specifically listed as covered is excluded.

General Overview:

This Plan provides dental benefits under several categories of dental services. Within each category, there are a number of subcategories of covered services.

PREVENTIVE SERVICES

- Cleanings (routine prophylaxis) - limited to two per calendar year.
- Topical fluoride treatments. A cleaning performed with a fluoride treatment is a separate dental service.
- Space maintainers - fixed appliances to maintain a space created by the premature loss of a primary tooth or teeth.

DIAGNOSTIC SERVICES

- Oral exams - limited to two per calendar year.
- Full-mouth X-rays - limited to one per calendar year, unless necessary due to an Injury, combined with panoramic / panorex X-rays and bitewing X-rays.
- Panoramic / panorex X-rays - limited to one per calendar year, unless necessary due to an Injury, combined with full-mouth X-rays and bitewing X-rays.
- Bitewing X-rays - limited to one per calendar year, combined with full-mouth X-rays and panoramic / panorex X-rays.
- Ancillary - emergency oral exams and palliative treatment for relief of dental pain.
- X-rays – all other dental X-rays when Medically Necessary as part of the treatment of a Covered Expense.

BASIC SERVICES

An alternate benefit may apply to specific services. Refer to the Alternate Benefits section in this SPD for more details.

- Restorative fillings – amalgam, silicate, acrylic, synthetic porcelain, and composite fillings.
- Preformed stainless steel crowns – limited to Dependent Children with deciduous primary teeth only.
- Endodontics – root canal treatments, root canal fillings, pulp vitality tests, and other related procedures.
- Periodontics – debridement and exams, and other related procedures necessary to treat a disease of the supporting tissues of the teeth. Periodontal splinting is not a covered expense.

- Periodontal maintenance.
- Oral surgery – extractions and other oral surgery including preoperative and postoperative care.
- Crowns.
- Local anesthesia when Medically Necessary.
- General anesthesia – when administered by a Dentist due to oral or dental surgery when Medically Necessary.
- Rebase procedures for denture or bridges -limited to two per calendar year. Not covered during the first six months after initial placement.
- Reline procedures for dentures or bridges - limited to two per calendar year. Not covered during the first six months after initial placement.

Limitations for Basic Services

Reline procedures for dentures or bridges are not covered until You have been covered under the Plan for 12 consecutive months.

MAJOR SERVICES

An alternate benefit may apply to specific services. Refer to the Alternate Benefits section in this SPD for more details.

The alternate benefit of a filling may be applied if there is not enough evidence to support major decay or traumatic Injury.

If two or more teeth are missing in the same arch or two or more bridges are being performed in the same arch, an alternate benefit of a partial denture may be applied.

- Inlays or onlays.
- Installation of removable or fixed bridgework.
- Installation of partial and complete dentures, including six-month post-installation care.

Limitations for Major Restorative Services

Major services are not covered until You have been covered under the Plan for 12 consecutive months.

Replacement of a bridge or denture will be covered only if the appliance was installed at least five years prior to its replacement. This provision will not apply if:

- Replacement is Medically Necessary due to the placement of an initial opposing full denture;
- Replacement is Medically Necessary due to the extraction of additional natural teeth. Such extraction must leave the bridge or partial denture unserviceable;
- The bridge or denture is damaged beyond repair while in the oral cavity. The Injury must occur while You are covered under this Plan; or
- The existing denture is a temporary denture, placed while You were covered under this Plan. Replacement by a permanent denture must be required and performed within 12 months of the date the temporary denture was placed.

Expenses Incurred for prosthodontic services performed on teeth other than permanent teeth are not covered.

Expenses Incurred at any time to replace a bridge or denture that meets, or can be made to meet, commonly held dental standards of functional acceptability are not covered.

The initial installation of a bridge or denture, replacing natural teeth that were extracted prior to Your effective date, is not covered. Such installation will be covered if Medically Necessary due to the loss or extraction of additional natural teeth after Your effective date.

ORTHODONTIC BENEFITS PROVISION

The Plan will pay Covered Expenses for Orthodontic Procedures. This benefit is subject to Medical Necessity and all other Plan provisions.

DEPENDENT CHILD LIMITATION

This provision applies only to an eligible Dependent Child who is from age 8 to 19 on the date the Orthodontic Procedure begins. This provision does not apply to You or Your spouse. Benefits will terminate under this provision for a Dependent Child on the date such Child turns age 19.

ORTHODONTIC PROCEDURE

Orthodontic Procedure means movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth. Orthodontic Procedure includes minor treatment to control harmful habits and diagnostic services (casts, consultations, exams, X-rays, and related photos taken by the Dentist).

ORTHODONTIC TREATMENT PLAN

The Treatment Plan is a Dentist's report, on a form satisfactory to the Plan, that:

- Provides a classification of the malocclusion;
- Recommends and describes necessary treatment by Orthodontic Procedures;
- Estimates the duration over which treatment will be completed;
- Estimates the total charge for such treatment; and
- Is accompanied by cephalometric X-rays, study models, and such other supporting evidence as the Plan may reasonably require.

COVERED ORTHODONTIC EXPENSES

In order to be payable, orthodontic treatment must be needed for one or more of the following conditions:

- Overbite or overjet of at least four millimeters; or
- Upper and lower arches in either protrusive or retrusive relation of at least one cusp; or
- Cross-bite; or
- An arch length difference of more than four millimeters in either the upper or lower arch.

Orthodontic services are not covered until You have been covered under the Plan for 12 consecutive months.

ADDITIONAL PROVISION

This provision will not apply to any charges for an Orthodontic Procedure if the active orthodontic appliance is placed before the Covered Person is eligible for benefits under this provision. A 12-month Waiting Period applies.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) applies whenever a Covered Person has dental coverage under more than one Plan, as defined below. It does not, however, apply to prescription benefits. The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules determine which plan will pay first (i.e., which is the Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim and will reduce the benefits it pays so that the total payment between the Primary Plan and the Secondary Plan does not exceed the Covered Expenses Incurred. Up to total of 100% of charges Incurred may be paid between the plans.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group dental plans, whether insured or self-insured.
- Group health plans, whether insured or self-insured.
- Foreign policies.
- Medical coverage related to dental care under group or individual automobile policies (including no-fault policies). See the order of benefit determination rules (below).
- Medicare or other governmental benefits, as permitted by law, not including Medicaid.

However, this Plan does not coordinate benefits with individual health or dental plans.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan. If a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an allowable expense and a benefit paid.

When this Plan is secondary, and when not in conflict with a network contract requiring otherwise, covered charges will not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's contracted amount and the provider's regular billed charge.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule that will apply:

- The plan that has no coordination of benefits provision is considered primary.

- When medical payments related to dental care are available under motor vehicle insurance (including no-fault policies), this Plan will always be considered secondary regardless of the individual's election under Personal Injury Protection (PIP) coverage with the auto carrier.

- If an individual is covered under one plan as a dependent and another plan as an employee, member, or subscriber, the plan that covers the person as an employee, member, or subscriber (that is, other than as a dependent) is considered primary. This does not apply to COBRA participants. See continuation coverage below. The Primary Plan must pay benefits without regard to the possibility that another plan may cover some expenses. This Plan will deem any Employee plan beneficiary to be eligible for primary benefits from his or her employer's benefit plan.

- The plan that covers a person as a dependent is generally secondary. The plan that covers a person as a dependent is primary only when both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a dependent. See continuation coverage below.

- If an individual is covered under a spouse's plan and also under his or her parent's plan, the Primary Plan is the plan that has covered the person for the longer period of time. In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parent's plans, the plan of the parent or spouse whose birthday falls earlier in the calendar year is the Primary Plan. If the parents and/or spouse have the same birthday, the plan that has covered the parent or spouse for the longer period of time is the Primary Plan.

- If one or more plans cover the same person as a dependent child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide dental care coverage.

    If both parents have the same birthday, the plan that has covered either of the parents the longest is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the child's dental care expenses or dental care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years starting after the plan is given notice of the court decree.

  - If the parents are not married and reside separately, or are divorced or legally separated (whether or not they have ever been married), the order of benefits is:

    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the non-custodial parent; and then
    - The plan of the spouse of the non-custodial parent.

- Active or Inactive Employee: If an individual is covered under one plan as an active employee (or dependent of an active employee) and is also covered under another plan as a retired or laid-off employee (or dependent of a retired or laid-off employee), the plan that covers the person as an active employee (or dependent of an active employee) will be primary. This rule does not apply if the rule in the third paragraph (above) can determine the order of benefits. If the other plan does not have this rule, this rule is ignored.

- Continuation Coverage Under COBRA or State Law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a dependent. If the two plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if one of the first four bullets above applies.

- Longer or Shorter Length of Coverage: The plan that has covered the person as an employee, member, subscriber, or retiree the longest is primary.

- If an active employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active employee, member, or subscriber is considered primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses may be shared equally between the plans. This Plan will not pay more than it would have paid had it been primary.

TRICARE

If an eligible Employee is on active military duty, TRICARE is the only coverage available to that Employee. Benefits are not coordinated with the Employee's dental insurance plan.

In all instances where an eligible Employee is also a TRICARE beneficiary, TRICARE will pay secondary to this employer-provided Plan.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about dental care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. However, if the Plan needs assistance in obtaining the necessary information, each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD-PARTY ORGANIZATION

A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as if it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than the Plan should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid, or from any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, REIMBURSEMENT AND OFFSET

The Plan has a right to subrogation and reimbursement. References to “You” or “Your” in this Right of Subrogation, Reimbursement, and Offset section include You, Your estate, Your heirs, Your representative(s), Your Dependents, and Your beneficiaries unless otherwise stated.

Subrogation applies when the Plan has paid benefits on Your behalf for an Illness or Injury for which any Third-Party is allegedly responsible. The right to subrogation means that the Plan is substituted to and will succeed to any and all legal claims that You may be entitled to pursue against any Third-Party for the benefits that the Plan has paid that are related to the Illness or Injury for which any Third-Party is considered responsible.

The right to reimbursement means that if it is alleged that any Third-Party caused or is responsible for an Illness or Injury for which You receive a settlement, judgment, or other recovery from any Third-Party, You must use those proceeds to fully return to the Plan 100% of any benefits You receive. The right of reimbursement will apply to any benefits received at any time until the rights are extinguished, resolved, or waived in writing.

The following persons and entities are considered third parties:

- A person or entity alleged to have caused You to suffer an Illness, Injury, or damages, or who is legally responsible for the Illness, Injury, or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Illness, Injury, or damages.
- The Plan Sponsor in a Workers’ Compensation case or other matter alleging liability.
- Any person or entity who is or may be obligated to provide benefits or payments to You, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners’, or otherwise), Workers' Compensation coverage, other insurance carriers, or Third-Party administrators.
- Any person or entity against whom You may have any claim for professional and/or legal malpractice arising out of or connected to an Illness or Injury You allege or could have alleged were the responsibility of any Third-Party.
- Any person or entity that is liable for payment to You on any equitable or legal theory.

You agree as follows:

- You will cooperate with the Plan in protecting the Plan’s legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:
  - Notifying the Plan, in writing, of any potential legal claim(s) You may have against any Third-Party for acts that caused benefits to be paid or become payable.
  - Providing any relevant information requested by the Plan.
  - Signing and/or delivering such documents as the Plan or our agents reasonably request to secure the subrogation and reimbursement claim.
  - Responding to requests for information about any accident or Injuries.
  - Making court appearances.
  - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
  - Complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate or deny future benefits, take legal action against You, and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any Third-Party to the extent not recovered by the Plan due to You or Your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect Third-Party settlement funds held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against any Third-Party before You receive payment from that Third-Party. Further, our first priority right to payment is superior to any and all claims, debts, or liens asserted by any medical providers, including, but not limited to, Hospitals or Emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible Third-Party and/or insurance carrier.

- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to You, no matter how those proceeds are allocated, captioned, characterized, or classified, and regardless of the theory of recovery. Payments include, but are not limited to, economic, non-economic, pecuniary, consortium, punitive, bad faith, and any other alleged damages. The Plan is not required to help You to pursue Your claim for damages or personal Injuries and no amount of associated costs, including attorneys' fees, will be deducted from our recovery without the Plan's express written consent. No so-called "fund doctrine" or "common-fund doctrine" or "attorney's fund doctrine" will defeat this right.

- Regardless of whether You have been fully compensated or made whole, the Plan may collect from You the proceeds of any full or partial recovery that You or Your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "made-whole doctrine" or "make-whole doctrine," claim of unjust enrichment, nor any other equitable limitation will limit our subrogation and reimbursement rights.

- Benefits paid by the Plan may also be considered to be benefits advanced.

- If You receive any payment from any party allegedly arising out of Illness or Injury and the Plan alleges some or all of those funds are due and owed to the Plan, You and/or Your representative will hold those funds in trust, either in a separate bank account in Your name or in Your representative's trust account.

- By participating in and accepting benefits from the Plan, You agree that:

  - Any amounts recovered by You from any Third-Party constitute Plan assets (to the extent of the amount of Plan benefits provided on behalf of the Covered Person);
  - You and Your representative will be fiduciaries of the Plan with respect to such amounts; and
  - You will be liable for and agree to pay any costs and fees (including reasonable attorneys' fees) Incurred by the Plan to enforce its reimbursement rights.

- The Plan's rights to recovery will not be reduced due to Your own alleged negligence.

- By participating in and accepting benefits from the Plan, You agree to assign to the Plan any benefits, claims, or rights of recovery You have under any automobile policy (including no-fault benefits, Personal Injury Protection benefits, and/or medical payment benefits), under other coverage, or against any Third-Party, to the full extent of the benefits the Plan has paid for the Illness or Injury. By agreeing to provide this assignment in exchange for participating in and accepting benefits, You acknowledge and recognize the Plan's right to assert, pursue, and recover on any such claim, whether or not You choose to pursue the claim, and You agree to this assignment voluntarily.

- Upon the Plan's request, You will assign to the Plan all rights of recovery against third parties, to the extent of the Covered Expenses the Plan has paid for the Illness or Injury.

- The Plan may, at its option, take necessary and appropriate action to preserve the Plan's rights under these provisions, including, but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative, or other Third-Party; and filing suit in Your name or Your estate's name, which does not obligate the Plan in any way to pay You part of any recovery the Plan might obtain.

- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

- In the case of Your death, giving rise to any wrongful death or survival claim, the provisions of this section apply to Your estate, the personal representative of Your estate, and Your heirs or beneficiaries. In the case of Your death, the Plan's right of reimbursement and right of subrogation will apply if a claim can be brought on behalf of You or Your estate that can include a claim for past medical expenses or damages. The obligation to reimburse the Plan is not extinguished by a release of claims or settlement agreement of any kind.

- No allocation of damages, settlement funds, or any other recovery by You or any other person or party will be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

- The provisions of this section apply to a Dependent Child wo allegedly incurs an Illness or Injury caused by a third party and to the parents, guardian, or other representative of that Dependent Child. If a parent or guardian brings a claim for damages arising out of a minor's Illness or Injury, the terms of this subrogation and reimbursement clause will apply to that claim.

- If any Third-Party causes or is alleged to have caused You to suffer an Illness or Injury while You are covered under this Plan, the provisions of this section continue to apply, even after You are no longer covered.

- In the event that You do not abide by the terms of the Plan pertaining to reimbursement, the Plan may terminate benefits to You, Your Dependents, or the subscriber; deny future benefits; take legal action against You; and/or set off from any future benefits the value of benefits the Plan has paid relating to any Illness or Injury alleged to have been caused or caused by any Third-Party to the extent not recovered by the Plan due to Your failure to abide by the terms of the Plan. If the Plan incurs attorneys' fees and costs in order to collect from third party recoveries held by You or Your representative, the Plan has the right to recover those fees and costs from You. You will also be required to pay interest on any amounts You hold that should have been returned to the Plan.

- The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

- In the case of occupational Illness or Injury, the Plan's recovery rights will apply to all sums recovered, regardless of whether the Illness or Injury is deemed compensable under any Workers' Compensation or other coverage. Any award or compromise Workers' Compensation settlement, including any lump-sum settlement, will be deemed to include the Plan's interest and the Plan will be reimbursed in first priority from any such award or settlement.

GENERAL EXCLUSIONS

The Plan does not pay for expenses Incurred for the following, even if deemed to be Medically Necessary, unless otherwise stated below. The Plan does not apply exclusions to treatment listed in this SPD as covered dental benefits based upon the source of the Injury when the Plan has information that the Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

1. **Acts of War:** Illness or Injury caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

2. **Appointments Missed:** Appointments the Covered Person did not attend.

3. **Athletic Mouth Guards.**

4. **Before Effective Date and After Termination:** Services, supplies, or expenses Incurred before coverage begins or after coverage ends under this Plan.

5. **Congenital:** Care of a congenital or developmental malformation, including congenitally missing teeth.

6. **Cosmetic:** Services or treatment for cosmetic purposes as determined by the Plan, including, but not limited to bleaching. This exclusion does not apply to Accidental Dental Injury or to orthodontic services.

7. **Denture Duplication.**

8. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical or dental reports and itemized bills.

9. **Excess Charges:** Charges or the portion thereof that are in excess of the Usual and Customary charge, the Negotiated Rate, or the fee schedule.

10. **Experimental or Investigational, or Unproven:** Services, supplies, medicines, treatment, facilities, or equipment that the Plan determines are Experimental, Investigational, or Unproven, including administrative services associated with Experimental, Investigational, or Unproven treatment.

11. **Fractures:** Treatment of fractures not including teeth or alveolar processes.

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

13. **Implants** and related services.

14. **Initial Installation of a Complete or Partial Denture,** fixed bridgework, if treatment involves replacing one or more natural teeth missing or lost prior to the date the Covered Person became covered under this Plan.

15. **Interest and Legal Fees.**

16. **Medications,** whether prescription or over the counter, other than those administered while in the Dentist's office as part of treatment.

17. **Military:** A military-related Illness of or Injury to a Covered Person on active military duty, unless payment is legally required.

18. **Multiple Surgical and Periodontal Procedures** in the same area. Benefits will be limited to the most extensive and inclusive procedure.

19. **Myofunctional Therapy.**

20. **Not Medically Necessary:** Services, supplies, treatment, facilities, or equipment that the Plan determines are not Medically Necessary.

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

22. **Orthodontic Services,** unless covered elsewhere in this document.

23. **Orthognathic Surgery,** unless covered elsewhere in this document.

24. **Preventive Control Programs** including oral hygiene instruction; plaque control; dietary planning; lab tests; anaerobic culture, except in connection with periodontal disease; sensitivity testing; and bite registrations.

25. **Professionally Recognized Standards:** Procedures that are not necessary and that do not meet professionally recognized standards of care.

26. **Programs** for oral hygiene or plaque control.

27. **Replacement** of lost, missing, or stolen appliances regardless of any other provision of this Plan.

28. **Services At No Charge or Cost:** Services for which the Covered Person would not be obligated to pay in the absence of this Plan or that are available to the Covered Person at no cost, or for which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense Code, or as required by law.

29. **Services Not Furnished By a Dentist or Dental Hygienist** who is acting under a Dentist's supervision and direction, except for X-rays ordered by a Dentist.

30. **Services Provided By a Close Relative.** See the Glossary of Terms section of this SPD for a definition of "Close Relative."

31. **Splints** unless necessary as the result of an Accidental Injury.

32. **Supplies** for plaque control or oral hygiene that can be purchased over the counter.

33. **Treatment** for the purpose of altering vertical dimension, restoring occlusion, splinting, or replacing tooth structure lost as a result of abrasion, attrition, or erosion, unless covered elsewhere in this document.

34. **Treatment of Disturbances** of the temporomandibular joint, craniomandibular dysfunctions, myofascial pain syndrome, or any other disorder of the joint linking the jaw to the skull and the associated muscles. This exclusion also pertains to temporomandibular joint radiographs.

Benefits not specifically included in the Covered Expenses section of this document are considered excluded.

CLAIMS AND APPEAL PROCEDURES

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures are designed to ensure and verify that claim determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals.

PERSONAL REPRESENTATIVE

Personal Representative means a person (or provider) who may contact the Plan on the Covered Person's behalf to help with claims, appeals, or other benefit issues. A minor Dependent must have the signature of a parent or Legal Guardian in order to appoint a Third-Party as a Personal Representative.

If a Covered Person chooses to use a Personal Representative, the Covered Person must submit proper documentation to the Plan stating the following: the name of the Personal Representative, the date and duration of the appointment, and any other pertinent information. In addition, the Covered Person must agree to grant his or her Personal Representative access to his or her Protected Health Information. The Covered Person should contact the Claims Administrator to obtain the proper forms. All forms must be signed by the Covered Person in order to be considered official.

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will accept assignment and coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not accept assignment or coordinate payment directly with the Plan, the Covered Person will need to send the claim to the Plan within the timelines outlined below in order to receive reimbursement. The address for submitting medical claims is on the back of the group dental identification card.

A Covered Person who receives services in a country other than the United States is responsible for ensuring the provider is paid. If the provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse the Covered Person for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if the paid date is not known.

A complete claim must be submitted in writing and should include the following information:

- Covered Person's/patient's ID number, name, sex, date of birth, address, and relationship to Employee
- Authorized signature from the Covered Person
- Diagnosis
- Date of service
- Place of service
- Procedures, services, or supplies (narrative description)
- Charges for each listed service
- Number of days or units
- Patient's account number (if applicable)
- Total billed charges
- Provider's billing name, address, and telephone number
- Provider's Taxpayer Identification Number (TIN)
- Signature of provider
- Billing provider
- Any information on other insurance (if applicable)
- Whether the patient's condition is related to employment, an auto accident, or another accident (if applicable)
- Assignment of benefits (if applicable)

TIMELY FILING

Covered Persons are responsible for ensuring that complete claims are submitted to the Third-Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. If Medicare or Medicaid paid as primary in error, the timely filing requirement may be increased to three years from the date of service. A Veteran's Administration hospital has six years from the date of service to submit the claim. A complete claim means that the Plan has all the information that is necessary in order to process the claim. Claims received after the timely filing period will not be allowed.

HOW DENTAL BENEFITS ARE CALCULATED

When UMR receives a claim for a service that has been provided to a Covered Person, it will determine if the service is a covered benefit under this group dental Plan. If the service is not a covered benefit, the claim will be denied, and the Covered Person will be responsible for paying the provider for these costs. If the service is a covered benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for covered benefits are paid according to the billed charges, a Negotiated Rate, or based on the Usual and Customary amounts minus any Deductible, Plan Participation rate, Co-pay, or penalties that the Covered Person is responsible for paying.

Negotiated Rate: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service. The Negotiated Rate is what the Plan will pay to the provider, minus any Deductible, Plan Participation rate, or penalties that the Covered Person is responsible for paying. If a network contract is in place, the network contract determines the Plan's Negotiated Rate.

(Applies to Benefit Plan(s) 001) Usual And Customary (U&C) is the amount that the Plan determines for reimbursement to dental care providers in the same geographical area (or greater area, if necessary) for the same services, treatment or materials. As it relates to charges made by a network provider, the term "Usual and Customary" means the Negotiated Rate as contractually agreed to by the provider and network (see above)..Covered Persons may be responsible for amounts over which the Plan determines to be the Usual and Customary amounts.

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-covered benefits, penalties, or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears to be correct. If You have any questions or concerns about the EOB form, call the Plan at the number listed on the EOB form or on the back of the group dental identification card. The provider will receive a similar form for each claim that is submitted.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

UMR will process claims within the following timelines, although a Covered Person may voluntarily extend these timelines:

Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan may have an additional 15-day extension when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims may be denied for any of the following reasons:

- Termination of Your employment.
- A Covered Person's loss of eligibility for coverage under the dental Plan.
- Charges are Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- A Covered Person reached the Maximum Benefit under this Plan.
- Amendment of the group dental Plan.
- Termination of the group dental Plan.
- The Employee, Dependent, or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a covered benefit under this Plan.
- Services are not considered Medically Necessary.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- The Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations, or penalties.
- Application of the Usual and Customary fee limits, the fee schedule, or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Procedures are considered Experimental, Investigational, or Unproven.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

If a claim is being denied, in whole or in part, and the Covered Person will owe any amount to the provider, the Covered Person will receive an initial claim denial notice, usually referred to as an Explanation of Benefits (EOB) form, within the timelines described above. The EOB form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person may take to submit the claim for appeal (review).

If an internal rule or guideline was relied upon, or if the denial was based on Medical Necessity or Experimental, Investigational, or Unproven treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that were relied upon, and such information will be provided free of charge.

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim, the Covered Person or his or her Personal Representative may request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before taking any outside legal action.

- The Covered Person must file the appeal within 180 days of the date he or she received the EOB form from the Plan showing that the claim was denied. The Plan will assume the Covered Person received the EOB form seven days after the Plan mailed the EOB form.
- The Covered Person or his or her Personal Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- The Covered Person may submit written comments, documents, records, and other information related to the claim to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records, and other information submitted that relates to the claim. This will include comments, documents, records, and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based, in whole or in part, on a dental judgment, the Plan will consult with a dental care professional with training and experience in the relevant dental field. This dental care professional may not have been involved in the original denial decision and may not be supervised by the dental care professional who was involved. If the Plan has consulted with dental or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- A Covered Person who is not satisfied with the decision following the first appeal has the right to appeal the denial a second time.
- The Covered Person or his or her Personal Representative must submit a written request for a second review within 30 calendar days following the date he or she received the Plan's decision regarding the first appeal. The Plan will assume the Covered Person received the determination letter regarding the first appeal seven days after the Plan sent the determination letter.
- The Covered Person may submit written comments, documents, records, and other pertinent information to explain why he or she believes the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- The Covered Person has the right to submit evidence that his or her claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The second review will take into account all comments, documents, records, and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal and are not under the supervision of those individuals.

- If the benefit denial was based, in whole or in part, on a dental judgment, the Plan will consult with a dental care professional with training and experience in the relevant dental field. This dental care professional may not have been involved in the original denial decision or first appeal and may not be supervised by the dental care professional who was involved. If the Plan has consulted with dental or vocational experts in connection with the claim, these experts will be identified upon the Covered Person's request, regardless of whether or not the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting him or her know if the claim is being approved or denied. The notification will provide the Covered Person with the information outlined under the "Adverse Benefit Determination" section above.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no effect on his or her rights to any other benefits under the Plan. If You have any questions regarding the voluntary level of appeal, including applicable rules, a Covered Person's right to representation (i.e., to appoint a Personal Representative), or other details, please contact the Plan.

Appeals should be sent within the prescribed time period as stated above to the following address(es).

Note: Appeal Request forms are available at www.umr.com to assist You in providing all the recommended information to ensure a full and fair review of Your Adverse Benefit Determination. You are not required to use this form.

Send dental appeals to:
UMR
CLAIMS APPEAL UNIT
PO BOX 30546
SALT LAKE CITY UT 84130-0546

TIME PERIODS FOR MAKING DECISIONS ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide such evidence to You free of charge and sufficiently in advance of the due date of the response to the Adverse Benefit Determination. If such evidence is received at a point in the process where the Plan is unable to provide You with a reasonable opportunity to respond prior to the end of the period stated below, the time period will be tolled to allow You a reasonable opportunity to respond to the new or additional evidence.

URGENT CLAIM APPEALS THAT REQUIRE IMMEDIATE ACTION

A request by a Covered Person or his or her authorized representative for the review and reconsideration of coverage that requires notification or approval prior to receiving medical care may be considered an urgent claim appeal. Urgent claim appeals must meet one or both of the following criteria in order to be considered urgent in nature:

- A delay in treatment could seriously jeopardize life or health or the ability to regain maximum functionality.
- In the opinion of a Physician with knowledge of the medical condition, a delay in treatment could cause severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

UMR must respond to the urgent claim appeal request as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receiving the request for review.

The timelines below will apply only to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

Post-Service Claims: Within a reasonable period of time, but no later than 60 calendar days after the Plan receives the request for review.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person's coverage should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the Plan Sponsor determines the payment to the Covered Person, or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Fraud is a crime for which an individual may be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete, or misleading information with intent to injure, defraud, or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that You receive (e.g., COBRA notices). A few examples of events that require Plan notification are divorce, a Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA. (Please note that the examples listed are not all-inclusive.)

These actions will result in denial of the Covered Person's claim or in termination of the Covered Person's coverage under the Plan and are subject to prosecution and punishment to the full extent under state and/or federal law.

Each Covered Person must:

- File accurate claims. If someone else, such as the Covered Person's spouse or another family member, files claims on the Covered Person's behalf, the Covered Person should review the claim form before signing it;
- Review the Explanation of Benefits (EOB) form. The Covered Person should make certain that benefits have been paid correctly based on his or her knowledge of the expenses Incurred, and the services rendered;
- Never allow another person to seek dental treatment under his or her identity. If the Covered Person's Plan identification card is lost, the Covered Person should report the loss to the Plan immediately;
- Provide complete and accurate information on claim forms and any other forms. He or she should answer all questions to the best of his or her knowledge; and
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

In order to maintain the integrity of this Plan, each Covered Person is encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline at 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under the Family and Medical Leave Act of 1993 (FMLA), his or her employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided the following conditions are met:

- Contributions are paid; and
- The Employee has a written, approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the FMLA and any amendment; or
- The leave period required by applicable state law.

An Employee may choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken. For more information, please contact Your Human Resources or Personnel office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree, or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy, at no charge, of the written procedures that the Plan uses when administering Qualified Medical Child Support Orders.

This group dental Plan also complies with the provisions of the TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.

HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care, and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan will Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care, or Health Care Operations.

The Plan Sponsor will Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care, or Health Care Operations that it performs on behalf of this Plan.

This Plan agrees that it will Disclose a Covered Person's PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will Use and Disclose a Covered Person's PHI (including Electronic PHI) only for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;

- The Plan Sponsor will promptly report to this Plan any breach, or impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any breach or security incident with respect to Electronic PHI of which the Plan Sponsor becomes aware;

- The Plan Sponsor and the Plan will not Use genetic information for underwriting purposes. For example, underwriting purposes will include determining eligibility, coverage, or payment under the Plan, with the exception of determining medical appropriateness of a treatment;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Each Covered Person has the right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books, and records related to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of Plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

The following Employees, classes of Employees, or other workforce members under the control of the Plan Sponsor may be given access to a Covered Person's PHI for Plan Administrative Functions that the Plan Sponsor performs on behalf of the Plan as set forth in this section:

Clark County Risk Management

This list includes every Employee, class of Employees, or other workforce members under the control of the Plan Sponsor who may receive a Covered Person's PHI. If any of these Employees or workforce members Use or Disclose a Covered Person's PHI in violation of the terms set forth in this section, the Employees or workforce members will be subject to disciplinary action and sanctions, including the possibility of termination of employment. If the Plan Sponsor becomes aware of any such violation, the Plan Sponsor will promptly report the violation to this Plan and will cooperate with the Plan to correct the violation, to impose the appropriate sanctions, and to mitigate any harmful effects to the Covered Person.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy, and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a person to whom the CE Discloses Protected Health Information (PHI) so that a person may carry out, assist with the performance of, or perform a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third-Party Administrators, health care clearinghouses, data processing firms, billing firms, and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse, or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Person's PHI. This includes medical or dental records, billing records, enrollment records, Payment records, claims adjudication records, and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of six years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities related to the renewal of a contract for insurance;
- Conducting or arranging for medical (or dental) review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management, and care coordination;
- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk related to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present, or future physical or mental health condition of a Covered Person, the provision of health care, or the past, present, or future Payment for the provision of health care; and
- Identifies the Covered Person, or there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan, including quality assurance, claims processing, auditing, and monitoring.

Plan Sponsor means Your employer.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic, or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management, and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend, or amend this Plan at any time, in whole or in part, including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. No agent or representative of this Plan will have the authority to legally change the Plan terms or SPD or waive any of its provisions, either purposefully or inadvertently. If a misstatement affects the existence of coverage, the relevant facts will be used in determining whether coverage is in force under the terms of this Plan and in what amount. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material reduction of benefits to the Plan, or may, alternatively, furnish such notification through communications maintained by the Plan Sponsor or Plan Administrator at regular intervals of no greater than 90 days.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination. All claims Incurred prior to termination, but not submitted to either the Plan Sponsor or the Third-Party Administrator within 75 days of the Effective Date of termination of this Plan due to bankruptcy, will be excluded from any benefit consideration.

The Plan will assume that the Covered Person receives the written amendment or termination letter from the Plan Administrator seven days after the letter is mailed to the Covered Person.

No person will become entitled to any vested rights under this Plan.

DISTRIBUTION OF ASSETS UPON TERMINATION OF PLAN

Contact Your Health Benefits or Personnel office for information regarding distribution of assets upon termination of Plan.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as, a contract of employment between any Covered Person and the employer.

GLOSSARY OF TERMS

Accidental Dental Injury / Injury means damage to the mouth, teeth, and supporting tissues due directly to a blow from outside the mouth.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination, or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Calendar Year Maximum Benefit means the maximum amount of covered benefits payable during a calendar year while a person is covered under this Plan. Once the Calendar Year Maximum Benefit is met, no further covered benefits will be available for the remainder of that calendar year.

Child (Children) means any of the following individuals with respect to an Employee: a natural biological Child; a natural child of the covered grandfathered Domestic Partner; a stepchild; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Employee's or spouse's Legal Guardianship; or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Close Relative means a member of the immediate family. Immediate family includes the Employee, spouse, grandfathered Domestic Partner, mother, father, grandmother, grandfather, stepparents, step-grandparents, siblings, stepsiblings, half-siblings, Children, Children of grandfathered Domestic Partner, stepchildren, and grandchildren.

Co-pay means the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits, if applicable.

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to qualifying events.

Common-Law Marriage means a partnership whereby two adult individuals are considered married because they have lived together for a certain period of time, hold themselves to be married even without a license and a formal ceremony, and meet other applicable requirements of the state in which the Common-Law Marriage was established.

Covered Expenses means any expense, or portion thereof, that is Incurred as a result of receiving a covered benefit under this Plan.

Covered Person means an Employee, Retiree, or Dependent who is enrolled under this Plan.

Deductible means an amount of money paid once per Plan Year by the Covered Person (up to a family limit, if applicable) before any Covered Expenses are paid by the Plan. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the dental care benefits to which it applies.

Dental Hygienist means a person who is licensed to practice dental hygiene and who works under the supervision and direction of a Dentist.

Dentist means a person who is licensed to practice dentistry, and who is practicing within the scope of such license. The term also includes any physician who furnishes any dental services that such physician is licensed to perform.

Dependent – see the Eligibility and Enrollment section of this SPD.

Domestic Partner / Domestic Partnership means an unmarried person of the same sex with whom the covered Employee shares a committed relationship, who is jointly responsible for the other's welfare and financial obligations, who is at least 18 years of age, who is not related by blood, who maintains the same residence, and who is not married to or legally separated from anyone else.

In order for Your Domestic Partner to qualify as a Dependent, You and Your partner must complete a certification declaring that You and Your partner:

- Are in a relationship of mutual support, care, and commitment, and are responsible for each other's welfare;
- Have maintained this relationship for the past six months and intend to do so indefinitely;
- Have shared a primary residence for the past six months and intend to do so indefinitely;
- Are not married to anyone else and do not have other Domestic Partners;
- Are financially interdependent.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as his or her Enrollment Date, as Enrollment Date is defined by the Plan.

Emergency Dental Care means care of a dental condition that is required unexpectedly and immediately because of an Injury or Illness.

Employee – see the Eligibility and Enrollment section of this SPD.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the date that coverage begins. **(Applies to Elected Officials)**
- For anyone who applies for coverage when first eligible, the first day of the Waiting Period. **(Applies to All Other Employees)**
- For anyone who enrolls under the Special Enrollment Provision, or for Late Enrollees, the first day coverage begins.

Experimental, Investigational, or Unproven means any drug, service, supply, care, or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational, or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);
- Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials OR at least one or more large, controlled, national, multi-center, population-based studies;
- Items based on anecdotal and Unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;
- Items that have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care, or treatment is considered Experimental, Investigational, or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™, or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence.

FMLA means the Family and Medical Leave Act of 1993, as amended.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information, among other things.

Illness means a bodily disorder, disease, or physical sickness affecting the mouth, teeth, or gums.

Incurred means the date on which a service or treatment is given, a supply is received, or a facility is used, without regard to when the service, treatment, supply, or facility is billed, charged, or paid.

Independent Contractor means someone who signs an agreement with the employer as an Independent Contractor, or an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer, and who retains control over how work is completed. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor will be made consistent with Section 530 of the Internal Revenue Code.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Legal Guardianship / Legal Guardian means an individual recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Maximum Benefit means the maximum amount or the maximum number of days or treatments that are considered a Covered Expense by the Plan.

Medically Necessary / Medical Necessity means treatment, services, supplies, medicines, or facilities necessary and appropriate for the diagnosis, care, or treatment of an Illness or Injury that meet all of the following criteria as determined by the Plan:

- In accordance with *Generally Accepted Standards of Dental Practice*; and
- The health intervention is for the purpose of treating a dental condition; and
- It is the most appropriate supply or level of service, considering potential benefits and harm to the patient; and
- It is known to be effective in improving dental outcomes. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, and finally by expert opinion; and
- It is cost-effective for a specific condition, compared to alternate interventions, including the option of no intervention. The term "cost-effective" does not necessarily mean for the lowest price; and
- It is not primarily for the convenience or preference of the Covered Person, of the Covered Person's family, or of any provider; and

- It is not Experimental, Investigational, cosmetic, or custodial in nature; and
- It is currently, or at the time the charges were Incurred, recognized as acceptable medical practice by the Plan.

The fact that a Dentist has performed, prescribed, recommended, ordered, or approved a service, Treatment Plan, supply, medicine, equipment, or facility, or the fact that such service is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, Treatment Plan, supply, medicine, equipment, or facility Medically Necessary.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act, as amended.

Negotiated Rate means the amount that providers have contracted to accept as payment in full for Covered Expenses of the Plan.

Pediatric Dental Services means services provided to individuals under the age of 19.

Placed for Adoption / Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means the CLARK COUNTY, NEVADA Group Dental Benefit Plan.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means an employer who sponsors a group dental plan.

QMCSO means a Qualified Medical Child Support Order in accordance with applicable law.

Qualified means licensed, registered, and/or certified in accordance with applicable state law, and the particular service or treatment being provided is within the scope of the license, registration, and/or certification.

Retired Employee / Retiree means a person who was employed full-time by the employer who is no longer regularly at work and who is now retired under the employer's formal retirement program.

Third-Party Administrator (TPA) means a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled means, as determined by the Plan in its sole discretion:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is qualified by education, training, or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in activities of daily living and/or substantial gainful activities that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.

Treatment Plan means the Dentist's report to the Plan that:

- Lists the dental care recommended by the Dentist for the Covered Person; and
- Shows the Dentist's normal fee for each dental procedure; and
- Includes preoperative X-rays and all other diagnostic materials needed by the Plan; and
- Is prepared on a form acceptable to the Plan.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross-section of accurate data.

Waiting Period means the period of time that must pass before coverage becomes effective for an Employee or Dependent who is otherwise eligible to enroll under the terms of this Plan. Refer to the Eligibility and Enrollment section of this Plan to determine if a Waiting Period applies.

You / Your means the Employee.

IN WITNESS WHEREOF, the parties hereto have caused this contract to be signed and intend to be legally bound thereby.

DATE: _____

ATTEST:

BY: _____
LYNN MARIE GOYA, County Clerk

ATTEST:

BY: _____
LYNN MARIE GOYA, County Clerk

ATTEST:

BY: _____
LYNN MARIE GOYA, County Clerk

ATTEST:

BY: _____
BRIAN GULLBRANTS, Vice Chair

ATTEST:

BY: _____
JOHN ENTSMINGER

ATTEST:

BY: _____
DEANNA HUGHES

ATTEST:

BY: _____
ANA DIAZ

COUNTY OF CLARK

BY: _____
TICK SEGERBLOM, Chair
Board of County Commissioners

CLARK COUNTY WATER RECLAMATION DISTRICT

BY: _____
TICK SEGERBLOM, Chair
Board of Trustees

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA
BY: _____
WILLIAM MCCURDY II, Chair
Board of Trustees

LAS VEGAS CONVENTION AND VISITORS AUTHORITY

BY: _____
JAMES B. GIBSON, Chair
Board of Directors

LAS VEGAS VALLEY WATER DISTRICT

BY: _____
MARILYN KIRKPATRICK, President
Board of Directors

CLARK COUNTY REGIONAL FLOOD CONTROL DISTRICT

BY: _____
JUSTIN JONES, Chair
Board of Directors

REGIONAL TRANSPORTATION COMMISSION OF SOUTHERN NEVADA
BY: _____
JUSTIN JONES, Chair
Board of Commissioners

ATTEST:

BY: _____
FERMIN LEGUEN, M.D.
District Health Officer or Designee

ATTEST:

BY: _____
TRUDY CASEY

ATTEST:

BY: _____
LYNN MARIE GOYA, County Clerk

ATTEST:

BY: _____
TANAKA WILSON

ATTEST:

BY: _____
LYNN MARIE GOYA, County Clerk

ATTEST:

BY: _____
STAFF ATTORNEY

APPROVED AS TO FORM:

STEVEN B. WOLFSON, District Attorney

BY: Lisa Logsdon
LISA LOGSDON
County Counsel

SOUTHERN NEVADA HEALTH DISTRICT

BY: _____
MARILYN KIRKPATRICK, Chair
Board of Health

HENDERSON DISTRICT PUBLIC LIBRARIES

BY: _____
ANGELA BROMMEL, Chair
Board of Trustees

MOUNT CHARLESTON FIRE PROTECTION DISTRICT

BY: _____
ROSS MILLER, Chair
Board of Fire Commissioners

LAS VEGAS METROPOLITAN POLICE DEPARTMENT

BY: _____
SHERIFF KEVIN MCMAHILL

MOAPA VALLEY FIRE PROTECTION DISTRICT

BY: _____
MARILYN KIRKPATRICK, Chair
Board of Fire Commissioners

EIGHTH JUDICIAL DISTRICT COURT

BY: _____
STEVEN GRIERSON
Court Executive Officer

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

SELF-FUNDED GROUP MEDICAL AND DENTAL BENEFITS PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

RECOMMENDATION SUMMARY

STAFF: Approve and authorize the Chair to sign the Self-Funded Group Medical and Dental Benefits Preferred Provider Organization (PPO) Plan among Clark County, Clark County Water Reclamation District, University Medical Center of Southern Nevada, Las Vegas Convention and Visitors Authority, Las Vegas Valley Water District, Clark County Regional Flood Control District, Regional Transportation Commission of Southern Nevada, Southern Nevada Health District, Henderson District Public Libraries, Mount Charleston Fire Protection District, Las Vegas Metropolitan Police Department, Moapa Valley Fire Protection District and Eighth Judicial District Court adopting the Self-Funded Group Medical and Dental Benefits EPO Plan, effective January 1, 2025.

TECHNICAL ADVISORY: The Technical Advisory Committee did not hear this item.

CITIZENS ADVISORY: The Citizens Advisory Committee did not hear this item.

RFCD AGENDA
ITEM #14
DATE: 11/14/2024

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT
AGENDA ITEM

SUBJECT:

AMENDMENT TO THE INTERLOCAL AGREEMENT ADOPTING AN AMENDED SELF-FUNDED GROUP MEDICAL AND DENTAL BENEFITS PREFERRED PROVIDER ORGANIZATION (PPO) PLAN

PETITIONER:

STEVEN C. PARRISH, P.E., GENERAL MANAGER/CHIEF ENGINEER

RECOMMENDATION OF PETITIONER:

THAT THE BOARD APPROVE AND AUTHORIZE THE CHAIR TO SIGN AN AMENDMENT TO THE SELF-FUNDED GROUP MEDICAL AND DENTAL BENEFITS PREFERRED PROVIDER ORGANIZATION (PPO) PLAN AMONG CLARK COUNTY, CLARK COUNTY WATER RECLAMATION DISTRICT, UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA, LAS VEGAS CONVENTION AND VISITORS AUTHORITY, LAS VEGAS VALLEY WATER DISTRICT, CLARK COUNTY REGIONAL FLOOD CONTROL DISTRICT, REGIONAL TRANSPORTATION COMMISSION OF SOUTHERN NEVADA, SOUTHERN NEVADA HEALTH DISTRICT, HENDERSON DISTRICT PUBLIC LIBRARIES, MOUNT CHARLESTON FIRE PROTECTION DISTRICT, LAS VEGAS METROPOLITAN POLICE DEPARTMENT, MOAPA VALLEY FIRE PROTECTION DISTRICT AND EIGHTH JUDICIAL DISTRICT COURT ADOPTING AN AMENDED SELF-FUNDED GROUP MEDICAL AND DENTAL BENEFITS PPO PLAN, EFFECTIVE, JANUARY 1, 2025 (FOR POSSIBLE ACTION)

FISCAL IMPACT:
The FY 2024-25 budget includes sufficient funds for the Self-Funded Group Medical and Dental Benefits PPO Plan.

BACKGROUND:

Clark County established a Self-Funded Group Medical and Dental Benefits program in 1984 to provide group medical and dental benefits to the employees of Clark County and affiliated entities. The program consists of a Preferred Provider Organization (PPO) plan and an Exclusive Provider Organization (EPO) plan. Annually, the Plan is put before the Regional Flood Control District Board for approval.

RFCD AGENDA
ITEM # 14
Date: 11/14/2024

Following are the proposed Plan modifications for the upcoming plan year, effective January 1, 2025:

- The clarification of a benefit rule pertaining to the child of a surviving spouse.
- Changing the employee timeframe to provide documents from 90 days to 45 days. This is in alignment with the eligibility timeframe.
- The addition of a $30 specialist copay for University Medical Center of Southern Nevada outpatient clinics.
- The addition of copays for walk-in retail health clinics.
- The addition of copays for hospice care services.
- The removal of the 60-day benefit limitation for inpatient rehabilitation care.
- The removal of a pharmacy benefit for GLP-1-FSA approved weight loss medications(s).
- The addition of genetic testing to the Care Management program (prior authorization process).
- The addition of maximum benefit amounts for Center of Excellence facilities.
- The removal of "no benefit" for residential treatment facilities.
- The addition of a $35 insulin cost to the Employer Group Waiver Plan, which covers Medicare retirees.
- The change from 20 days to 30 days for the Plan Administrator to respond to second level appeals. This is in alignment with the timeframe for first level appeals.

The amended Plan has been discussed with represented members, as required by the governing bargaining agreements. The Clark County Board of County Commissioners approved this item at their October 15, 2024, Board meeting. Staff recommends approval.

Respectfully submitted,

RFCD AGENDA
ITEM # 14
Date: 11/14/2024

Steven C. Parrish, P.E.
General Manager/Chief Engineer

111424 Self Funded-Benefits Plan-PPO item

CLARK COUNTY
SELF-FUNDED GROUP MEDICAL AND DENTAL BENEFITS PLAN

Plan Document
Effective January 1,
~~2024~~2025

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TABLE OF CONTENTS

INTRODUCTION

This Plan Document describes the medical and dental benefits available to Plan Participants who are eligible to participate in the Clark County Self-Funded Group Medical and Dental Benefits Plan, as effective January 1, 20254. Coverage under the Plan will take effect for a Plan Participant when applicable waiting periods are satisfied, and eligibility requirements are met.

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

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

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

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

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

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

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

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

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

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

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

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

ELIGIBILITY PROVISIONS

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

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

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

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

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

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

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

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

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

Special Provisions for Elected Officials

The following provisions shall apply concerning benefits for Elected Officials.

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

Special Provisions for Firefighters Transferring to an M-Plan

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

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

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

Dependent Eligibility

A Dependent is any one of the following persons:

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

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

Guardianship/Legal Custody Children
This coverage is only available to those guardianship/legal custody children who the Employee covered as a dependent on January 1, 2024..

Subject to the foregoing limitation, if a covered Employee or spouse is the court appointed Legal Guardian or has court ordered Legal Custody of a minor child or minor children, these children may be enrolled in this Plan as covered dependents until that minor reaches majority (age eighteen in Nevada) provided the child physically resides with the covered Employee or spouse and is claimed as a dependent on their tax return.

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

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

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

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

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

Ineligible for Dependent Coverage
These persons are excluded as Dependents:

- Individuals living in the covered Employee's home, but who are not eligible as defined;
- The legally separated or divorced/annulled former Spouse of the Employee;
- An Employee's Domestic Partner regardless of gender. Domestic Partners enrolled in the plan prior to January 1, 2018, will remain eligible;
- Parents of any Employee;
- Any person who is on active duty in any military service of any country;
- Any person who is covered or eligible for coverage under the Plan as an Employee;
- An Employee's spouse who is not a United States Citizen, unless the individual is a lawful resident actively seeking permanent residency in the United States; or
- Persons legally present in the United States on a temporary basis, including those on a temporary visa, are not eligible for dependent coverage on the Plan; or
- The child of a surviving spouse (dependent must be enrolled on plan at the time of Guarantors death to be eligible).

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

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

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

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

ENROLLMENT

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

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

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

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

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

Enrollment Requirements for Newborn Children

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

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

Enrollment Requirements for Newly Eligible Dependents

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

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

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

Members shall have ~~90~~ 45 days from the date of the Plan's receipt of the enrollment request, to provide a copy of the certified birth certificate, certified marriage certificate, or other necessary dependent documentation, as required by the Administrator, to verify dependent eligibility.

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

Enrollment Requirements for Dependents who suffer Involuntary Loss of Coverage

In the event an eligible dependent loses other group health insurance coverage involuntarily the employee may enroll such dependent within 31 days of such involuntary loss of coverage. To enroll the dependent, the employee must complete and submit an approved dependent enrollment/change form within 31 days of such loss. Additionally, the employee will be required to submit a copy of verification of such loss from the former employer/plan administrator, and any other applicable documentation (i.e., certified marriage certificate, certified birth certificate, etc.). If the dependent, who suffers involuntary loss of coverage, is not enrolled within 31 days, enrollment may only take place as provided in the Open Enrollment Provisions.

Effective Dates for Special Enrollments

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

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

Medicaid or State Child Health Insurance Plan (SCHIP)

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

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

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

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

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

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

Other Miscellaneous Enrollment Requirements

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

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

Required Documentation for covered Employees and their covered Dependents

Covered Employees who wish to switch medical plans or add an eligible Dependent during annual open enrollment or due to a qualifying event shall have ~~90~~ 45 days from the date of the Plan's receipt of the enrollment request, to provide a copy of the certified birth certificate, certified marriage certificate, other necessary dependent documentation, as required by the Administrator, to verify dependent eligibility. A copy of the Dependent's Social Security card, or proof you have filed for it, is also required.

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

The mid-year Enrollment Period for newly eligible Dependents is a period of 60 days and begins on the date of the marriage, birth, adoption, or placement for adoption. If the Dependent is not enrolled by the end of the 60th day following the event, enrollment can only take place as provided in the annual open enrollment Provisions and will be subject to the Plan's annual open enrollment limitations. Covered Employees shall have ~~90~~ 45 days from the date of the Plan's receipt of the enrollment request, to provide a copy of the certified birth certificate, certified marriage certificate, or other necessary dependent documentation, as required by the Administrator, to verify dependent eligibility.

Timely Enrollment and Notification

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

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

Disenrollment of Ineligible Dependents and Notification of Medicare Entitlement

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

1. Date of death of spouse;
2. Effective date of the dissolution of marriage or final divorce decree;

3. Date of legal separation;
4. Retiree or covered dependent of Retiree that becomes eligible or ineligible for Medicare; or
5. Employee changes family status (i.e., no eligible Dependents, eligible Spouse only, eligible Spouse and Children only, and eligible Children only).
6. Dependent is no longer an eligible dependent as defined by the plan.

Dual Choice of Health Care Benefits

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

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

Effective Date

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

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

Effective Date of Dependent Coverage.

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

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

Open Enrollment Period

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

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

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

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

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

Employees and/or Dependents Enrolling as Late Participants

Employees who have previously waived their group health insurance may elect to enroll during the annual open enrollment period for the following calendar year.

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

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

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

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

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

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

Section 125 Tax Regulations on This Plan

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

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

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

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

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

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

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

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

Changes in Coverage of Spouse or Dependent Under Another Employer's Plan: The Participant may make a coverage election change if the plan of the Participant's Spouse or Dependent: (a) incurs a change such as adding or deleting a benefit option; (b) allows election changes due to Special Enrollment, Change in Status, Court Order or Medicare or Medicaid Eligibility/Entitlement; or (c) this Plan, and the other plan have different periods of Coverage or open enrollment periods.

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

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

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

TERMINATION OF BENEFITS

When Employee Coverage Terminates

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

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

Good Faith Reliance upon Information Provided

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

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

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

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

Rehiring a Terminated Employee

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

When Dependent Coverage Terminates

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

1. The date the Plan is terminated.

2. The date that the Employee's coverage under the Plan terminates for any reason including death. (See the Continuation of Coverage section.)
3. The date Dependent coverage is terminated under the Plan.
4. On the last day of the calendar month that he or she ceases to be a Dependent as defined by the Plan. (See the Continuation of Coverage section.)
5. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
6. The end of the 45-day period following the Administrator's initial request for certified birth certificates, certified marriage certificates or other necessary dependent documentation.

Extension of Benefits

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

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

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

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

Family and Medical Leave Act

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

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

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

Military Leave of Absence

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

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

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

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

CONTINUATION OF COVERAGE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Clark County and/or Affiliates ceases to provide any group health plan to any of its employees;
2. Any required premium for continuation coverage is not paid in a timely manner;
3. A qualified beneficiary first becomes, after the date of COBRA election, covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary other than such an exclusion or limitation which does not apply to or is satisfied by such beneficiary by reason of the Health Insurance Portability and Accountability Act;
4. A qualified beneficiary first becomes, after the date of COBRA election, entitled to Medicare;

5. A qualified beneficiary extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled;
6. A qualified beneficiary notifies The Plan Administrator they wish to cancel continuation coverage.
7. For cause, on the same basis that the plan terminates the coverage of similarly situated non-COBRA participants.

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

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

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

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

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

IF YOU HAVE QUESTIONS

If you have questions about your COBRA coverage, you should contact The COBRA Administrator, or you may contact the Centers for Medicare and Medicaid (CMS) via email at phig@cms.hhs.gov or call toll free at 1-877-267-2323.
You may also visit the COBRA section on the CMS website:
https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/cobra_fact_sheet

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

COORDINATION OF BENEFITS PROVISION

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

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

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

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

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

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

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

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

Order of Benefit Determination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Coordination with Medicare

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

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

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

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

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

How Much This Plan Pays When It is Secondary to Medicare

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

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

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

IMPORTANT HIGHLIGHTS

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

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

(1) MANDATORY PRE-AUTHORIZATION

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

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

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

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

The Clark County Self-Funded Group Medical and Dental Benefits Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers:
https://www.clarkcountynv.gov/government/departments/risk_management/employee_and_retiree_health_benefits.php

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

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

GENERAL PROVISIONS

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

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

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

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

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

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

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

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

Assignment, Reimbursement & Third-Party Recovery

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. **Defined terms:**

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

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

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

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

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

8. **Caveats:**

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

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

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

MEDICAL EXPENSE BENEFIT PROVISION

Verification of Eligibility

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

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

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

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

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

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

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

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

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

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

SCHEDULE OF MEDICAL BENEFITS

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

Benefits and Services	Preferred Network (University Medical Center)	In-Network	Out-of-Network
Hospital Services			
• Inpatient	10% coinsurance *(Deductible not applicable)*	20% coinsurance after $100 co-pay *(Deductible applies)*	40% coinsurance after $750 co-pay *(Deductible applies)*
• Outpatient	10% coinsurance *(Deductible not applicable)*	20% coinsurance after $100 co-pay *(Deductible applies)*	40% coinsurance after $300 co-pay *(Deductible applies)*
	Precertification is required for inpatient treatment.		
Physician Office Visits			
• Primary Care Visit	$10 co-pay *(Deductible not applicable)*	$20 co-pay *(Deductible waived)*	40% coinsurance *(Deductible applies)*
• Specialist Visit	$30 co-pay *(Deductible not applicable* $20 co-pay (UMC Quick Care only) *(Deductible not applicable)*	20% coinsurance *(Deductible waived)*	40% coinsurance *(Deductible applies)*
• Urgent Care		20% coinsurance *(Deductible waived)*	40% coinsurance *(Deductible applies)*
• Walk-in Retail Health Clinic		$20 co-pay *(Deductible waived)*	40% coinsurance *(Deductible applies)*
Acupuncture	N/A	20% coinsurance *(Deductible applies)*	40% coinsurance *(Deductible applies)*
	Limited to 20 visits per calendar year.		
Ambulance Service			
• Ground or Air	N/A	20% coinsurance after $100 co-pay and in-network deductible	
	N/A	20% coinsurance after $100 co-pay and in-network deductible	
• Scheduled Inter-Facility	Deductible and co-pay are waived if patient is admitted. Air ambulance is covered to the nearest facility when treatment of a life-threatening condition is required. Scheduled inter-facility air transport requires precertification and is covered when a higher level of care is medically necessary to treat a life-threatening condition from the level of care available at the patient's current facility.		

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

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

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

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

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

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

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

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

~~Weight Loss GLP-1 FSA approved weight loss medications~~	~~25% coinsurance up to a maximum amount of $250 per prescription.~~ ~~$3,000 per Plan Participant (does not accumulate to the above Prescription Out-of-Pocket Maximum)~~

CARE MANAGEMENT PROGRAM

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

The Case Management program consists of the following:

a. Precertification of the Medical Necessity for the following non-Emergency Services before Medical and/or Surgical services are provided:

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

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

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

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

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

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

Here's how the program works

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

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

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

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

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

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

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

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

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

Concurrent review, discharge planning

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

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

Preadmission Testing Service

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

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

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

Case Management

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

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

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

Case Management occurs in the following situations:

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

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

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

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

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

COVERED MEDICAL EXPENSES

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

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

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

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

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

Autism Spectrum Disorder – Covered charges include medically necessary services that are generally recognized and accepted procedures for screening, diagnosing, and treating Autism Spectrum Disorders. Covered Services must be provided by a duly licensed physician, psychologist, or Behavior Analyst (including an Assistant Behavior Analyst and/or Certified Autism Behavior Interventionist).

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

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

The following terms apply to the coverage for Autism:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If the Center of Excellence facility determines that an on-site evaluation would be beneficial, the Claims Administrator will coordinate the travel and care for the Participant, and a companion caregiver. Travel expenses will be ~~covered at 100% with no annual deductible in accordance with travel policies in effect~~limited to a maximum benefit of $10,000 per transplant. Lodging and meals are limited to $200.00 per day. Travel and Housing at designated transplant facility for pre-transplant evaluation and up to one year from date of transplant.

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

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

- The Participant and designated caregiver must agree to abide by program requirements.
- The Participant must be safe to travel for medical care and must not require emergency care at the time of travel.
- The Center of Excellence at which the Participant will receive services will be determined by the geographical location of residence and indicated service.

- The Participant acknowledges that the Center of Excellence must receive necessary medical records prior to acceptance into the program.

- The Participant must identify the designated caregiver. The caregiver must agree to (and be able to) meet Caregiver requirements.
- The Participant must provide the Center of Excellence physician with contact information for a local physician who has agreed to manage follow-up care after the Participant returns home from the Center of Excellence.
- Centers of Excellence services must be preauthorized by the Claims Administrator of the program in order to be covered under the Plan.

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

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

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

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

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

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

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

Durable Medical Equipment – Rental and fitting of durable basic (i.e., non-luxury) medical equipment (but not to exceed the purchase price) or purchase of such equipment where only purchase is permitted or

where purchase is more cost-effective due to a long-term need for the equipment. Such equipment must be prescribed by a Physician and required for therapeutic use in treatment of an active Illness or Accidental Injury. Durable medical equipment includes such items as braces, crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen and dialysis equipment, seat lifts, TENS, pumps, power operated vehicles, speech generating devices, insulin infusion pump, osteogenesis stimulators, neuromuscular stimulators, etc.

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

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

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

Gene / Cell Therapy – covered for conditions approved by the FDA and in accordance with Plan Prior Authorization and Medical Necessity requirements.

Gender Reassignment – Charges for services related to gender reassignment will be covered in accordance with medical necessity guidelines in accordance with Senate Bill 163 (Nevada 2023). Benefits include pre- and post-surgical hormone therapy. ***A candidate for gender reassignment must be confirmed with gender dysphoria in accordance with clinical guidelines.***

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

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

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

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

<u>Limitations</u>

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

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

- Services of any social worker;
- Transportation services.

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

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

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

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

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

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

Newborns and Mothers' Health Protection Act

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

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

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

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

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

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

Orthotics – Custom molded devices for the feet.

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

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

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

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

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

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

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

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

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

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

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

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

A description of Women's Preventive Services can be found at: https://www.hrsa.gov/womens-guidelines-2019 / or at https://www.healthcare.gov/preventive-care-benefits/.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Speech Therapy – Speech therapy by a qualified speech therapist, other than a close relative, to restore or rehabilitate any speech loss or impairment caused by injury or illness, (except a mental, psychoneurotic or personality disorder) or by surgery for that injury or illness and includes speech therapy undertaken for correction of physical bodily function, i.e., swallowing. Speech therapy undertaken for correction of stuttering is not an eligible charge. In the case of congenital defect, expenses will be considered only if incurred after corrective surgery for the defect. Additional visits subject to review for medical necessity.

Substance Abuse – For Plan purposes substance abuse is physical and/or emotional dependence on drugs, narcotics, alcohol, or other addictive substances to a debilitating degree. It does NOT include tobacco dependence or dependence on ordinary drinks containing caffeine. Psychiatrists (M.D.), psychologists (Ph.D.), counselors (LCSW, LMFT, & LADC), or any other practitioner of the healing arts licensed and regulated by a State or Federal Agency may bill the Plan directly. All licensed mental health providers acting within the scope of their license may bill the plan for covered substance abuse services.

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

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

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

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

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

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

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

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

MEDICAL EXCLUSIONS AND LIMITATIONS

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

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

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

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

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

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

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

- Necessitated by a non-occupational accidental injury, disease, or infection which occurs and is treated while the patient is covered by the Plan.
- Surgery is performed to reconstruct a prior mastectomy, which was medically necessary;
- Necessary to correct a congenital abnormality in a child. Deemed medically necessary and in accordance with clinical guidelines for the treatment of gender dysphoria."

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

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

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

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

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

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

they provide.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Infertility Treatment – Expenses for the promotion of conception including, but not limited to

artificial insemination, in vitro fertilization, GIFT (Gamete Intra Fallopian Transfer), fertility studies, sterility studies, non-surgical procedures, and related treatment. However, charges for testing to determine the diagnosis of infertility are covered.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The amount is based on either:

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

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

Note: Covered health services that use the Recognized Amount to determine Your cost-sharing may be higher or lower than if cost-sharing for these covered health services was determined based upon a Covered Expense.

Relative Providing Services – Charges for treatment or services of physicians, nurses, chiropractors, physiotherapists, or other practitioners, who live in your home and/or if the provider of service is the employee, employee's spouse/grandfathered domestic partner, child, brother, sister, or parent, whether the relationship is by blood or exists in law.

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

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

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

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

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

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

Third Party Liabilities – Any expenses caused by a third party when payment for such expenses

has been paid (or will be paid) by the third party or the third party's insurance company (Please refer to the Coordination of Benefits and Subrogation sections).

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

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

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

PRESCRIPTION DRUG EXPENSE BENEFIT

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

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

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

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

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

Qualifying expenses include:

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

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

Coverage for Injectable Medications

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

Limits To The Prescription Drug Benefit

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

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

No prescription benefits will be paid for charges incurred for:

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

Employer Group Waiver Plan (EGWP)

The Plan Administrator offers a Medicare Employer Group Waiver Plan (EGWP) to Medicare-eligible retirees and Medicare eligible dependents covered under the Plan. The EGWP meets requirements applicable to Medicare Part D and retirees and dependents enrolled in either Medicare Part A or B or Parts A and B will be automatically enrolled in the EGWP upon becoming Medicare-eligible. The Plan Administrator will collect the Medicare premium for Part D drug plan coverage except any additional premium imposed due to exceeding the income threshold as defined by the Social Security Administration. Covered drugs will be subject to the formulary approved by the Centers for Medicare and Medicaid Services. This includes the requirement that you won't pay more than $35 for a one-month supply of each insulin product covered by our plan, no matter what the cost-sharing tier it's on.

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

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

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

Contact the Pharmacy Benefit Manager for more information regarding EGWP.

CLAIMS PROCEDURES FOR SUBMITTING A CLAIM

How To File A Claim

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

Preferred Network and In-Network (PPO) Claims

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

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

To avoid a delay in claims processing, the PPO Provider should be provided with the Plan Participant's ID card listing the current billing instructions for the claim's administrator. If the claim is the result of an accident, please give date, place, and cause of accident, and a completed Accident Detail Form available from the Claims Administrator @ https://www.umr.com

Out-of-Network Claims

When a Plan Participant incurs medical expenses for which it is believed reimbursement is due under the terms of the Plan, the necessary documentation must be filed with the Claims Administrator, UMR, P.O. Box 30541, Salt Lake City, UT 84130-0541 (EDI #39026). Claim forms can be obtained from the Claims Administrator.

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

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

Claim Timely Filing

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

The Claim Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves

the right to have a Plan Participant seek a second medical opinion.

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

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

Claim Overpayments

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

Non-U.S. Providers of Emergency Services

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

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

PROTECTION FROM BALANCE BILLING

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

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

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

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

ALLOWED AMOUNTS

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

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

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

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

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

OUT-OF-NETWORK BENEFITS

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

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

    - The reimbursement rate as determined by a state All Payer Model Agreement. -39- 7670-00-414937, 7670-05-414937
    - The reimbursement rate as determined by state law.
    - The initial payment made by the claim's administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
    - The amount determined by Independent Dispute Resolution (IDR).
    - For the purpose of this provision, the term "certain network facility" is limited to a Hospital, a Hospital Outpatient department, a critical access Hospital, an ambulatory surgical center, and any other facility specified by the Secretary of Health and Human Services.

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

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

- The reimbursement rate as determined by a state All Payer Model Agreement.
- The reimbursement rate as determined by state law.

- The initial payment made by the claim's administrator, or the amount subsequently agreed to by the Out-of-Network provider and the claims administrator.
- The amount determined by Independent Dispute Resolution (IDR).

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

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

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

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

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

How To Appeal A Claim Denial

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

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

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

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

Appeals of Adverse Benefit Determinations Will be Considered as Follows:

1. First Level Appeal – Plan Administrator
   The Plan Participant or the Plan Participant's authorized representative has **180 days** after receipt of an Explanation of Benefits (EOB) to appeal an adverse benefit determination to the Plan Administrator, through the Claims Administrator. The Plan Administrator will make a full and fair review of the claim, with no deference given to the initial determination. As part of the review, the Plan Participant or the Plan Participant's authorized representative are allowed to review all Plan documents and other papers that affect the claim and are allowed to submit issues and comments and argue against the denial in writing. The Plan Administrator will make a determination within ~~20~~ 30 days after receiving a claim appeal.

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

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

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

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

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

Frequently Asked Claims Procedure Questions:

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

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

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

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

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

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

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

Definitions and Rights Relevant to the Appeal Process

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

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

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

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

DENTAL BENEFITS

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

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

A. DEDUCTIBLE

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

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

B. BENEFIT PAYMENT

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

C. MAXIMUM BENEFITAMOUNT

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

D. DENTALCHARGES

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

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

SCHEDULE OF SELF-FUNDED DENTAL BENEFITS

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

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

COVERED DENTAL SERVICES

Class A Services: Preventative and Diagnostic Dental Procedures

Visits & Examinations

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

X-Rays

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

Class B Services: Basic Dental Procedures

Visits & Examinations

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

X-Rays & Pathology

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

Oral Surgery

- Includes local anesthesia and routine postoperative care

Extractions

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

Impacted Teeth

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

Alveolar or Gingival Reconstructions

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

Cysts & Neoplasms

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

Other Surgical Procedures

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

Anesthesia

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

Periodontics

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

Endodontics

Unless otherwise indicated, the limit shown is for one tooth

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

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

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

Restorative Dentistry

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

Amalgam Restorations - Primary Teeth

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

Amalgam Restorations - Permanent Teeth

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

Synthetic Restorations

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

Pins

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

Crowns

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

Full & Partial Denture Repairs

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

Adding Teeth to Partial Denture to Replace Extracted Natural Teeth

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

Recementation

- Inlay
- Crown
- Bridge

Repairs Crowns & Bridges

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

Restorative

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

Inlays

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

Crowns

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

Space Maintainers

- Includes all adjustments within 6 months after installation
- Fixed space maintainer (band type)

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

Class C Services: Major Dental Procedures

Prosthodontics

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

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

Removal Bridge (Unilateral)

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

Dentures and Partial

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

Dental Implants

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

Class D Services: Orthodontic Treatment and Appliances

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

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

1. Orthodontia benefits terminate when a dependent child turns 19.
2. Orthodontia treatment will include preliminary study, including x-ray, diagnostic casts, active treatment and retention appliance.
3. The plan will pay a lifetime maximum of $3,000 per covered dependent child.
4. Orthodontia benefits are subject to Coordination of Benefits provisions

   The benefits for orthodontic charges will be paid as follows:
   $750 - For Banding, or removable, fixed or cemented appliance for tooth guidance
   $125 per month for monthly adjustments

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

PREDETERMINATION OF BENEFITS

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

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

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

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

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

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

ALTERNATE TREATMENT

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

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

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

DENTAL EXCLUSIONS AND LIMITATIONS

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

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

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

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

Extension of Benefits

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

DEFINED TERMS

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

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

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

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

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

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

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

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

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

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

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

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

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

management and repricing; or

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

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

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

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

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

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

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

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

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

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

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

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

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

Effective Date – means January 1, 20255~~4~~. The provisions of the Plan as in effect on the date of service shall remain applicable with respect to Plan Participants on the date of service, and with respect to the Plan coverage available at the time the expenses were incurred.

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

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

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

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

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

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

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

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

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

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

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

tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

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

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

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

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

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

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

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

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

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

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

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

- Is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services;
- Has policies established by a professional group associated with the agency or organization which includes at least one registered graduate nurse (R.N.) to govern the services provided;

- Provides for full-time supervision of such services by a Physician or by a registered graduate nurse;
  Maintains a complete medical record on each patient; and
  Has a full-time administrator.

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

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

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

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

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

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

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

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

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

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

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

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

Initial Stability Period – An Initial Stability Period is a period of time during which an employee will either be considered to be a Full-Time Employee or Non-Full-Time Employee for purposes of eligibility for health benefits.

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

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

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

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

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

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

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

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

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

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

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

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

Medicare Entitlement – Means receiving coverage from Medicare. Normally this is accomplished when an individual who is age 65 signs up for Social Security benefits, which automatically enrolls the individual in the Medicare Program. Medicare coverage also is possible for individuals with kidney (end-stage renal) disease, or for individuals younger than age 65 who Social Security deems disabled, effective on the first day of the 25^{the} month after the date the individual's Social Security disability began. Social Security disability benefits do not begin until the sixth full month of disability.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Retired Employee – A former Employee of an Employer participating in this benefit plan, who has retired from active employment with the Employer, and who is receiving retirement benefits through the Nevada Public Employees Retirement Act (NRS Chapter 286) or the Las Vegas Valley Water District Retirement Plan, and who elects to continue Plan coverage upon retirement consistent with Plan and Nevada Revised Statute requirements or elects to reinstate Plan coverage as allowed by the Nevada Revised Statutes on the date of reinstatement.

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

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

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

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

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

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

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

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

Stability Period – A Stability Period is a period of time during which an employee will either be considered to be a Full-Time Employee or Non-Full-Time Employee for purposes of eligibility for health benefits. If an employee is determined to be Full-Time Employee during the immediately prior Measurement Period, that employee will be considered a Full-Time Employee eligible for health benefits for the

immediately subsequent Stability Period. However, if the employee is determined not to be a Full-Time Employee during the immediately prior Measurement Period, then that employee will be considered a Non-Full-Time Employee who is not eligible for health benefits for the immediately subsequent Stability Period, unless you have a Change in Employment Status that causes you to become eligible for health benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EFFECTIVE DATE: SEPTEMBER 23, 2024

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

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

Who Will Follow This Notice:

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

Our Pledge Regarding Medical Information:

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

We are required by law to:

- Make sure that medical information that identifies you is kept private;
  Provide you this Notice of our legal duties and privacy practices regarding your medical information; and follow the terms of the notice that are currently in effect. We may change the terms of our Notice at any time without advance notice to you. The new Notice will be effective for all medical information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may obtain a copy of the Notice by contact Clark County's HIPAA Compliance Office at (702) 455-3269. The current version of this Notice may also be found on Clark County's website at:https://www.clarkcountynv.gov/government/departments/audit_department/index.php

How We May Use And Disclose Medical Information About You:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe maybe the result of criminal conduct;
- About criminal conduct on County premises; or
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

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

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

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

YOUR RIGHTS

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

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

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

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

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

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

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

example, disclosures to your spouse).

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

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

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

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

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

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

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

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

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

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

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

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

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

the end of this Notice.

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

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

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

CHANGES TO THIS NOTICE

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

COMPLAINTS

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

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

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

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

You may also call (702) 455-3269 for further information about the complaint process.

We will not retaliate against you for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

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

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

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

CONTACTINFORMATION

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

Privacy Officer for the Benefits Administrator

Clark County HIPAA Compliance Program Management Office
P. O. Box 551120
Las Vegas, NV 89155
(702) 455-3269

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

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

RESPONSIBILITIES FOR PLAN ADMINISTRATION

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

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR.

1. To administer the Plan in accordance with its terms.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
3. To decide disputes which may arise relative to a Plan Participant's rights.
4. To prescribe procedures for filing a claim for benefits and to review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a Claims Administrator to pay claims.
7. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

In addition, the Plan Administrator shall have the following duties.

(1) **Contracting.** Contracting and administering all agreements necessary or incidental to the operation of the Group Plan. The agreements which the Plan Administrator is authorized to enter into on behalf of the Group Plan include, but are not limited to, agreements for claims administration, preferred providers, excess and aggregate insurance, and utilization review.

(2) **Trust Fund.** Administration of the expendable trust fund established for the deposit of contributions and the payment of expenses necessary for the operation of the Group Plan. The Plan Administrator's responsibilities regarding the trust fund shall include the collection of payments and contributions to the fund and making payments and transfer from the fund as required to affect the provisions of the Group Plan.

(3) **Executive Board.** The Plan Administrator shall establish an Executive Board not to exceed seven members which shall consist of representatives from management appointed from the governmental agencies participating in the Plan.

The Chief Administrative Officer for the Plan Administrator shall appoint the members of the Board and designate a Chairman and Vice-Chairman who will act in the absence or disability of the Chairman.

The duties of the Executive Board shall include monitoring the financial performance of the Plan including the administration of periodic independent actuarial studies, the evaluation and recommendation of contractors to the Plan Administrator, and the negotiation of Plan changes with the Nevada Service Employees Union subject to the approval of the governing bodies.

The Board shall meet at a mutually agreed upon time at least once every other month and may hold such other meetings as circumstances may require or render desirable for the performance of its function and discharge of its duties and responsibilities.

(4) Group Health Committee. The Plan Administrator shall establish a seven-member committee which shall consist of representatives from both labor and management appointed from the governmental agencies participating in the Plan. Effective January 1, 1990, the committee shall

be increased to nine members. Effective January 1, 1995, the committee shall be increased to ten members. The committee shall meet to resolve disputes and appeals from determinations made by the Claim Administrator and make Plan change recommendations to the Executive Board.

The Clark County Manager or his designee shall appoint the members of the committee and designate a Chairman and a Vice-Chairman who will act in the absence or disability of the Chairman.

The committee shall meet at a regularly appointed time at least once every other month and may hold such other meetings as circumstances may require or render desirable for the performance of its function and the discharge of its duties and responsibilities. A majority of the members shall constitute a quorum for all purposes. Action taken by the committee shall require a majority affirmative vote of the committee members present and voting. The committee will be responsible for Level 2 review of an adverse benefit determination as provided by the Plan Document. The committee may review and consider coverage determinations made by the Claims Administrator, but the committee may not authorize payment for services which are not covered by the Plan, or which are specifically excluded from Plan coverage.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator subject to the provisions of any applicable collective bargaining agreement. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction or withheld from Retiree's pension check.

Benefits are paid directly from the Plan through the Claims Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered. If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

TERMINATION OF THE PLAN

The Plan shall continue in full force and effect unless terminated, modified, altered or amended by the Plan Administrator as provided in this section.

Although the Plan Administrator has established the Plan with the bona fide intention and expectation that it will be able to make contributions indefinitely, nevertheless the County is not and shall not be under any obligation or liability whatsoever to continue its contributions or to maintain the Plan for any given length of time. The Plan Administrator may, in its sole and absolute discretion, on 30 days' notice, discontinue such contributions to terminate the Plan in accordance with its provisions at any time without liability whatsoever for such discontinuance or termination.

In the event that the Plan is terminated, the Plan will, to the extent of funds available, continue to pay all benefits then due and payable to the Covered Individual.

FINAL AUTHORITY OF THE PLAN DOCUMENT

The terms and provisions contained in this Plan Document and Summary Plan Description shall be final and binding upon all Participants. Contradictory benefit information received from any other source will not affect the terms of the Plan as set forth herein. Participants are advised to conclusively rely upon the benefit information provided in this Plan Document and Summary Plan Description only.

APPENDIX A – SPECIALPROVISIONS

SPECIAL PROVISIONS CONCERNING EMPLOYEES OF THE MOUNT CHARLESTON FIRE PROTECTION DISTRICT

The following provisions shall apply concerning benefits for the Employees of the Mount Charleston Fire Protection District and their covered dependents who were covered by the Public Employee's Benefit Plan (PEBP) and who enrolled in the Plan prior to June 1, 2015.

(1) Waiting Period. A Mount Charleston Fire Protection District employee described above and his or her dependents are not required to serve a waiting period.

(2) Effective Date June 1, 2015

SPECIAL PROVISIONS CONCERNING APPOINTED EMPLOYEES AND APPOINTED RETIREES OF THE LAS VEGAS METROPOLITAN POLICE DEPARTMENT (LVMPD)

The following provisions shall apply concerning benefits for Appointed Employees and Appointed Retirees of the Las Vegas Metropolitan Police Department (LVMPD) and their covered dependents, effective January 1, 2016, who were covered by the LVMPD Health and Welfare Trust, or the insurance offered through the Police Protective Associate – Civilian Employees, as of December 31, 2015, or who retired as an appointed employee where the LVMPD was their last Nevada public employer.

(1) Waiting Period. An Appointed LVMPD employee/retiree described above, and his or her dependents are not required to serve a waiting period.

(2) Enrollment. An Appointed LVMPD employee described above, and his or her covered dependents, must satisfy the Plan's requirements concerning eligibility and enrollment.

(3) Effective Date: January 1,2016.

SPECIAL PROVISIONS CONCERNING THE CHIEF OF THE MOAPA VALLEY FIRE PROTECTION DISTRICT

The following provisions shall apply concerning benefits for the Chief of the Moapa Valley Fire Protection District and his or her covered dependent(s).

(1) Waiting Period. Chief of the Moapa Valley Fire Protection District described above and his or her dependent(s) are not required to serve a waiting period.

(2) Effective Date July 21, 2020

SPECIAL PROVISIONS CONCERNING THE RESOLUTION FOR THE VOLUNTARY SEPARATION PROGRAM (VSP) APPROVED BY CLARK COUNTY, UNIVERSITY MEDICAL CENTER, AND WATER RECLAMATION DISTRICT EMPLOYEES:-

The VSP program provides for a total of 24 months coverage window, which consists of a core 18 months of COBRA plus an additional 6 months of continuation (or retiree coverage). The specific requirements for eligibility under this program can be found in the resolution approved by the Clark County Board of County Commissioners (and each respective employer mentioned above) and was limited to those who were approved between May 19, 2020, through August 7, 2020. While this was a voluntary program, the approval process was maintained by the employer and WILL NOT be considered outside the approved resolution.

This Plan Document will be amended from time to time to reflect any such statutory mandates and will be made available to all participants for future reference.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION
The Plan is a self-funded health plan, and the claims administration is provided through a third-party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME Self-Funded Group Medical and Dental Benefits Plan

PLAN EFFECTIVE DATE: January 1, ~~2024~~2025

PLAN YEAR ENDS: December 31st

GOVERNING LAW AND FORUM: The Plan is subject to, and governed by, the laws of the State of Nevada. Any and all claims, legal actions or proceedings relating to this Plan must be brought in the Eighth Judicial District Court of the State of Nevada. The aforementioned choice of forum is mandatory and not permissive in nature.

EMPLOYERINFORMATION
Clark County, Nevada
PO Box 551711
Las Vegas, Nevada 89155-1711
702.455.4544

ADDITIONAL PARTICIPATING EMPLOYERS	
Clark County Water Reclamation District 702.668.8066	University Medical Center of Southern Nevada 702.383.2230
Las Vegas Convention & Visitors Authority 702.892.7527	Las Vegas Valley Water District 702.258.3115
Regional Transportation Commission of Southern Nevada 702.676.1500	Clark County Regional Flood Control District 702.685.0000
Southern Nevada Health District 702.759.1101	Henderson District Public Libraries 702.207.4278
Mt. Charleston Fire Protection District 702.486.5123	Las Vegas Metropolitan Police Department Appointed Employees 702.828.2904
Chief of the Moapa Valley Fire Protection District 702.398-3568	Eighth Judicial District Court 702.671-4561

PLAN ADMINISTRATOR
Clark County, Nevada
PO Box 551711
Las Vegas, Nevada 89155-1711
702.455.4544

CLAIMSADMINISTRATOR
UMR Inc.
115 W. Wausau Ave.
Wausau, WI 54401
800.395.7069

IN WITNESS WHEREOF, the parties hereto have caused this contract to be signed and intend to be legally bound thereby.

DATE: _____

ATTEST:

BY: _____
LYNN MARIE GOYA, County Clerk

ATTEST:

BY: _____
LYNN MARIE GOYA, County Clerk

ATTEST:

BY: _____
LYNN MARIE GOYA, County Clerk

ATTEST:

BY: _____
BRIAN GULLBRANTS, Vice Chair

ATTEST:

BY: _____
JOHN ENTSMINGER

ATTEST:

BY: _____
DEANNA HUGHES

ATTEST:

BY: _____
ANA DIAZ

COUNTY OF CLARK

BY: _____
TICK SEGERBLOM, Chair
Board of County Commissioners

CLARK COUNTY WATER RECLAMATION DISTRICT

BY: _____
TICK SEGERBLOM, Chair
Board of Trustees

UNIVERSITY MEDICAL CENTER OF SOUTHERN NEVADA

BY: _____
WILLIAM MCCURDY II, Chair
Board of Trustees

LAS VEGAS CONVENTION AND VISITORS AUTHORITY

BY: _____
JAMES B. GIBSON, Chair
Board of Directors

LAS VEGAS VALLEY WATER DISTRICT

BY: _____
MARILYN KIRKPATRICK, President
Board of Directors

CLARK COUNTY REGIONAL FLOOD CONTROL DISTRICT

BY: _____
JUSTIN JONES, Chair
Board of Directors

REGIONAL TRANSPORTATION COMMISSION OF SOUTHERN NEVADA

BY: _____
JUSTIN JONES, Chair
Board of Commissioners

ATTEST:

BY: _____
FERMIN LEGUEN, M.D.
District Health Officer or Designee

ATTEST:

BY: _____
TRUDY CASEY

ATTEST:

BY: _____
LYNN MARIE GOYA, County Clerk

ATTEST:

BY: _____
TANAKA WILSON

ATTEST:

BY: _____
LYNN MARIE GOYA, County Clerk

ATTEST:

BY: _____
STAFF ATTORNEY

APPROVED AS TO FORM:

STEVEN B. WOLFSON, District Attorney

BY: Lisa Logsdon
LISA LOGSDON
County Counsel

SOUTHERN NEVADA HEALTH DISTRICT

BY: _____
MARILYN KIRKPATRICK, Chair
Board of Health

HENDERSON DISTRICT PUBLIC LIBRARIES

BY: _____
ANGELA BROMMEL, Chair
Board of Trustees

MOUNT CHARLESTON FIRE PROTECTION DISTRICT

BY: _____
ROSS MILLER, Chair
Board of Fire Commissioners

LAS VEGAS METROPOLITAN POLICE DEPARTMENT

BY: _____
SHERIFF KEVIN MCMAHILL

MOAPA VALLEY FIRE PROTECTION DISTRICT

BY: _____
MARILYN KIRKPATRICK, Chair
Board of Fire Commissioners

EIGHTH JUDICIAL DISTRICT COURT

BY: _____
STEVEN GRIERSON
Court Executive Officer

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

FIRST AMENDMENT TO THE PROFESSIONAL SERVICES AGREEMENT WITH JOSHUA TREE PRODUCTIONS, INC.
TO PROVIDE ADDITIONAL SERVICES FOR "OPEN" AND "CLOSED" CAPTIONING FOR RECORDING AND EDITING OF UP TO SIX FLOOD CHANNEL TELEVISION SHOWS

RECOMMENDATION SUMMARY

STAFF:	Approve
TECHNICAL ADVISORY:	The Technical Advisory Committee did not hear this item.
CITIZENS ADVISORY:	The Citizens Advisory Committee did not hear this item.

RFCD AGENDA
ITEM #15
DATE: 11/14/2024

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

FIRST AMENDMENT TO THE PROFESSIONAL SERVICES AGREEMENT WITH JOSHUA TREE PRODUCTIONS, INC.

PETITIONER:

STEVEN C. PARRISH, P.E., GENERAL MANAGER/CHIEF ENGINEER

RECOMMENDATION OF PETITIONER:

APPROVE AND AUTHORIZE THE CHAIR TO SIGN THE FIRST AMENDMENT TO THE PROFESSIONAL SERVICES AGREEMENT WITH JOSHUA TREE PRODUCTIONS, INC., TO PROVIDE ADDITIONAL SERVICES FOR "OPEN" AND "CLOSED" CAPTIONING FOR RECORDING AND EDITING OF UP TO SIX FLOOD CHANNEL TELEVISION SHOWS (FOR POSSIBLE ACTION)

FISCAL IMPACT: $ 98,530 – Original Agreement
$ 4,800 – First Amendment
$103,330 – Total Agreement

BACKGROUND:

On August 8, 2024 the District Board of Directors approved a Professional Services Agreement with Joshua Tree Productions, Inc., to provide recording and editing of The Flood Channel television program that airs on government access cable stations. The agreement will include up to five shows focusing on the construction of flood control projects, flood safety, and stormwater quality. The remaining show will combine segments from the previous year as a "Best Of" episode. This agreement is from August 8, 2024, through June 30, 2025.

The First Amendment to the Professional Services Agreement will provide additional services which contain "Open" and "Closed" captioning.

Joshua Tree Productions, Inc. will perform the following services for the District:

- record and edit up to six television shows;
- as producer, will produce, write and direct, The Flood Channel episodes;
- store the District's digital library;

- coordinate with the District for show content, production, and direction, scheduling videographer and editing equipment; and
- provide supplemental services which may include recording of storms and/or special events;
- provide “Open” captioning;
- provide “Closed” captioning.

The above outline is an example of the services that will be performed as part of the television show recording and editing in coordination with the District.

The FY 2024-2025 budget identifies sufficient funding for this First Amendment to the Professional Services Agreement. The First Amendment to the Agreement has been reviewed by the RFCD Attorney and is included in the backup.

Respectfully submitted,

RFCD AGENDA
ITEM #15
Date: 11/14/2024

Steven C. Parrish, P.E.
General Manager/Chief Engineer

Regional Flood Control District
AGENDA ITEM DEVELOPMENT

Staff Discussion:

Date: 11/04/2024

FIRST AMENDMENT TO THE PROFESSIONAL SERVICES AGREEMENT WITH JOSHUA TREE PRODUCTIONS, INC.

On August 8, 2024 the District Board of Directors approved a Professional Services Agreement with Joshua Tree Productions, Inc., to provide recording and editing of The Flood Channel television program that airs on government access cable stations. The agreement will include up to five shows focusing on the construction of flood control projects, flood safety, and stormwater quality. The remaining show will combine segments from the previous year as a "Best Of" episode. This agreement is from August 8, 2024, through June 30, 2025.
The First Amendment to the Professional Services Agreement will provide additional services which contain "Open" and "Closed" captioning.

Joshua Tree Productions, Inc. will perform the following services for the District:

- record and edit up to six television shows;
- as producer, will produce, write and direct, The Flood Channel episodes;
- store the District's digital library;
- coordinate with the District for show content, production, and direction, scheduling videographer and editing equipment; and
- provide supplemental services which may include recording of storms and/or special events;
- provide "Open" captioning;
- provide "Closed" captioning.

The above outline is an example of the services that will be performed as part of the television show recording and editing in coordination with the District.

The FY 2024-2025 budget identifies sufficient funding for this First Amendment to the Professional Services Agreement. The First Amendment to the Agreement has been reviewed by the RFCD Attorney and is included in the backup.

Staff Recommendation:

Approve.

Discussion by Technical Advisory Committee:

AGENDA
Date:

The Technical Advisory Committee did not hear this item.

Recommendation:

Discussion by Citizens Advisory Committee:

AGENDA #Date:

The Citizens Advisory Committee did not hear this item.

Recommendation:

111424 Joshua Tree-aid

FIRST AMENDMENT TO THE PROFESSIONAL SERVICES AGREEMENT
CLARK COUNTY REGIONAL FLOOD CONTROL DISTRICT
AND
JOSHUA TREE PRODUCTIONS, INC.
FOR VIDEO PRODUCTION SERVICES

THIS FIRST AMENDMENT TO THE AGREEMENT is made and entered into this 14th day of November, 2024, by and between the CLARK COUNTY REGIONAL FLOOD CONTROL DISTRICT (hereinafter referred to as "DISTRICT") and, JOSHUA TREE PRODUCTIONS, INC. which is authorized to do business in the state of Nevada (hereinafter referred to as "CONSULTANT"), for video production services.

WITNESSETH

WHEREAS, a Professional Services AGREEMENT was approved on August 8, 2024; and

WHEREAS, the District desires to have additional services to include open and closed captioning for final production videos; and

WHEREAS, the CONSULTANT has the necessary experience and qualifications to perform the required television production services; and

WHEREAS, the parties agree to amend the Professional Services AGREEMENT to provide the services and to pay the additional fees associated with said services.

NOW, THEREFORE, in consideration of the mutual covenants and agreements contained in this AGREEMENT, the parties do mutually agree as follows:

SECTION I: SERVICES

Section I, paragraph 6 shall be added to read as follows:

A. The DISTRICT, in its sole discretion, shall determine the number of shows the CONSULTANT will produce during the term of the AGREEMENT. For each show the DISTRICT desires, it will give a separate written notice to proceed for the show to the CONSULTANT. The CONSULTANT shall perform services as specified in this AGREEMENT. The CONSULTANT agrees to provide videographer, editor, and/or associated video production services in order to provide for the DISTRICT up to 6 (six) half-hour information television news shows described as follows:

1. The CONSULTANT will produce, write and direct the DISTRICT's information television news shows. Five (5) of the shows will contain all new materials and elements; and the remaining show will re-package segments from the past year for a "Best Of" episode.

a. The CONSULTANT will coordinate with the DISTRICT producer a minimum of 30 (thirty) days in advance regarding dates and times when the videographer will be available.

b. The DISTRICT will schedule video time fifteen (15) days in advance.

2. The CONSULTANT will provide a vehicle to transport videographer and equipment to locations in the field throughout Clark County. This may include the DISTRICT's Producer as a passenger in the CONSULTANT's vehicle.

3. The CONSULTANT agrees to produce a final product of twenty-eight minutes and thirty seconds (28:30) using the most current industry standards per show in a form and content acceptable to the DISTRICT.

4. The CONSULTANT will keep a current catalogue of the B-roll videotaped for each show on the DISTRICT owned computer server (Serial Number QP717014Y0T) located at the CONSULTANT's office.

5. The CONSULTANT agrees to provide all materials and supplies necessary to perform the services outlined in this AGREEMENT.

6. The CONSULTANT shall provide "Open" and "Closed" captioning for all 6 (six) half-hour informational television shows. For purposes of this AGREEMENT, "Open" captioning means continuous and constant visible captions throughout the show recording. "Closed" captioning means that the viewer has control as to whether the captions are visible during playback. The CONSULTANT will convert the audio into transcribed text and apply it throughout the video editing process to each show. The CONSULTANT must review the entire production to select placement for each caption.

SECTION II: COMPENSATION AND TERMS OF PAYMENT

Section II shall be changed to read as follows:

A. The maximum cost to the DISTRICT for Services shall not exceed One Hundred Three Thousand, Three-Hundred Thirty Dollars and No Cents ($103,330.00) unless the DISTRICT receives a written request, with justification, and the DISTRICT approves in writing, a change in SECTION I, SERVICES and an increase in compensation. If approved, a supplement to this AGREEMENT must be executed.

1. For Services performed, except for "Open" and "Closed" captioning, set forth in Section 2 below, the DISTRICT agrees to pay the CONSULTANT on a per show basis as follows:

Eighteen Thousand Eight Hundred and Fifty Dollars and No Cents ($18,850.00) per show for show number 1, number 2, number 3, number 4 and number 5 and Four Thousand, Two Hundred and Eighty Dollars and No Cents ($4,280.00) for the remaining show number 6 defined in SECTION I: SERVICES, A.1 for a total amount not to exceed Ninety-Eight Thousand, Five Hundred and Thirty Dollars and No Cents ($98,530.00).

2. For additional services for "Open" and "Closed" captioning for all 6 (six) Flood Channel shows in the amount of Eight Hundred Dollars and No Cents ($800.00) per show in the amount not to exceed Four Thousand Eight-Hundred Dollars and No Cents ($4,800.00).

3. The total amount of this First Amendment to the AGREEMENT shall not exceed One Hundred Three Thousand, Three-Hundred Thirty Dollars and No Cents ($103,330.00).

B. Compensation for the work on Services will be paid upon successful completion for each show as solely determined by the DISTRICT. Payment will be made within thirty (30) days upon receipt of an invoice from the CONSULTANT, if the work is satisfactorily performed.

All other sections of the original AGREEMENT shall remain unchanged.

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IN WITNESS THEREOF, the DISTRICT and the CONSULTANT have caused this FIRST AMENDMENT TO THE AGREEMENT for Video Production Services to be executed as of the date and year first above.

Date of Board Approval:

_____

CLARK COUNTY REGIONAL FLOOD CONTROL DISTRICT

By: _____
JUSTIN JONES, Chair

Date:_____

JOSHUA TREE PRODUCTIONS, INC.

By_____
Paul Bean, President

ATTEST:

By:_____ Date:_____
Deanna Hughes
Secretary to the Board

APPROVED AS TO FORM:

By:_____ Date:_____
Christopher D. Figgins
RFCD Attorney

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

CADIZ STORM DRAIN – RACETRACK TO PUEBLO
SECOND SUPPLEMENTAL INTERLOCAL CONTRACT – HEN04R23

RECOMMENDATION SUMMARY

STAFF:	Approve subject to approval of the Ten-Year Construction Program Amendment item on this agenda.
TECHNICAL ADVISORY:	Approve subject to approval of the Ten-Year Construction Program Amendment item on this agenda.
CITIZENS ADVISORY:	Approve subject to approval of the Ten-Year Construction Program Amendment item on this agenda.

RFCD AGENDA
ITEM #16
DATE: 11/14/2024

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT
AGENDA ITEM

SUBJECT:
CADIZ STORM DRAIN – RACETRACK TO PUEBLO

PETITIONER:
CITY OF HENDERSON

RECOMMENDATION OF PETITIONER:
THAT THE REGIONAL FLOOD CONTROL DISTRICT APPROVE THE SECOND SUPPLEMENTAL INTERLOCAL CONTRACT FOR DESIGN TO INCREASE FUNDING OF THE CADIZ STORM DRAIN – RACETRACK TO PUEBLO (HEN04R23) – FOR POSSIBLE ACTION

FISCAL IMPACT:

	Current Funding	Increase/Decrease	Proposed Funding
Design	$482,880	$97,705	$580,585
Right-of-Way	$ 41,380	$ 0	$ 41,380
Environmental	$ 30,000	$ 0	$ 30,000
CLOMR/LOMR	$ 35,740	$ 0	$ 35,740
Entity Design Labor	$ 35,000	$ 0	$ 35,000
Total ILC Value	$625,000	$97,705	$722,705

BACKGROUND:

An interlocal contract was entered into between the District and the City of Henderson on September 14, 2023 to provide funding for design, environmental. Right-of-way, Conditional Letter of Map Revision/Letter of Map Revision (CLOMR/LOMR) and entity design labor for the subject project. A First Supplemental Interlocal Contract was approved February 8, 2024 which provided additional funding necessary to complete the project design, obtain right-of-way and process the CLOMR/LOMR. This Second Supplemental Interlocal Contract will increase funding for additional design and analyses to extend the proposed storm drain lateral on Racetrack Road to Essex Avenue, an approximate 1,400 linear feet, the addition of drop inlets at the intersections of Racetrack Rd/Essex Ave, and Racetrack Rd/Dublin Ave, to collect the 100-year storm event flows.

Respectfully submitted,

DocuSigned by:
Lance Olson
E3CEEE5587A04...

Lance M. Olson, P.E.
Director of Public Works
City of Henderson

TAC AGENDA ITEM #11 Date: 10/31/2024	RFCD AGENDA ITEM #16 Date: 11/14/2024
CAC AGENDA ITEM #11 Date:11/04/2024	

Regional Flood Control District
AGENDA ITEM DEVELOPMENT

Staff Discussion:

Date: 10/21/2024

CADIZ STORM DRAIN – RACETRACK TO PUEBLO
SECOND SUPPLEMENTAL INTERLOCAL CONTRACT – HEN04R23

An interlocal contract was entered into between the District and the City of Henderson on September 14, 2023 to provide funding for design, environmental. Right-of-way, Conditional Letter of Map Revision/Letter of Map Revision (CLOMR/LOMR) and entity design labor for the subject project. A First Supplemental Interlocal Contract was approved February 8, 2024 which provided additional funding necessary to complete the project design, obtain right-of-way and process the CLOMR/LOMR. This Second Supplemental Interlocal Contract will increase funding for additional design and analyses to extend the proposed storm drain lateral on Racetrack Road to Essex Avenue, an approximate 1,400 linear feet, the addition of drop inlets at the intersections of Racetrack Rd/Essex Ave, and Racetrack Rd/Dublin Ave, to collect the 100-year storm event flows.

District funding will be provided as follows:

	Current Funding	Increase/Decrease	Proposed Funding
Design	$482,880	$97,705	$580,585
Right of Way	$ 41,380	$ 0	$ 41,380
Environmental	$ 30,000	$ 0	$ 30,000
CLOMR/LOMR	$ 35,740	$ 0	$ 35,740
Entity Design Labor	$ 35,000	$ 0	$ 35,000
Total ILC Value	$625,000	$97,705	$722,705

The RFCD Attorney has reviewed the contract.

Staff Recommendation:

Approve subject to approval of the Ten-Year Construction Program Amendment item on this agenda.

Discussion by Technical Advisory Committee:

AGENDA
#11 Date: 10/31/2024

Recommendation:

Approve subject to approval of the Ten-Year Construction Program Amendment item on this agenda.

Discussion by Citizens Advisory Committee:

AGENDA
#11 Date: 11/04/2024

Recommendation:

Approve subject to approval of the Ten-Year Construction Program Amendment item on this agenda.

SECOND SUPPLEMENTAL INTERLOCAL CONTRACT

CADIZ STORM DRAIN- RACETRACK TO PUEBLO

THIS SECOND SUPPLEMENTAL INTERLOCAL CONTRACT (CONTRACT) made and entered into as of the _____ day of _____, 2024 by and between the Clark County Regional Flood Control District, hereinafter referred to as "DISTRICT", and CITY OF HENDERSON hereinafter referred to as "CITY".

W I T N E S S E T H

WHEREAS, pursuant to Chapter 543 of the Nevada Revised Statutes, the DISTRICT may approve a project to design and construct flood control improvements, and;

WHEREAS, the flood control improvements proposed herein are the same as those generally identified in the 2018 Flood Control Master Plan Update as Structure(s) No. C1CA0000, hereinafter referred to as "PROJECT"; and

WHEREAS, the flood control improvements proposed herein are the same as those generally identified in the 2023 Flood Control Master Plan Update as Structure(s) No. C1CA0000, hereinafter referred to as "PROJECT"; and

WHEREAS, the PROJECT is identified and shown on the attached Exhibit "A"; and

WHEREAS, the PROJECT has been approved by the DISTRICT on its annual Ten Year Construction Program; and

WHEREAS, the DISTRICT approved an interlocal contract on September 14, 2023 and a first supplemental interlocal contract on February 8, 2024 to provide funds for design, Conditional Letter of Map Revision/Letter of Map Revision (CLOMR/LOMR), environmental, entity design labor and right-of-way for the PROJECT; and

WHEREAS, the CITY desires to increase funding; and

WHEREAS, the PROJECT has regional flood control significance and is located in the same hydrographic area as the CITY and County of Clark.

NOW, THEREFORE, in consideration of the covenants, conditions, contracts, and promises of the parties hereto, the DISTRICT and the CITY agree to the following:

SECTION I - SCOPE OF THE PROJECT

This SECOND SUPPLEMENTAL INTERLOCAL CONTRACT applies to design associated with the Cadiz Storm Drain – Racetrack to Pueblo. The basic improvements

shall consist of flood water facilities including pipes, channels, dikes, energy dissipators, channel structures, channel access and other appurtenances as may be necessary to control floodwaters. The improvements shall be funded through DISTRICT funds as herein described. This PROJECT is further identified and shown on the attached Exhibit "A".

SECTION II - PROJECT COSTS shall be revised as follows:

The DISTRICT agrees to fund PROJECT costs within the limits specified below:

1. The design shall not exceed $580,585.

2. The entity design labor shall not exceed $35,000.

3. Environmental costs shall not exceed $30,000.

4. Right-of-Way shall not exceed $41,380.

5. CLOMR/LOMR shall not exceed $35,740.

6. The total cost of this CONTRACT shall not exceed $722,705. which includes all the items described in the paragraphs above.

7. A written request must be made to the DISTRICT and approved by the Board to reallocate funds between phases of the PROJECT. No other approval by the Lead Entity is required.

8. A written request must be made to the DISTRICT and a Supplemental Interlocal Contract must be approved by the Board to increase the total cost of the CONTRACT noted above prior to payment of any additional funds.

The remainder of the original Interlocal Contract dated September 14, 2023, and first supplemental interlocal contract dated February 8, 2024 shall remain unchanged.

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IN WITNESS WHEREOF, this Second Supplemental Interlocal Contract is hereby executed as of the date first set forth above.

Date of District Action: REGIONAL FLOOD CONTROL DISTRICT

_____ BY:_____
JUSTIN JONES, Chair

ATTEST:

_____
DEANNA HUGHES,
Secretary to the Board

Approved as to Form:

BY:_____
CHRISTOPHER FIGGINS
RFCD Attorney

Date of Council Action: _____

CITY OF HENDERSON
CLARK COUNTY, NEVADA

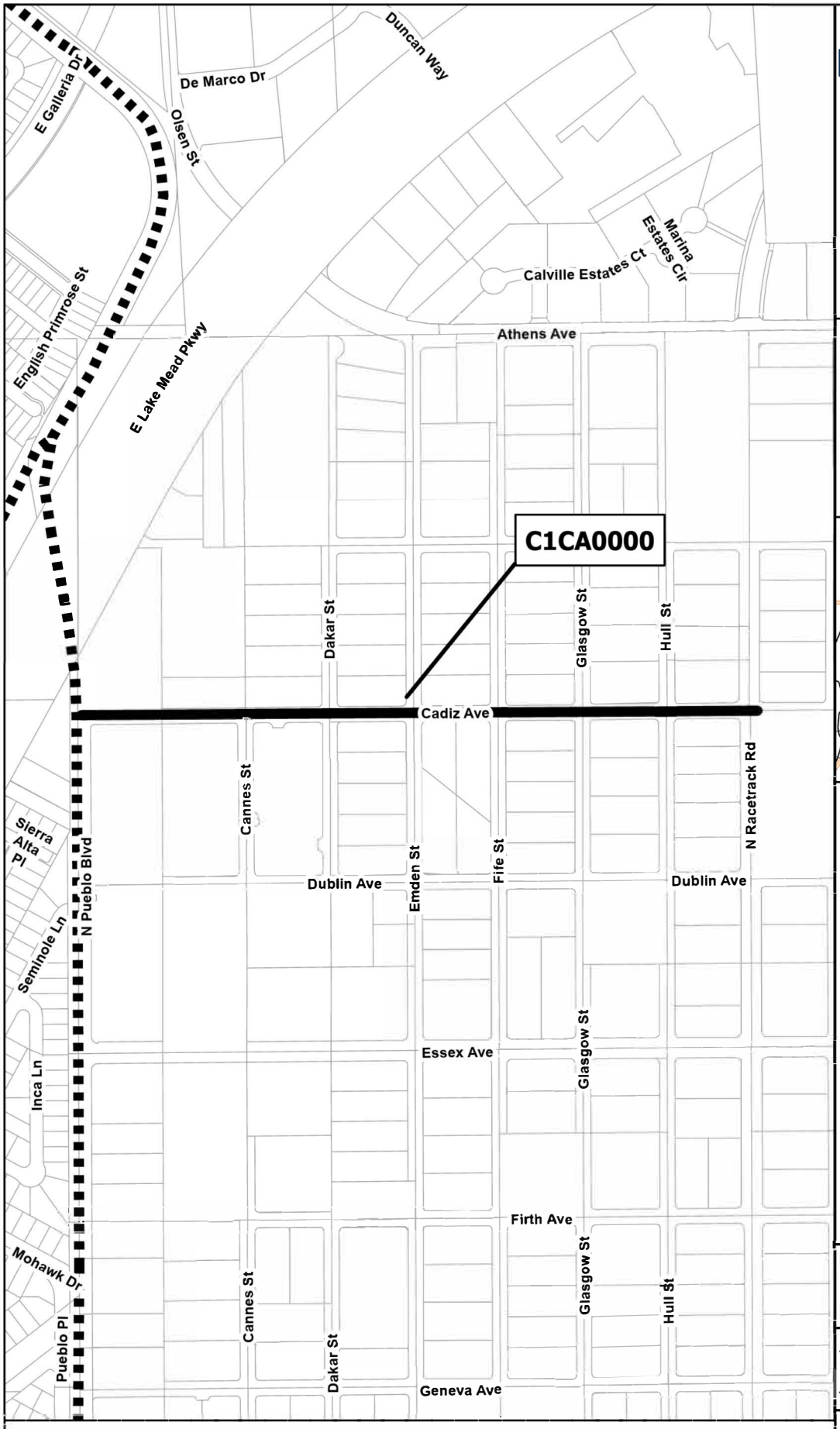
_____ _____
RICHARD A. DERRICK Date
City Manager/CEO

ATTEST: APPROVED AS TO FUNDING:

_____ _____
JOSE LUIS VALDEZ, CMC MARIA GAMBOA
City Clerk Director of Finance

APPROVED AS TO CONTENT: APPROVED AS TO FORM:

_____ _____ _____
LANCE M. OLSON, P.E. NICHOLAS G. VASKOV CAO
Director of Public Works City Attorney Review



HENDERSON

PUBLIC WORKS
GEOSPATIAL SECTION

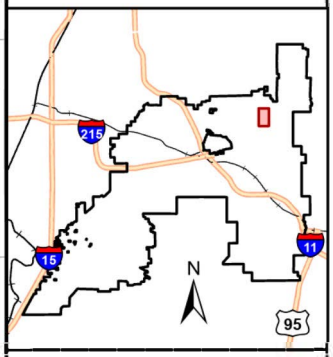
240 WATER STREET | HENDERSON, NV 89015
702-267-1300

This map is offered as a general reference guide only. Neither warranty of accuracy is intended nor should any be assumed.

City of Henderson

REGIONAL FLOOD CONTROL DISTRICT

EXHIBIT A



Legend

- PROPOSED FACILITIES
- EXISTING FACILITIES
- HENDERSON APARS

NOT TO SCALE

MAP NAME:

EXHIBIT A

AUTHOR:	DATE:
ths2	09/30/2024

SHEET 1 OF 1

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EXHIBIT A

CADIZ STORM DRAIN - RACETRACK TO PUEBLO HEN04R23

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

FLAMINGO WASH, UPRR TO HOTEL RIO DRIVE
FOURTH SUPPLEMENTAL INTERLOCAL CONTRACT – CLA10F10

RECOMMENDATION SUMMARY

STAFF:	Approve subject to approval of the Ten-Year Construction Program Amendment item on this agenda.
TECHNICAL ADVISORY:	Approve subject to approval of the Ten-Year Construction Program Amendment item on this agenda.
CITIZENS ADVISORY:	Approve subject to approval of the Ten-Year Construction Program Amendment item on this agenda.

RFCD AGENDA
ITEM #17
DATE: 11/14/2024

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

FLAMINGO WASH, UPPR TO HOTEL RIO DRIVE

PETITIONER:

DENIS CEDERBURG, DIRECTOR OF PUBLIC WORKS

RECOMMENDATION OF PETITIONER:

THAT THE CLARK COUNTY REGIONAL FLOOD CONTROL DISTRICT APPROVE SUPPLEMENTAL NO. 4 TO THE INTERLOCAL CONTRACT FOR DESIGN TO INCREASE FUNDING AND EXTEND THE PROJECT COMPLETION DATE FOR FLAMINGO WASH, UPRR TO HOTEL RIO DRIVE CLA10F10 (FOR POSSIBLE ACTION)

FISCAL IMPACT:

	CURRENT	REVISED	FISCAL IMPACT
Design	$ 342,000.00	$ 417,000.00	$ 75,000.00
Right-of-Way	$ 60,500.00	$ 60,500.00	$ 0.00
Environmental	$ 3,500.00	$ 3,500.00	$ 0.00
CLOMR/LOMR	$ 60,000.00	$ 60,000.00	$ 0.00
Entity Design Labor	$ 40,000.00	$ 40,000.00	$ 0.00
Total ILC Value	$ 506,000.00	$ 581,000.00	$ 75,000.00

BACKGROUND:

On April 8, 2010, the Regional Flood Control District entered into an interlocal contract with Clark County to provide funding for design, environmental, and right-of-way for the subject project. Supplemental No. 1 dated June 11, 2015 provided additional funding for design, environmental, and right-of-way and extended the term of the contract. Supplemental No. 2 dated June 11, 2020 changed the name of the project and extended the term of the contract. Supplemental No. 3 dated July 8, 2021 increased funding for design and right-of-way and added line items for entity design labor and Conditional Letter of Map Revision/Letter of Map Revision (CLOMR/LOMR).

This fourth supplemental interlocal contract will increase design funds to cover consultant design services for the additional hydrologic analysis that were preformed to evaluate flows along Flamingo Road between the Flamingo Wash and Valley View Boulevard, alternative alignment

TAC AGENDA ITEM #12 **Date:** 10/31/2024	**RFCD AGENDA ITEM** # 17 **Date:** 11/14/2024
CAC AGENDA ITEM #12 **Date:** 11/04/2024	

evaluations for regional facilities to minimize both present and future cost to the master plan, and additional design to be able reduce/eliminate the acquisition cost to the project associated with the Union Pacific Rail Road. This fourth supplemental interlocal contract will also extend the project completion date from June 30, 2025 to December 30, 2026 to complete design and provide support through construction.

Respectfully submitted,

TAC AGENDA ITEM #12 **Date:** 10/31/2024	**RFCD AGENDA ITEM** # 17 **Date:** 11/14/2024
CAC AGENDA ITEM #12 **Date:** 11/04/2024	

DENIS CEDERBURG
Director of Public Works

Regional Flood Control District
AGENDA ITEM DEVELOPMENT

Staff Discussion:

Date: 10/21/2024

FLAMINGO WASH, UPPR TO HOTEL RIO DRIVE
FOURTH SUPPLEMENTAL INTERLOCAL CONTRACT – CLA10F10

On April 8, 2010, the Regional Flood Control District entered into an interlocal contract with Clark County to provide funding for design, environmental, and right-of-way for the subject project. Supplemental No. 1 dated June 11, 2015 provided additional funding for design, environmental, and right-of-way and extended the term of the contract. Supplemental No. 2 dated June 11, 2020 changed the name of the project and extended the term of the contract. Supplemental No. 3 dated July 8, 2021 increased funding for design and right-of-way and added line items for entity design labor and Conditional Letter of Map Revision/Letter of Map Revision (CLOMR/LOMR).

This fourth supplemental interlocal contract will increase design funds to cover consultant design services for the additional hydrologic analysis that were preformed to evaluate flows along Flamingo Road between the Flamingo Wash and Valley View Boulevard, alternative evaluations for regional facilities to minimize both present and future cost to the master plan, and additional design to be able reduce/eliminate the acquisition cost to the project associated with the Union Pacific Rail Road. This fourth supplemental interlocal contract will also extend the project completion date from June 30, 2025 to December 30, 2026 to complete design and provide support through construction.

District funding will be provided as follows:

	Current Funding	Increase/Decrease	Proposed Funding
Design	$342,000.00	$75,000.00	$417,000.00
Right of Way	$ 60,500.00	$ 0.00	$ 60,500.00
Environmental	$ 3,500.00	$ 0.00	$ 3,500.00
CLOMR/LOMR	$ 60,000.00	$ 0.00	$ 60,000.00
Entity Design Labor	$ 40,000.00	$ 0.00	$ 40,000.00
Total ILC Value	$506,000.00	$75,000.00	$581,000.00

The RFCD Attorney has reviewed the contract.

Staff Recommendation:

Approve subject to approval of the Ten-Year Construction Program Amendment item on this agenda.

Discussion by Technical Advisory Committee:

AGENDA
#12 Date: 10/31/2024

Recommendation:

Approve subject to approval of the Ten-Year Construction Program Amendment item on this agenda.

Discussion by Citizens Advisory Committee:	AGENDA #12 Date: 11/04/2024

Recommendation:

Approve subject to approval of the Ten-Year Construction Program Amendment item on this agenda.

111424 CLA10F-ilc-aid

SUPPLEMENTAL NO. 4 TO THE INTERLOCAL CONTRACT FOR FLAMINGO WASH, UPRR TO HOTEL RIO DRIVE

THIS FOURTH SUPPLEMENTAL INTERLOCAL CONTRACT (CONTRACT), made and entered into this _____ day of _____, 2024, by and between the Clark County Regional Flood Control District, hereinafter referred to as "DISTRICT", and the County of Clark, hereinafter referred to as "COUNTY".

W I T N E S S E T H

WHEREAS, pursuant to Chapter 543 of the Nevada Revised Statutes, the DISTRICT may approve a project to design and construct flood control improvements; and

WHEREAS, the flood control improvements proposed herein are generally described in the 2008, 2013 and 2018 Master Plan Updates, as Structure No's. FLWA 0893 and 0896, hereinafter referred to as "Project"; and

WHEREAS, the flood control improvements proposed herein are generally identified in the 2023 Master Plan Update as Structure No's. FLWA 0893 and 0896, hereinafter referred to as "Project"; and

WHEREAS, the Project is identified and shown on the attached Exhibit "A"; and

WHEREAS, the Project has been approved by the DISTRICT on its annual Ten Year Construction Program; and

WHEREAS, the DISTRICT approved interlocal contracts to provide funds for design, right-of-way acquisition, environmental, Conditional Letter of Map Revision/Letter of Map Revision (CLOMR/LOMR) and entity design labor for the Project; and

WHEREAS, it is necessary to increase design; and

WHEREAS, the Project has regional flood control significance and is located in the same hydrographic area as the Las Vegas Valley.

NOW, THEREFORE, in consideration of the covenants, conditions, contracts, and promises of the parties hereto, the DISTRICT and the COUNTY agree to supplement the Interlocal Contract approved April 8, 2010; and supplemental Interlocal Contracts approved June 11, 2015, June 11, 2020 and July 8, 2021and agree to the following:

SECTION II - PROJECT COSTS, **shall be changed to read as follows:**

The DISTRICT agrees to fund PROJECT costs within the limits specified below:

1. Design in an amount not to exceed $417,000.00.

2. Right-of-way acquisition including appraisals, title and escrow, negotiations, legal fees, recording fees, etc. in an amount not to exceed $60,500.00.

3. Environmental in an amount not to exceed $3,500.00.

4. CLOMR/LOMR in an amount not to exceed $60,000.00.

5. Entity Design Labor in the amount not to exceed $40,000.00.

6. The total cost of this Interlocal CONTRACT shall not exceed $581,000.00, which includes all the items described in the paragraphs above.

7. A written request must be made to the DISTRICT and approved by the Board to reallocate funds between phases of the PROJECT. No other approval by the Lead Entity is required.

8. A written request must be made to the DISTRICT and a supplemental interlocal contract must be approved by the Board to increase the total cost of the CONTRACT noted above prior to payment of any additional funds.

SECTION III – GENERAL, paragraph 14 shall be changed to read as follows:

14. The items covered in Section II – PROJECT COSTS must be completed to the satisfaction of the DISTRICT prior to December 30, 2026. The DISTRICT may, at any time thereafter, grant extensions or terminate this CONTRACT after thirty (30) days' notice.

The remainder of the original Interlocal Contract and supplemental interlocal contracts shall remain unchanged.

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IN WITNESS WHEREOF, this Supplemental No. 4 to the Interlocal Contract is hereby executed as of the date first set forth above.

Date of Commission Action: CLARK COUNTY BOARD OF COMMISSIONERS

_____ By: _____

TICK SEGERBLOM
Chair

Attest:

_____

LYNN MARIE GOYA
County Clerk

Approved as to Form:

_____

JASON B. PATCHETT
Deputy District Attorney

********** **********

Date of District Action: REGIONAL FLOOD CONTROL DISTRICT

_____ By: _____

JUSTIN JONES, Chair

Attest:

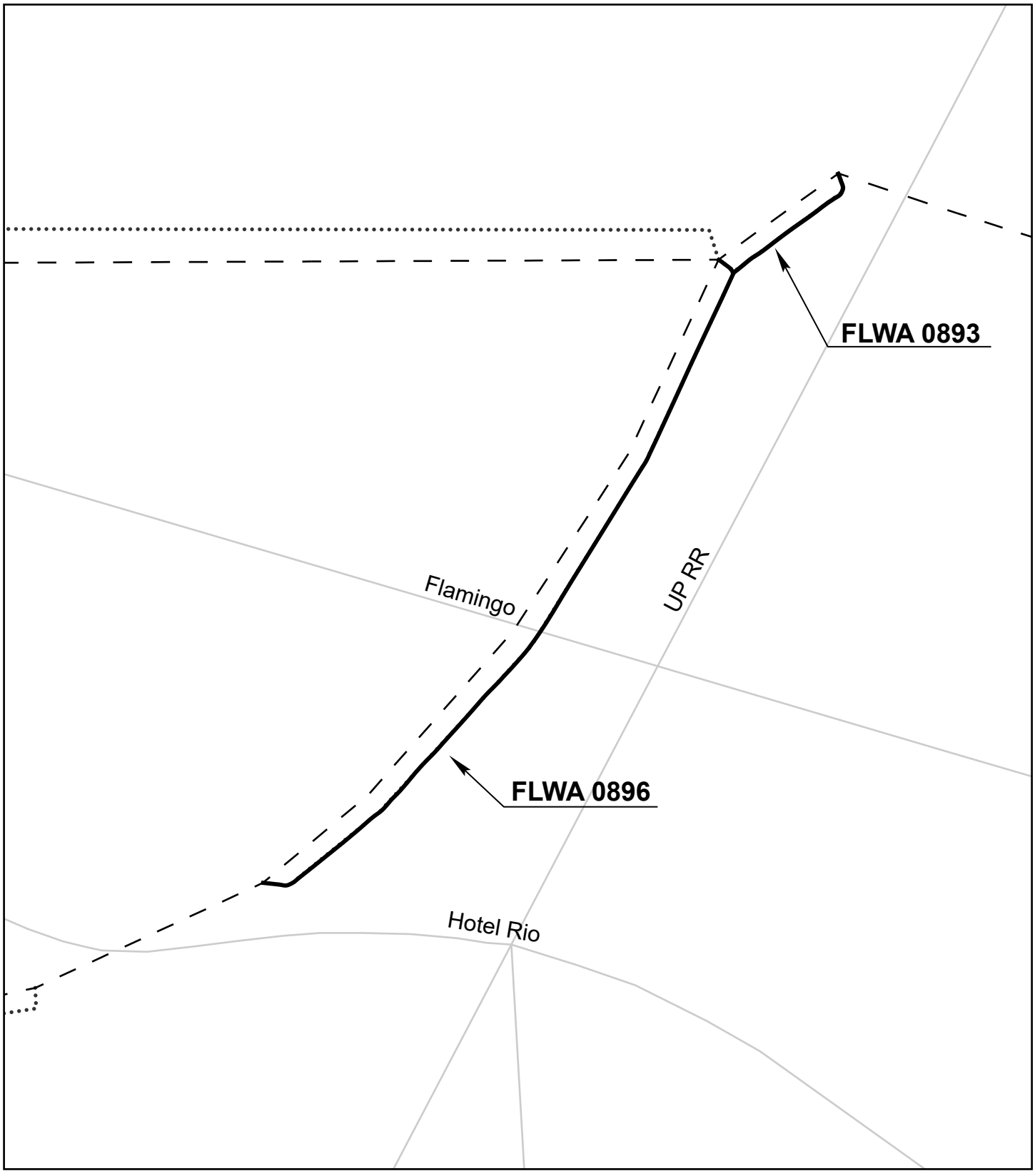
_____

DEANNA HUGHES
Secretary to the Board

Approved as to Form:

_____

CHRISTOPHER FIGGINS
RFCD Attorney



Legend

- Proposed
- Existing
- Future

Exhibit A

N
W E
S

CLARK COUNTY NEVADA	**Project Number: CLA10F10**	CLARK COUNTY PUBLIC WORKS
		SCALE: NOT TO SCALE
	Flamingo Wash, UPRR to Hotel Rio Drive	DATE: 10-11-2024
		SHEET NUMBER: 1 OF 1

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

FINANCIAL STATEMENTS
FISCAL YEAR THAT ENDED JUNE 30, 2024

RECOMMENDATION SUMMARY

STAFF: Accept.

TECHNICAL ADVISORY: The Technical Advisory Committee did not hear this item.

CITIZENS ADVISORY: The Citizens Advisory Committee did not hear this item.

RFCD AGENDA
ITEM #18
DATE: 11/14/2024

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT
AGENDA ITEM

SUBJECT:
ANNUAL FINANCIAL AUDIT - FISCAL YEAR ENDED JUNE 30, 2024

PETITIONER:
STEVEN C. PARRISH, P.E., GENERAL MANAGER/CHIEF ENGINEER

RECOMMENDATION OF PETITIONER:
ACCEPT THE FINANCIAL STATEMENTS, ACCOMPANYING INFORMATION AND REPORT OF INDEPENDENT AUDITORS FOR THE REGIONAL FLOOD CONTROL DISTRICT AS PREPARED BY CROWE LLP FOR THE FISCAL YEAR THAT ENDED JUNE 30, 2024 (FOR POSSIBLE ACTION)

FISCAL IMPACT: None

BACKGROUND:

An annual financial audit for the fiscal year that ended June 30, 2024, was performed by independent auditors, Crowe LLP, for the Regional Flood Control District. A copy of the Auditor's Required Communication to the Board of Directors, along with the Component Unit Financial Statements, which include the *Independent Auditor's Report*, *Management's Discussion and Analysis*, *Financial Statements*, and accompanying information are included in the backup.

It was the opinion of the independent auditors that "the financial statements referred to above present fairly, in all material respects, the respective financial position of the governmental activities and each major fund of the Clark County Regional Flood Control District as of June 30, 2024, and the respective changes in financial position for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Respectfully submitted,

Jessica Honour
Administrative Services Director

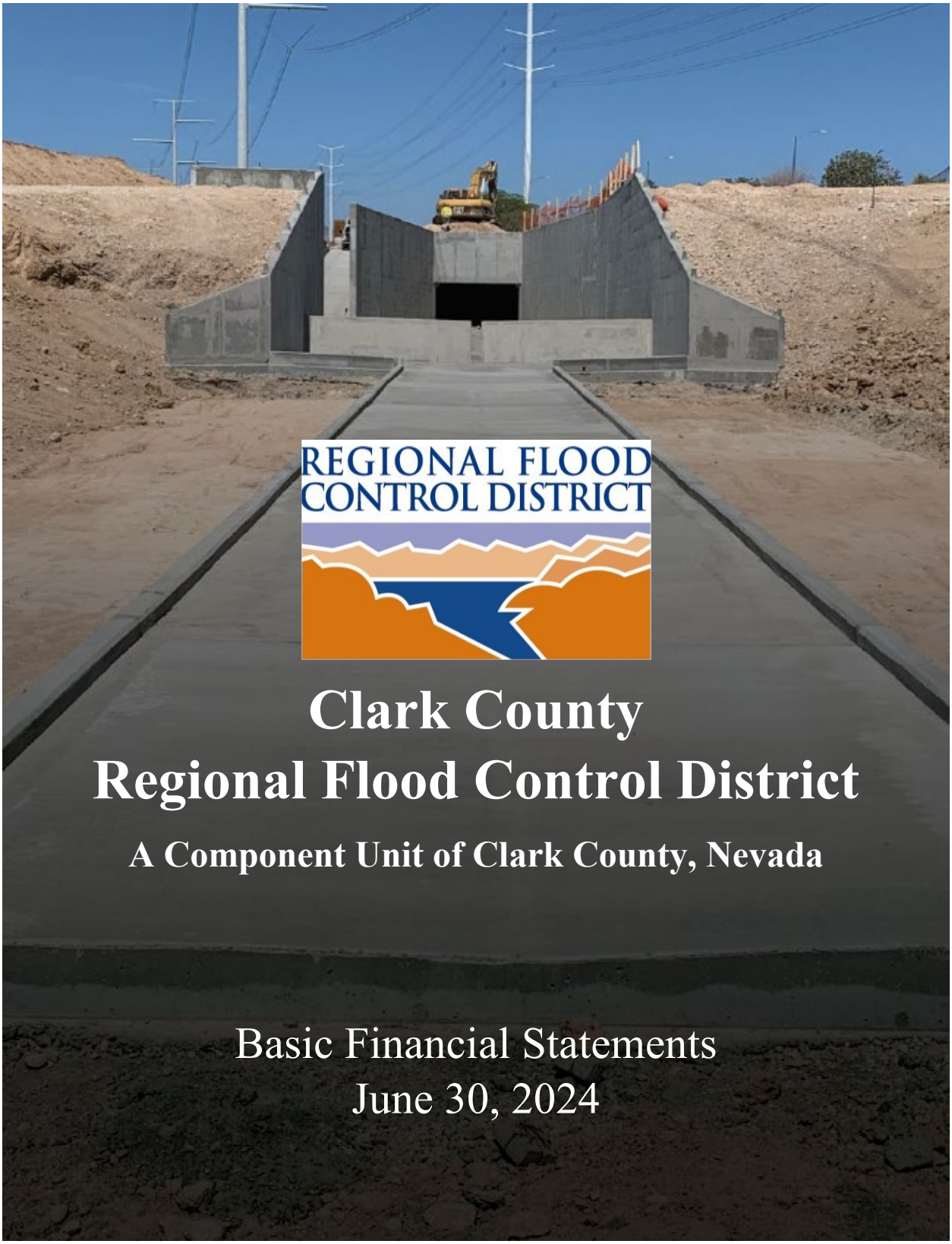
RFCD AGENDA
ITEM # 18
Date: 11/14/2024

COMPONENT UNIT FINANCIAL STATEMENTS

JUNE 30, 2024

A COMPONENT UNIT OF CLARK COUNTY, NV

REGIONAL FLOOD CONTROL DISTRICT
CLARK COUNTY, NEVADA



Clark County
Regional Flood Control District

A Component Unit of Clark County, Nevada

Basic Financial Statements
June 30, 2024

Clark County Regional Flood Control District Board of Directors

Justin Jones
Chair / Commissioner
Clark County

Isaac Barron
Vice-Chair / Councilman
City of North Las Vegas

Carolyn Goodman
Mayor
City of Las Vegas

Joe Hardy
Mayor
City of Boulder City

Paul Wanlass
Councilman
City of Mesquite

Brian Knudsen
Mayor Pro Tem
City of Las Vegas

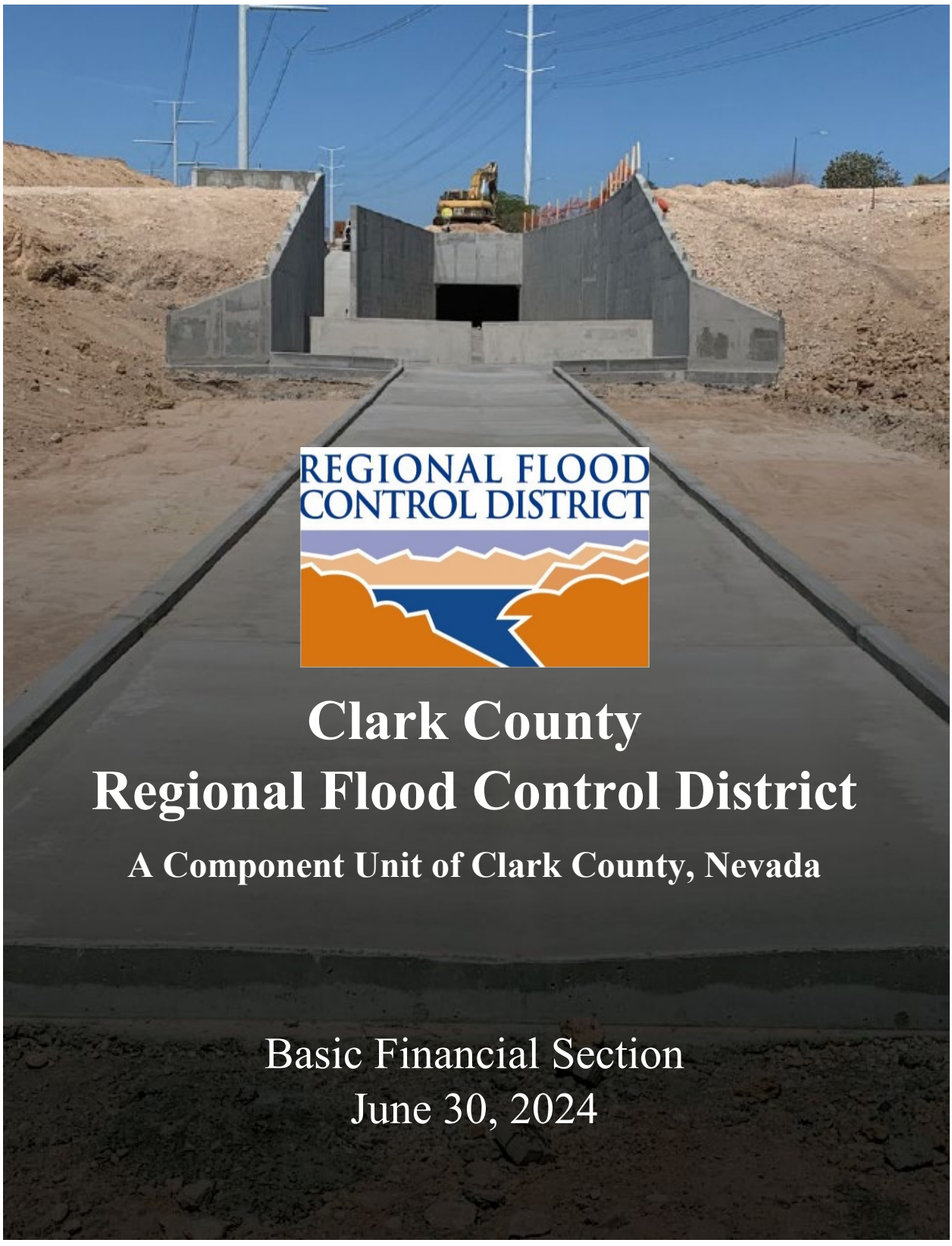
Dan Shaw
Councilman
City of Henderson

Tick Segerblom
Commissioner
Clark County

Appointed Official

Steven C. Parrish, P.E.
General Manager/Chief Engineer

Clark County Commissioners
Tick Segerblom, Chair
William McCurdy II, Vice-Chair
James Gibson
Justin Jones
Marilyn Kirkpatrick
Michael Naft
Ross Miller



Clark County
Regional Flood Control District

A Component Unit of Clark County, Nevada

Basic Financial Section
June 30, 2024

INDEPENDENT AUDITOR'S REPORT

Board of Directors
Clark County Regional Flood Control District
Las Vegas, Nevada

Report on the Audit of the Financial Statements

Opinions

We have audited the financial statements of the governmental activities and each major fund of the Clark County Regional Flood Control District (the "District"), a component unit of Clark County, Nevada, as of and for the year ended June 30, 2024, and the related notes to the financial statements, which collectively comprise the District's basic financial statements as listed in the table of contents.

In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, the respective financial position of the governmental activities and each major fund of the Clark County Regional Flood Control District, as of June 30, 2024, and the respective changes in financial position for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinions

We conducted our audit in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States (*Government Auditing Standards*). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the District, and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

(Continued)

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that management's discussion and analysis, budgetary comparison information, schedule of changes in total OPEB liability and related ratios, schedule of proportionate share of net pension liability, schedule of defined benefit plan contributions and related notes as listed in the table of contents be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

(Continued)

Supplementary Information

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise the District's basic financial statements. The officials schedule and budgetary comparison supplementary information is presented for purposes of additional analysis and is not a required part of the basic financial statements.

Such information is the responsibility of management and, except for that portion marked "unaudited," was derived from, and relates directly to, the underlying accounting and other records used to prepare the basic financial statements. That information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, that information is fairly stated in all material respects in relation to the basic financial statements as a whole. The information marked "unaudited" has not been subjected to the auditing procedures applied in the audit of the basic financial statements and, accordingly, we do not express an opinion or provide any assurance on it.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards,* we have also issued our report dated October 31, 2024 on our consideration of the District's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the District's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the District's internal control over financial reporting and compliance.

Crowe LLP

Crowe LLP

Sacramento, California
October 31, 2024

The Clark County Regional Flood Control District's (the "District") discussion and analysis for the fiscal year that ended June 30, 2024, is designed to: (a) assist the reader in focusing on significant financial issues, (b) provide an overview of the District's financial activities, (c) identify changes in the District's financial position (its ability to address subsequent years' challenges), (d) identify any material deviations from the financial plan (the approved budget), and (e) identify individual fund issues or concerns. The District is a component unit of Clark County, Nevada (the "County").

We encourage readers to read this information in conjunction with the financial statements and accompanying notes to gain a more complete picture of the information presented.

FINANCIAL HIGHLIGHTS

- The auditors' report offers an unmodified opinion that the District's financial statements are presented fairly in all material respects.
- Total net capital assets at June 30, 2024, equaled $2.2 million, and include only buildings, equipment, and construction in progress (Flood Threat Recognition System installations). Each year the District provides millions of dollars in funding to six member entities for flood control infrastructure assets, but the District does not own those assets. All infrastructure assets are owned by the jurisdiction in which the capital asset is located.
- Flood control infrastructure is funded from the RFCD Construction fund. The District expended $82.3 million for flood control infrastructure—a 13.8 percent increase from the prior year due to several projects that are currently under construction.
- Sales tax revenue increased to $159.5 million—3.4 percent greater than the prior fiscal year resulting from an expanding economy in Southern Nevada. This is the fourth consecutive fiscal year with an increase in sales tax revenues.
- Operating expenditures in the Regional Flood Control District fund totaled $24.1 million—$8.7 million for District operations and $15.4 million for flood control facilities maintenance.
    - Operating expenditures increased by nearly $0.8 million or 9.7 percent from the prior year mainly as a result of costs associated with the Las Vegas Valley Master Plan Update and for flood safety programs.
    - Operating expenditures were 5.4 percent of sales tax revenue.
    - Flood control maintenance expenditures increased by 45.4 percent as a result of major storm events and large scheduled repair/replacement projects during the fiscal year.
- Transfers-out of the Regional Flood Control District fund totaled $144.9 million—$97.0 million for the Capital Improvement Program and $47.9 million for debt service.
- At year-end, the District had six outstanding general obligation bond issues totaling $593.4 million—a 4.4 percent decrease from the prior year primarily as a result of principal payments. The District had no new or refunded debt issuances during the fiscal year.

OVERVIEW OF THE FINANCIAL STATEMENTS

The financial statements of the District report long-term and short-term financial information about District activities. The District's financial statements are prepared in conformity with accounting principles generally accepted in the United States of America. All assets and liabilities associated with the operation of the District are included in the statement of net position.

The discussion and analysis is intended to serve as an introduction to the District's basic financial statements, which are composed of government-wide financial statements, fund financial statements, and notes to the basic financial statements.

Government-Wide Financial Statements

- The government-wide financial statements are designed to provide readers with a broad overview of the District's finances in a manner similar to a private-sector business.
- The statement of net position presents information on all of the District's assets, deferred outflows, liabilities, and deferred inflows, with the difference reported as net position.
- The statement of activities presents information showing how the District's net position changed during the most recent fiscal year. All changes in net position are reported as soon as the underlying event giving rise to the change occurs, regardless of the timing of related cash flows (accrual accounting). Therefore, revenues and expenses are reported in this statement for some items that will only result in cash flows in future fiscal periods (e.g., uncollected taxes and earned but unused vacation and sick leave).

Fund Financial Statements

- The fund financial statements provide more detailed information about the District. A fund is a grouping of related accounts used to maintain control over resources that have been segregated for specific activities or objectives. The District, like other state and local governments, uses fund accounting to ensure and demonstrate compliance with finance-related legal requirements. The District's four funds are all governmental fund types.
- Governmental funds are used to account for essentially the same functions reported as governmental activities in the government-wide financial statements. However, unlike the government-wide financial statements, governmental fund financial statements focus on near-term inflows and outflows of spendable resources, as well as on balances of spendable resources available at the end of the fiscal year (modified accrual accounting). Such information may be useful in evaluating the District's near-term financial requirements.
- Since the focus of governmental funds is narrower than that of the government-wide financial statements, it is useful to compare the information presented for governmental funds with similar information presented for governmental activities in the government-wide financial statements. By doing so, readers may better understand the long-term impact of the District's near-term financing decisions. Both the governmental fund balance sheet and the governmental fund statement of

revenues, expenditures, and changes in fund balances provide a reconciliation to facilitate this comparison between governmental funds and governmental activities.

- The District adopts an annual appropriated budget for four governmental funds. A budgetary comparison schedule is provided for each of the District's governmental funds to demonstrate compliance with the budget, and a reconciliation has been prepared to explain the differences between budgetary inflows and outflows and GAAP revenues and expenditures.

Notes to Financial Statements

- The notes to the basic financial statements provide additional information that is essential to a full understanding of the data provided in the government-wide and fund financial statements.

FINANCIAL ANALYSIS OF THE DISTRICT OVERALL

Net Position

The District uses pay-as-you-go funds and debt financing to provide funding for flood control infrastructure in Clark County. As of June 30, 2024, the County has issued fifteen general obligation bonds/notes on behalf of the District to accelerate funding for flood control infrastructure. Of the fifteen general obligation bonds/notes, eight are original issues and seven are refunding bonds. At the end of the fiscal year, six bond issues—three original issues and three refunding issues—in the amount of $593.4 million were outstanding.

The District provides funding for the design and construction of flood control infrastructure in Clark County, but the District does not retain ownership of any of the assets. All infrastructure assets are owned by the jurisdiction in which the flood control asset is located. Therefore, infrastructure assets are not recorded in the District's financial statements. The only capital assets recorded in the District's financial statements are purchased from the Regional Flood Control District fund and includes buildings, equipment, and construction in progress (Flood Threat Recognition System installations) in the amount of $2.2 million, net of accumulated depreciation. The District's net position is negative $218.5 million as a result of having general obligation bond liabilities recorded in the financial statements without corresponding infrastructure assets. The change in net position is largely the result of previously issuing additional bonds to pay for flood control infrastructure projects. Net position of the District as of June 30, 2023, and June 30, 2024, are summarized and discussed below:

Clark County Regional Flood Control District
Net Position

	Governmental Activities	
	2024	2023
Assets		
Current and other assets	$ 426,418,788	$ 406,389,665
Net capital assets	2,174,877	2,552,687
Total Assets	428,593,665	408,942,352
Deferred Outflows	15,993,209	17,007,993
Liabilities		
Long-term debt outstanding	631,703,807	660,804,587
Other liabilities	29,751,738	32,796,755
Total Liabilities	661,455,545	693,601,342
Deferred Inflows	1,643,528	1,678,889
Net Position		
Net investment in capital assets	2,174,877	2,552,687
Restricted	67,678,592	17,286,666
Unrestricted	(288,365,668)	(289,169,239)
Total Net Position	$ (218,512,199)	$ (269,329,886)

Generally, increases or decreases in net position may serve over time as a useful indicator of a government's financial condition. However, examining net position is not a useful indicator of the financial condition of the District as noted above. Several factors indicate that the District is a financially sound governmental agency that has and will continue to remain financially solvent and meet its current and future obligations.

- Over the past 20 years, sales tax revenue growth averaged 4.5 percent annually.
- Fiscal year 2023-24 sales tax collections hit another all-time peak since the inception of the District and increased by 3.4 percent over the previous year, which indicates the District's main revenue source is stable.
- The District possesses adequate reserves to guard against unanticipated reductions in revenue with an unassigned fund balance of $19.2 million in the District's operating fund.
- Operating expenditures, excluding flood control facilities maintenance, have historically been less than 10.0 percent of sales tax revenue and are projected to remain comparable next year.
- Flood control capital improvement projects are fully funded when projects are approved by the District's Board of Directors.
- The District has committed to a debt coverage ratio of at least 100 percent of revenues on all outstanding Bonds. Actual coverage for all debt at June 30, 2024, was 338 percent.

Changes in Net position

The District's primary revenue source is a one-quarter of the one percent sales tax levy on sales in Clark County. Other revenue is derived from interest earnings, grants, and miscellaneous other sources. Expenditures are broadly defined to include public works and interest on long-term debt.

The table below and the subsequent discussion details the changes in net position:

Clark County Regional Flood Control District
Changes in Net Position

	Governmental Activities	
	2024	2023
Revenues:		
General Revenues:		
Sales and use tax	$ 159,483,862	$ 154,269,560
State grants	-	35,257
Interest income	17,352,348	5,223,815
Other	127,126	443,767
Total Revenues	176,963,336	159,972,399
Expenses:		
Public works	102,200,898	90,732,356
Interest on long-term debt	23,944,751	19,811,884
Total Expenses	126,145,649	110,544,240
Change in net position	50,817,687	49,428,159
Net Position – Beginning	(269,329,886)	(318,758,045)
Net Position – Ending	$ (218,512,199)	$ (269,329,886)

- Sales and use tax increased by $5.2 million, or 3.4 percent from the prior year. The increase largely reflects the growing and diversified Southern Nevada economy.
- Even though construction spending increased on several infrastructure projects during the year, pooled resources also increased mostly due to increase in sales and use tax. At June 30, cash balances increased from $378.9 million to $397.8 million. In compliance with GASB Statement No. 31 interest income reflects a market value adjustment which resulted in an overall increase in interest income of $12.1 million from the prior year.
- Public works expenditures, excluding interest on long-term debt, increased by $11.5 million, or 12.6 percent. Typically, flood control project construction expenditures are the most significant

component of expenditures and vary year-to-year as a result of several factors: 1) The number and dollar amounts of projects funded; 2) Project phase (i.e. design or construction)—approximately 80.0 percent of project expenditures are spent on construction projects, which typically move slowly at the beginning, quickly in the middle and slower at the end; and 3) Project delays may result from the time it takes to secure project rights-of-way, environmental issues, or weather interruptions. These factors tend to create a cyclical effect of infrastructure spending with years of lower expenditures as projects are designed or delayed and years of significant expenditures as projects are constructed and placed in service.

FINANCIAL ANALYSIS OF THE DISTRICT'S FUNDS

The District uses fund accounting to ensure and demonstrate compliance with finance-related legal requirements and utilized four governmental funds to manage its operations. The Regional Flood Control District fund (the District's general operating fund) accounts for operations and flood control facilities maintenance. One debt service fund, Flood Control Debt Service, accounts for principal and interest payments on the District's six outstanding general obligation bonds. One capital project fund, RFCD Construction, accounts for pay-as-you-go and debt-financed capital project expenditures.

- At the end of the fiscal year, the District's governmental funds reported a combined ending fund balance of $408.9 million, which is an increase of $23.0 million, or 6.0 percent, from the prior year.
- Nearly 4.7 percent, or $19.2 million, of combined fund balances constitute the fund balance that is unassigned and can be used for specific projects in the Ten-Year Construction Program.
- The remainder of fund balances has internal or external limitations on its use as follows: 1) open interlocal contracts or other agreements for the design and construction of flood control infrastructure ($194.5 million); 2) capital projects funds for future flood control infrastructure projects ($157.4 million); 3) future Other Post-Employment Benefits (OPEB) obligations and open purchase orders or interlocal contracts for District operations and maintenance of flood control facilities ($12.8 million); and 4) future debt service obligations ($25.1 million).
- The Regional Flood Control District fund is the chief operating fund of the District. The fund balance of the operating fund decreased 19.1 percent from the prior year from $39.5 million to $32.0 million. A majority of the decrease resulted from additional transfers to the RFCD Construction Fund for the design and construction of flood control infrastructure and additional Maintenance Work Program expenditures.
- As a measure of the operating fund's liquidity, it may be useful to compare both unassigned fund balance and total fund balance to total fund expenditures and transfers. For the fiscal year ending June 30, 2024, unassigned fund balance of $19.2 million represents 11.3 percent of total operating fund expenditures and transfers-out (including flood control facilities maintenance), which total $169.0 million, whereas total fund balance of $32.0 million represents 18.9 percent of that same amount.
- The fund balance of the Regional Flood Control District Debt Service fund increased by $1.7 million, or 7.4 percent, as a result of timing difference between transfers-in from the Regional Flood Control District fund and debt service payments.
- The fund balance of the RFCD Construction fund increased by $28.8 million, or 8.9 percent. The increase is a result of project closeouts and transfers from the Regional Flood Control District fund for future projects.

To maintain compliance with GAAP reporting requirements resulting from GASB 54, the District reports four governmental funds. However, for budgetary purposes, the District adopted an annual appropriated budget for four governmental funds in fiscal year 2024. Schedules of Revenues, Expenditures, and Changes in Fund Balances – Budget and Actual may be found under the Required Supplementary Information or the Supplementary Information section of these Component Unit Financial Statements, and a reconciliation is provided to explain GAAP and budgetary differences.

The District's Board of Directors (the "Board") approved the fiscal year 2024 budget on April 13, 2023.

- Actual resources in the Regional Flood Control District fund were $1.7 million more than the budget mainly as a result of sales tax revenues, which exceeded projections because of the expanding economy in Southern Nevada and additional interest income revenue received.
- Transfers from other funds were $350,000 as a result of earned interest on capital funds.
- Actual expenditures in the Regional Flood Control District fund were $3.4 million less than the budget primarily because of the cost savings in salaries and benefits for vacant positions and the timing differences that exist between the execution of multi-year professional services contracts and the payments made on those contracts.
- Transfers to other funds were as budgeted, to maintain an appropriate level of fund balance in the Regional Flood Control District fund.
- The one budget amendment of $2.9 million made during the year allowed additional funds for maintenance needs as a result of supplemental Maintenance Work Program requests. This amendment was supported by the unanticipated beginning fund balance.

CAPITAL ASSETS AND DEBT ADMINISTRATION

Capital Assets

As of June 30, 2024, the District had invested $2.2 million, net of accumulated depreciation, in capital assets which included buildings, equipment, and construction in progress (Flood Threat Recognition System installations). Items with an individual or aggregate cost of more than $5,000 are capitalized. There were no significant additions or deletions this fiscal year. The decrease of capital assets by 14.8 percent is primarily the result of depreciation and the retirement of obsolete equipment after the upgrade to the Alert II Flood Threat Recognition System completed the prior year. As mentioned above, the District annually invests millions of dollars in flood control infrastructure, but the District does not own those capital assets. All infrastructure assets are owned by the jurisdiction in which the capital asset is located, and therefore, are not included in the table of capital assets below. The table below details the District's capital assets, net of accumulated depreciation:

Clark County Regional Flood Control District
Capital Assets (Net of Accumulated Depreciation)

	Governmental Activities	
	2024	2023
Buildings	$ 1,578,433	$ 1,653,682
Machinery and equipment	250,803	271,490
Construction in progress	345,641	627,515
Total	$ 2,174,877	$ 2,552,687

For additional information on the District's capital assets, see note 4 of the accompanying financial statements.

LONG-TERM DEBT

Liabilities

On behalf of the District, the County has issued $955.0 million in eight original issue general obligation bonds/notes (additionally secured with pledged revenues), as well as seven refunding general obligation bonds (additionally secured with pledged revenues). Outstanding debt includes remaining balances from the 2014 $100.0 million General Obligation Bonds, the 2015 $186.5 million General Obligation Refunding Bonds, the 2017 $110.0 million General Obligation Advanced Crossover Refunding Bonds, the 2019 $115.0 million General Obligation Bonds, the 2020A $185.5 million General Obligation Refunding Bonds and the 2020B $85.0 million General Obligation Bonds. At year-end, the District had $631.7 million in outstanding long-term debt liabilities including unamortized premium, which is a decrease of $29.1 million or 4.4 percent from the prior year. The table below details the District's outstanding long-term debt liabilities:

Outstanding Debt Liabilities

Debt Issue	Governmental Activities 2024	Governmental Activities 2023	Debt Retirement Fiscal Year
2014 General Obligation Bonds (Partially refunded by the 2020A General Obligation Bonds)	$ 4,012,484	$ 8,014,936	FY 2025
2015 General Obligation Bonds (Refunding of the 2006 General Obligation Refunding Bonds)	158,226,886	168,299,715	FY 2036
2017 General Obligation Bonds (Advanced Crossover Refunding of 2009B General Obligation Taxable Direct Pay BABs)	99,249,483	104,165,145	FY 2039
2019 General Obligation Bonds	101,530,357	107,409,568	FY 2039
2020A General Obligation Bonds (Refunding of the 2013 General Obligation Bonds and Partial Refunding of the 2014 General Obligation Bonds)	181,304,464	183,014,225	FY 2039
2020B General Obligation Bonds	87,380,133	89,900,998	FY 2046
Total	$ 631,703,807	$ 660,804,587	

For additional information on the District's debt, see note 6 of the accompanying financial statements.

The District may issue general obligation bonds or revenue bonds by means of the authority granted to the District by the Nevada State Legislature. However, to date, Clark County (County) has been the issuer of the District's flood control bonds and notes. The District has chosen to have Clark County issue all of the District's debt and be bound by the County's debt limits, due to its financial stability and bond rating. By having the County issue the debt, the District is able to obtain favorable interest rates. Nevada Revised Statute 244A.059 limits the aggregate principal amount of the County's general obligation debt to ten percent of the County's total reported assessed valuation. Based upon the assessed valuation for fiscal year 2023-24 of $137.5 billion, the County is limited to general obligation indebtedness in the aggregate amount of approximately $13.8 billion. The County has $2.7 billion of general obligation debt applicable to the limit outstanding as of June 30, 2024. Therefore, there remains approximately $11.1 billion of additional statutory debt capacity.

The outstanding bonds and notes of the District constitute direct and general obligations of the County, and the full faith and credit of the County is pledged for the payment of principal, interest, and any redemption premium. The bonds and notes are additionally secured by a pledge of the District's one-quarter of one percent sales tax revenue. The debt coverage ratio for this pledge of revenue on all outstanding general obligation bonds must be at least sufficient to pay an amount that is 100 percent of the combined maximum annual principal and interest requirements. For the fiscal year that ended June 30, 2024, the District has a coverage ratio of 338 percent on all outstanding debt.

ECONOMIC FACTORS AND NEXT YEAR'S BUDGET

The District's major revenue source (90.0 percent of historical revenues) is derived from local sales tax. Southern Nevada's economic diversification and competitiveness is a key contributor to the region's recent growth. Trends in current population, employment and gross domestic product reveal an expanding regional economy and in-migration data suggests the Las Vegas metropolitan area is an attractive destination for new residents and businesses. Fiscal year 2023-24 sales tax revenue was nearly $159.5 million, which was a 3.4 percent gain over the prior year. The District views this as a continuation of a growing local economy and long-term upward economic trend for Southern Nevada. As a result, we expect to see sales tax revenue modestly increase next fiscal year.

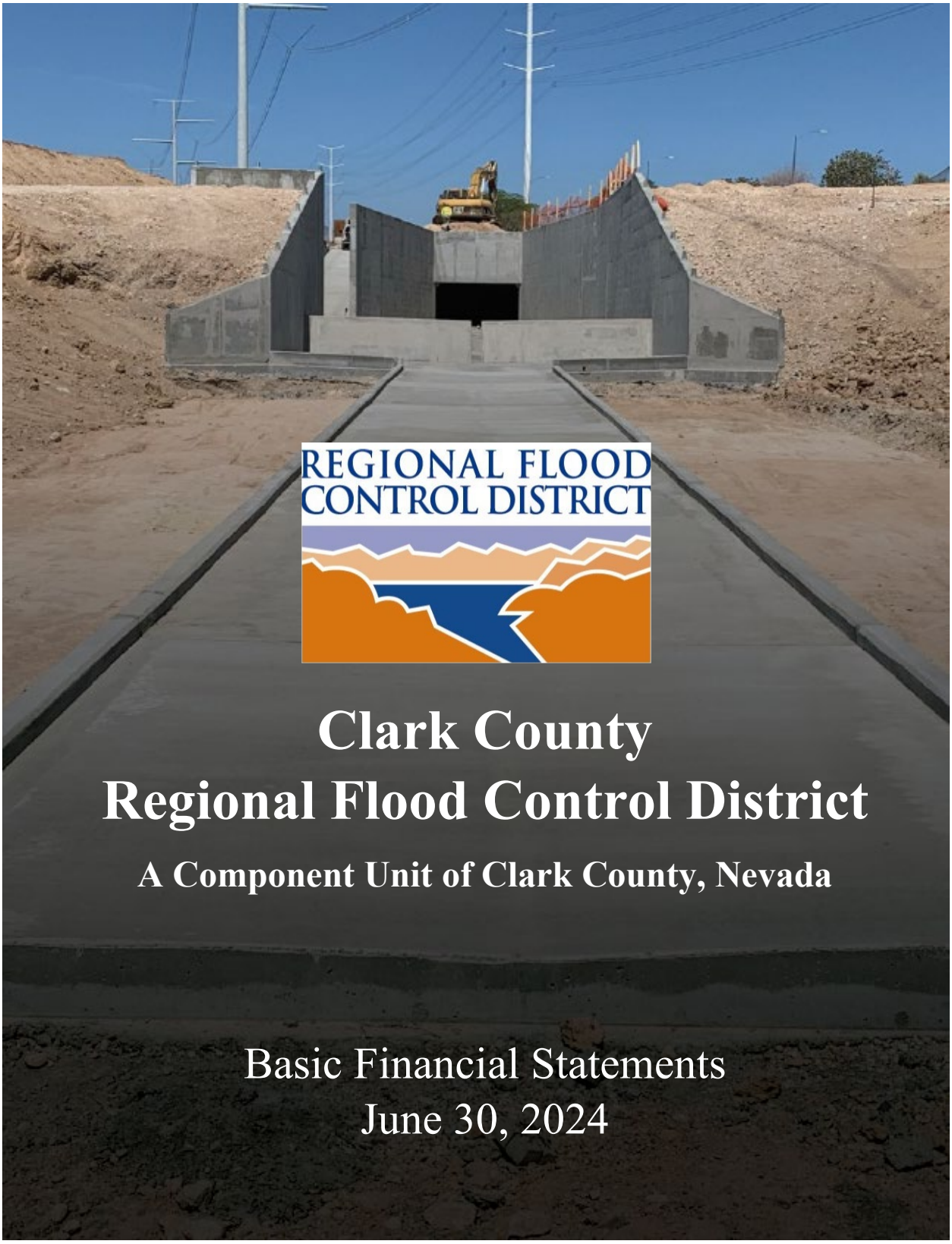
The District's fiscal year 2024-25 annual budget, approved by the Board of Directors on April 11, 2024, included forecasted sales tax revenues of $167.1 million, which is a 4.8 percent increase from actual receipts in fiscal year 2023-24, however, was a 3.3 percent increase from the fiscal year 2023-24 revised budget. District management will continue to monitor sales tax receipts and make budget adjustments to address significant differences from the sales tax revenue projections during the year if necessary.

On March 14, 2024, the Board approved a budget augmentation in the amount of $2.9 million, supported by unanticipated beginning fund balance, from remaining Maintenance Work Program funds from the previous fiscal year. Additional funding for maintenance of the Regional Flood Control Facilities within the City of Las Vegas was needed due to major storm events from Tropical Storm Hilary in August 2023. These storm events deposited significant debris and sediment as well as caused damage to a portion of the basins.

The fiscal year 2024-25 approved budget includes $12.6 million for operating, $22.0 million for the facilities maintenance program and $48.2 million for debt service. The Capital Improvement Program budget includes the authority to encumber/expend the entire amount of estimated resources for capital expenditures. The District uses zero-based budgeting where the entire available amount of estimated resources, $437.7 million, is budgeted for capital expenditures upon approval by the Board of Directors.

CONTACTING THE DISTRICT'S FINANCIAL MANAGEMENT

This financial report is designed to provide Clark County citizens and taxpayers, and our business partners, customers, and creditors with a general overview of the District's finances and to demonstrate the District's accountability for the resources it receives. If you have questions about this report or need additional financial information, contact the Clark County Regional Flood Control District at (702) 685-0000, by visiting our website at https://www.regionalflood.org/, or in person at 600 S. Grand Central Parkway, Suite 300, Las Vegas, Nevada 89106.



Clark County
Regional Flood Control District

A Component Unit of Clark County, Nevada

Basic Financial Statements
June 30, 2024

Clark County Regional Flood Control District
A Component Unit of Clark County, Nevada
Statement of Net Position
June 30, 2024

	Governmental Activities
Assets	
Cash and investments	
In custody of the County Treasurer	$ 348,284,251
In custody of other officials	500
With fiscal agent	49,548,592
Interest receivable	1,933,024
Due from other governmental units	26,650,795
Deposits	1,626
Capital assets not being depreciated	345,641
Capital assets being depreciated, net of accumulated depreciations	1,829,236
Total assets	428,593,665
Deferred Outflows of Resources	
Deferred amounts related to Pensions	2,022,630
Deferred amounts related to OPEB	451,126
Deferred loss on bond refundings	13,519,453
Total deferred outflows of resources	15,993,209
Total assets and deferred outflows of resources	444,586,874
Liabilities	
Accounts payable	17,418,533
Accrued payroll and other accrued liabilities	60,288
Accrued interest	3,448,313
Long-term liabilities	
Bonds and loans payable, due within one year	27,195,000
Bonds and loans payable, due after one year	604,508,807
Other non-current liabilities, due after one year	
Compensated absences	1,257,207
Total OPEB liability	1,539,048
Net pension liability	6,028,349
Total liabilities	661,455,545
Deferred Inflows of Resources	
Deferred amounts related to Pensions	326,768
Deferred amounts related to OPEB	1,316,760
Total deferred inflows of resources	1,643,528
Total liabilities and deferred inflows of resources	663,099,073
Net Position	
Net investment in capital assets	2,174,877
Restricted for debt service	18,130,000
Restricted for construction	49,548,592
Unrestricted	(288,365,668)
Total net position	$ (218,512,199)

See Notes to Financial Statements

Clark County Regional Flood Control District
A Component Unit of Clark County, Nevada
Statement of Activities
For the Fiscal Year Ended June 30, 2024

	Expenses	Program Revenues: Charges for Services	Program Revenues: Operating Grants and Contributions	Program Revenues: Capital Grants and Contributions	Net (Expenses) Revenues and Changes in Net Position: Primary Government: Governmental Activities
Governmental activities:					
Public Works	$ 102,200,898	$ -	$ -	$ -	$ (102,200,898)
Interest on long-term liabilities	23,944,751	-	-	-	(23,944,751)
Total governmental activities	$ 126,145,649	-	$ -	-	(126,145,649)
General Revenues					
Sales and use tax					159,483,862
Interest/investment income					17,352,348
Other					127,126
Total general revenues					176,963,336
Change in net position					50,817,687
Net position - beginning					(269,329,886)
Net position - ending					$ (218,512,199)

See Notes to Financial Statements

Clark County Regional Flood Control District
A Component Unit of Clark County, Nevada
Balance Sheet Governmental Funds
June 30, 2024

	Regional Flood Control District	Flood Control Debt Service	RFCD Construction	Total Governmental Funds
Assets				
Cash and investments				
In custody of the County Treasurer	$ 24,932,625	$ 24,964,736	$ 298,386,890	$ 348,284,251
In custody of other officials	500	-	-	500
With fiscal agent	-	-	49,548,592	49,548,592
Interest receivable	138,367	138,560	1,656,097	1,933,024
Due from other funds	-	-	16,000,000	16,000,000
Due from other governmental units	26,650,795	-	-	26,650,795
Deposits and other assets	1,626	-	-	1,626
Total assets	$ 51,723,913	$ 25,103,296	$ 365,591,579	$ 442,418,788
Liabilities				
Accounts payable	$ 3,674,222	$ -	$ 13,744,311	$ 17,418,533
Accrued payroll	60,288	-	-	60,288
Due to other funds	16,000,000	-	-	16,000,000
Total liabilities	19,734,510	-	13,744,311	33,478,821
Fund Balances				
Restricted	-	21,578,313	49,548,592	71,126,905
Committed	7,346,679	-	144,901,219	152,247,898
Assigned	5,466,731	3,524,983	157,397,457	166,389,171
Unassigned	19,175,993	-	-	19,175,993
Total fund balances	31,989,403	25,103,296	351,847,268	408,939,967
Total liabilities and fund balances	$ 51,723,913	$ 25,103,296	$ 365,591,579	$ 442,418,788

See Notes to Financial Statements

Total fund balance – governmental funds		$ 408,939,967
Amounts reported for governmental activities in the statement of net positions are different because:		
Capital assets used in governmental activities are not current financial resources and, therefore, are not reported in the fund financial statements, but are reported in the governmental activities on the statement of net position.		
Governmental capital assets	6,031,460	
Less: accumulated depreciation	(3,856,583)	
		2,174,877
Long-term liabilities and deferred outflows and inflows of resources, such as general obligation bonds and loans payable and compensated absences, are not due and payable in the current period and are not included in the fund financial statements but are included in the governmental activities on the statement of net position.		
Bonds payable	(631,703,807)	
Deferred loss on bond refundings	13,519,453	
Compensated absences	(1,257,207)	
Total Other post-employment benefits obligations	(1,539,048)	
Net pension liability	(6,028,349)	
Deferred outflows related to postemployment benefits other than pensions	451,126	
Deferred inflows related to postemployment benefits other than pensions	(1,316,760)	
Deferred outflows related to pensions	2,022,630	
Deferred inflows related to pensions	(326,768)	
		(626,178,730)
Accrued interest payable		(3,448,313)
Total net position – governmental activities		$ (218,512,199)

See Notes to Financial Statements

Clark County Regional Flood Control District
A Component Unit of Clark County, Nevada
Statement of Revenues, Expenditures and Changes in Fund Balances Governmental Funds
For the Fiscal Year Ended June 30, 2024

	Regional Flood Control District	Flood Control Debt Service	RFCD Construction	Total Governmental Funds
Revenues				
Intergovernmental revenue	$ 159,483,862	$ -	$ -	$ 159,483,862
Interest/investment income	1,569,825	1,080,856	14,701,667	17,352,348
Other	50,120	-	77,006	127,126
Total revenues	161,103,807	1,080,856	14,778,673	176,963,336
Expenditures				
Salaries and wages	2,752,201	-	-	2,752,201
Employee benefits	1,208,695	-	-	1,208,695
Services and supplies	19,966,356	1,500	295,766	20,263,622
Capital outlay to others	-	-	82,337,663	82,337,663
Debt Service:				
Principal	-	25,930,000	-	25,930,000
Interest and other charges	-	21,300,640	-	21,300,640
Capital outlay	189,841	-	-	189,841
Total expenditures	24,117,093	47,232,140	82,633,429	153,982,662
Excess (deficiency) of revenues over (under) expenditures	136,986,714	(46,151,284)	(67,854,756)	22,980,674
Other Financing Sources (Uses)				
Transfers from other funds	350,000	47,870,385	97,000,000	145,220,385
Transfers to other funds	(144,870,385)	-	(350,000)	(145,220,385)
Total other financing sources and uses	(144,520,385)	47,870,385	96,650,000	-
Net change in fund balances	(7,533,671)	1,719,101	28,795,244	22,980,674
Fund balances - beginning	39,522,534	23,384,195	323,052,024	385,958,753
Fund balances - ending	$ 31,989,403	$ 25,103,296	$ 351,847,268	$ 408,939,967

See Notes to Financial Statements

Net change in fund balances - total governmental funds		$ 22,980,674
Amounts reported for governmental activities in the statement of activities are different because:		
Governmental funds report outlays for capital assets as expenditures because such outlays use current financial resources. In contrast, the statement of activities reports only a portion of the outlay as expense. The outlay is allocated over the assets' estimated useful lives as depreciation expense for the period. The Regional Flood Control District utilizes capital projects funds to construct infrastructure, most of which is dedicated to other entities.		
Capital outlay recorded in governmental funds	82,527,504	
Less amounts dedicated to other entities	(82,633,429)	
Capitalized expenditures	(105,925)	
Less current year depreciation	(201,493)	
		(307,418)
Asset transferred to capital assets – Fleet vehicle procured using non-capital account and transferred to asset created using capital account.		(69,852)
Governmental funds report bond proceeds as current financial resources. In contrast, the statement of activities treats such issuance of debt as a liability. Governmental funds report repayment of bond principal as an expenditure. In contrast the statement of activities treats such repayments as a reduction in long-term liabilities. This is the amount by which repayments exceeded proceeds.		
Principal payments	25,930,000	
		25,930,000
Some expenses reported in the statement of activities do not require the use of current financial resources and these are not reported as expenditures in governmental funds.		
Change in accrued interest	203,588	
Amortization of bond premiums	3,170,780	
Amortization of deferred loss on refunding	(730,257)	
Change in long-term compensated absences	(122,741)	
Change in post-employment benefits other than pensions	18,281	
Change in deferred outflows related to postemployment benefits other than pensions	(41,309)	
Change in deferred inflows related to postemployment benefits other than pensions	117,461	
Change in deferred outflows related to pensions	(243,218)	
Change in deferred inflows related to pensions	(82,100)	
Change in net pension liability	(6,202)	
		2,284,283
Change in net position of governmental activities		$ 50,817,687

Note 1 - Summary of Significant Accounting Policies

The Reporting Entity

The Clark County Regional Flood Control District (the "District") was created by the Nevada State Legislature in 1986 to develop a coordinated and comprehensive plan to alleviate flooding problems and to fund and coordinate the construction of flood control structures.

The organization and funding of the District are governed by Nevada Revised Statutes Chapter 543. The governing board (the "Board") includes two representatives from Clark County (the "County") and the City of Las Vegas and one representative each from the cities of Boulder City, Henderson, Mesquite, and North Las Vegas. The District is funded by one quarter of one percent sales tax levy approved by Clark County voters in September 1986.

The District is an integral part of the Clark County, Nevada financial reporting entity and as such, the District is considered a component unit of the County. The accounting policies of the District conform to accounting principles generally accepted in the United States of America as applicable to governmental entities.

Government-Wide and Fund Financial Statements

The government-wide financial statements (i.e., the statement of net position and the statement of activities) report information on all of the activities of the District. The effect of interfund activity has been removed from these statements.

The statement of activities demonstrates the degree to which the direct expenses of a given function are offset by program revenues. Direct expenses are those that are clearly identifiable with a specific function or segment. Program revenues include 1) charges to customers or applicants who purchase, use, or directly benefit from goods, services, or privileges provided by a given function or segment and 2) grants and contributions that are restricted to meeting the operational or capital requirements of a particular function or segment. Taxes and other items not properly included among program revenues are reported instead as general revenues.

Separate financial statements are provided for governmental funds. All governmental funds are considered to be major funds, and they are reported as separate columns in the fund financial statements.

Measurement Focus, Basis of Accounting, and Financial Statement Presentation

Government-Wide Financial Statements

The government-wide financial statements are reported using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded when earned and expenses are recorded when a liability is incurred, regardless of the timing of related cash flows. Grants and equivalent items are recognized as revenue as soon as all eligibility requirements imposed by the provider have been met.

Amounts reported as program revenues include charges to customers or applicants for goods, services, or privileges provided. Internally dedicated resources are reported as general revenues rather than as program revenues. Likewise, general revenues include all taxes.

Fund Financial Statements

Governmental fund financial statements are reported using the current financial resources measurement focus and the modified accrual basis of accounting. Revenues are recognized as soon as they are both measurable and available. Revenues are considered to be available when they are collectible within the current year or soon enough thereafter to pay liabilities of the current year. For this purpose, the District considers revenues to be available if they are collected within 90 days after the end of the current fiscal year. Expenditures generally are recorded when a liability is incurred, as under accrual accounting. However, debt service expenditures, as well as expenditures related to compensated absences and claims and judgements, are recorded only when payment is due.

Sales taxes, interest revenue, and charges for services associated with the current fiscal year are considered to be susceptible to accrual and have been recognized as revenues in the current year.

The District reports the following major governmental funds:

Regional Flood Control District Fund – this is the general operating fund of the District. The general operating fund is used to account for all resources and costs of operations traditionally associated with governments, which are not accounted for and reported in other funds.

Flood Control Debt Service Fund – this fund is used to account for the payment of principal and interest, and the cost of operations associated with the debt service for the District's general obligation debt.

RFCD Construction Fund – this capital projects fund is used to account for the costs of capital improvements and constructing regional flood control facilities paid from sales tax proceeds, bond proceeds, and interest earnings.

Assets, Deferred Outflows (DOR), Liabilities, Deferred Inflows (DIR) and Net Position or Equity

Cash and Investments

Cash and cash equivalents include cash in the bank, cash on hand, demand deposits and short-term investments with maturities of three months or less from the date of acquisition.

The majority of all cash and investment transactions of the District are overseen by the Clark County Treasurer's office. Cash balances are combined and invested as permitted by law in combination with Clark County funds. Additionally, the District invests in money market mutual funds. Investments are reported at fair value on the balance sheet and statement of net position. Fair value is the amount at which a financial instrument could be exchanged in a current transaction between willing parties other than in a forced or liquidation sale. Changes in the fair value of District investments are part of interest earnings of the individual funds.

Receivables and Payables

Activities between funds that are representative of lending/borrowing arrangements outstanding at the end of the fiscal year are referred to as either "due to/from other funds."

Restricted Assets

Restricted assets consist of cash and cash equivalents, investments and certain receivables that are restricted in their use by bond covenants or other agreements. They are primarily used to pay the cost of capital projects and to meet debt services obligations.

Capital Assets

Capital assets, which include property, plant, and equipment, are reported in the government-wide financial statements. Capital assets are defined by the government as assets with an individual or aggregate cost of more than $5,000 are capitalized and an estimated useful life in excess of one year. Such assets are recorded at historical cost or estimated historical cost if purchased or constructed. Donated capital assets are recorded at acquisition value at the date of donation. The costs of normal maintenance and repairs that do not add to the value of the asset or materially extend asset lives are not capitalized.

Major outlays for capital assets and improvements are capitalized as projects are constructed. Significant projects in process are depreciated once the projects are placed in service. Prior to that time, they are reported as construction in progress.

Capital assets are depreciated using the straight-line method over the following estimated useful lives:

Assets	Years
Buildings	20-50
Equipment	1-20

Deferred Outflows and Deferred Inflows of Resources

Deferred outflows of resources represent a consumption of net position that applies to a future period so will not be recognized as an outflow of resources (expense/expenditure) until then. Bond refundings are unamortized balances resulting from bond refundings and deferred losses incurred on the re-association and revaluation of interest rate swaps paired to certain bonds that were refunded. The pension contributions resulted from the District pension related contributions subsequent to the measurement date but before the end of the fiscal year, differences between expected and actual experience, net difference between projected and actual investment earnings, changes in assumptions and changes in proportionate share of collective net pension liability since the prior measurement date, earnings on investments, and changes in proportion since the prior measurement date. The OPEB related deferred outflows result from OPEB related contributions and benefit payments made subsequent to the measurement date, but before the end of the fiscal year, differences between expected and actual experience, change in assumptions and net difference between projected and actual investment earnings.

Deferred inflows of resources represent an acquisition of net position that applies to a future period and so will not be recognized as an inflow of resources (revenue) until that time. Bond refundings are unamortized balances resulting from bond refundings. The pension related amounts result from the differences between projected and actual experience and changes in proportionate share of collective net pension liability since the prior measurement date. The OPEB related amounts result from differences between expected and actual experience, change in assumptions and net difference between projected and actual investment earnings.

Compensated Absences

It is the District's policy to permit employees to accumulate earned, but unused vacation and sick leave benefits. Such benefits are accrued when incurred in the government-wide financial statements.

Long-Term Obligations

In the government-wide financial statements, long-term debt and other long-term obligations are reported as liabilities. Bond premiums and discounts are amortized over the life of the bonds using the effective interest method. Bonds payable are reported net of the applicable bond premium or discount.

In the fund financial statements, governmental fund types recognize bond premiums and discounts, as well as bond issuance costs, during the current period. The face amount of debt issued is reported as other financing sources. Premiums received on debt issuances are reported as other financing sources whereas discounts on debt issuances are reported as other financing uses. Issuance costs, whether or not withheld from the actual debt proceeds received, are reported as debt service expenditures.

Net Position or Equity

In the government-wide financial statements, equity is classified as net position and displayed in three components:

- Net investment in capital assets – Capital assets, net of accumulated depreciation and reduced by the outstanding balances of any bonds, notes or other borrowings that are attributable to the acquisition, construction, or improvement of those assets net of unspent financing proceeds.

- Restricted net position – Net position with constraints placed on their use that are either (a) externally imposed by creditors, grantors, contributors, or laws or regulations of other governments; or (b) imposed by law through constitutional provisions or enabling legislation.

- Unrestricted net position – All other net position that does not meet the definition of "restricted" or "net investment in capital assets."

In governmental fund financial statements equity is classified as fund balance and is displaced in up to five components based primarily on the extent to which the District is bound to observe constraints imposed on the use of fund resources. The components are as follows:

- Nonspendable fund balances – Amounts that cannot be spent because they are either (a) not in spendable form; or (b) legally or contractually required to be maintained intact. The "not in spendable form" criterion includes items that are not expected to be converted to cash, for example, inventories and prepaid amounts. It also includes the long-term amount of loans and notes receivable.

- Restricted fund balances – Similar to restricted net position discussed above, these are amounts with constraints placed on their use either by (a) external groups such as creditors, grantors, contributors or laws and regulations or other governments; or (b) imposed by law through constitutional provision or enabling legislation.

- Committed fund balances – Amounts with constraints imposed by formal resolution of the Regional Flood Control District Board of Directors (the "Board") that specifically state the purpose of the commitment. Commitments can only be modified or rescinded through resolutions by the Board. Commitments can also include resources required to meet contractual obligations approved by the Board.

- Assigned fund balances – Amounts intended to be used by specific purposes by the General Manager as authorized by fiscal directives that do not meet the criteria to be classified as restricted or committed. The assigned fund balance represents management approved encumbrances that have been re-appropriated in the subsequent year. The General Manager has been delegated authority by the Board to assign amounts of ending fund balance.

- Unassigned – Amounts not contained in other classifications. For other governmental funds, the unassigned classification is used only to report a deficit balance resulting from expenditures exceeding those amounts restricted, committed, or assigned for specific purposes.

Based on the fund balance classification as noted above, when both restricted and unrestricted funds are available for expenditure, restricted funds should be spent first unless legal requirements disallow it. When expenditures are incurred for purposes for which amounts in any unrestricted fund balance classification could be used, committed funds are to be spent first, assigned funds second and unassigned funds last.

Use of Estimates

The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect certain reported amounts and disclosures. Accordingly, actual results could differ from these estimates.

Note 2 - Stewardship, Compliance and Accountability

Compliance with Nevada Revised Statutes

Per NRS 354.626, no governmental agency may expend or contract to expend funds in excess of amounts appropriated for that function. The District is required to report and explain expenditures or contracts to expend that exceeded budgeted appropriations for the General Fund, Special Revenue, and Capital Project Funds. As of June 30, 2024, the District had no exceptions to report.

Note 3 - Cash and Investments

The majority of all cash and investments of the District are included in the investment pool of the Clark County Treasurer (the "Treasurer") and the District's trustee, the Bank of New York Mellon. As of June 30, 2024, these amounts are distributed as follows:

Cash and investments held in Clark County Investment Pool	$ 348,284,251
Cash on hand	500
Cash with fiscal agent	49,548,592
Grand Total	$ 397,833,343

Clark County Investment Pool

The Treasurer invests monies held both by individual funds and through a pooling of monies. The pooled monies, referred to as the investment pool, are invested as a whole and not as a combination of monies from each fund belonging to the pool. In this manner, the Treasurer is able to invest the monies at a higher interest rate for a longer period of time. Interest is apportioned monthly to each fund in the pool based on the average daily cash balance of the fund for the month in which the investments mature.

According to state statutes, County monies must be deposited with federally insured banks, credit unions, or savings and loan associations within the County. The Treasurer is authorized to use demand accounts, time accounts, and certificates of deposit.

State statutes specifically require collateral for demand deposits and specify that collateral for time deposits may be of the same type as those described for permissible investments. Permissible state investments are similar to allowable County investments described below, except that statues permit a longer term and include securities issued by municipalities within the state of Nevada.

Due to the nature of the investment pool, it is not possible to separately identify any specific investment as being that of the District. Instead, the District owns a proportionate share of each investment, based on the District's participation percentage in the investment pool.

Trustee Cash

In accordance with the Master Indenture of Trust dated May 3, 2003, as amended, between the County and the Bank of New York Mellon ("Trustee"), the District uses the Trustee to retain all debt service reserve funds and to make all annual debt service payments to bondholders. As of June 30, 2024, the Trustee held $49,548,592 of the District's cash and investments restricted for debt service reserves, bond proceeds, and annual debt service payments.

Fair Value Measurement

In accordance with GASB Statement No. 72, investments and derivative instruments are valued at fair value. Securities classified at Level 1 of the fair value hierarchy are valued using prices quoted in active markets for those securities or offer same-day liquidity at a price of par. Securities classified at Level 2 of the fair value hierarchy are generally valued using a matrix pricing technique or are less liquid than Level 1 securities. Matrix pricing is the process of estimating the market price of a bond based on the quoted prices of more

frequently traded comparable bonds. Securities classified as Level 3 of the fair value hierarchy generally are not traded on the open market and include Forward Delivery Agreements, and State and Local Government Series (SLGS) securities which are purchased from the U.S. Department of Treasury through a subscription process but can be redeemed through the Bureau of Fiscal Service by a redemption request.

As of June 30, 2024, the $49,548,592 held by the Trustee was invested in short-term investments with entities as indicated in the tables below:

Investment Type	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Total
Money Market Funds	$ 49,548,592	-	$ 49,548,592
	$ 49,548,592	$ -	$ 49,548,592

Credit Risk

All deposits are subject to credit risk. Credit risk is defined as the risk that another party to a deposit or investment transaction (counterparty) will not fulfill its obligations. The County's investment policy applies the prudent-person rule: "In investing the County's monies, there shall be exercised judgment and care under the circumstances then prevailing which persons of prudence, discretion, and intelligence exercise in the management of their own affairs, not for speculation, but for investment, considering the probable safety of their capital as well as the probable income to be derived." Although the County reports securities' ratings by Moody's Investor Service, state statutes and the County's Investment Policy require securities be rated by one nationally recognized rating service (such as Standard & Poor's and Fitch Ratings).

As of June 30, 2024, the $49,548,592 of investments held by the Trustee were categorized by credit quality rating as follows:

Investment Ratings	Moody's	S&P
Morgan Stanley Money Market Funds	N/A	N/A

Interest Rate Risk

Interest rate risk is defined as the risk that changes in interest rates will adversely affect the fair value of an investment. Through its investment policy, the County manages its exposure to fair value losses arising from increasing interest rates by limiting the duration of its investment pool portfolio to less than 2.5 years. Duration is a measure of the present value of a fixed income's cash flow and is used to estimate the sensitivity of a security's price to interest rate changes.

As of June 30, 2024, the $49,548,592 held by the Trustee was invested in short-term investments with entities as indicated in the tables below:

		Investment Maturities (in Years)	
Investment Type	Fair Value 06/30/2024	Less Than 1	1 to 3
Morgan Stanley Money Market Fund	$ 49,548,592	$ 49,548,592	$ -
	$ 49,548,592	$ 49,548,592	$ -

Concentrations of Credit Risk

Concentration of credit risk is defined as the risk of loss attributed to the magnitude of a government's investment in a single issuer. The County's investment policy limits the amount that may be invested in obligations of any one issuer, except direct obligations of the U.S. government or federal agencies, to no more than five percent of the total cash and investments.

At June 30, 2024, there were no investments held which exceeded five percent of the total cash and investments.

GASB Statement No. 31

GASB Statement No. 31 requires the County to adjust the carrying amount of its investment portfolio to reflect the change in fair or market values. Interest revenue is increased or decreased in relation to this adjustment of unrealized gain or loss. Net interest income in the funds reflects this positive or negative market value adjustment.

Note 4 - Capital Assets

Capital asset activity for the year ended June 30, 2024, was as follows:

	Balance June 30, 2023	Increases	Decreases	Balance June 30, 2024
Governmental activities:				
Capital assets not being depreciated:				
Construction in progress	$ 627,515	$ 96,921	$ (378,795)	$ 345,641
Capital assets being depreciated:				
Buildings	3,289,509	-	-	3,289,509
Equipment	2,396,232	103,262	(103,184)	2,396,310
Total capital assets being depreciated	5,685,741	103,262	(103,184)	5,685,819
Less: accumulated depreciation for				
Buildings	1,635,827	75,249	-	1,711,076
Equipment	2,124,742	126,244	(105,479)	2,145,507
Total accumulated depreciation	3,760,569	201,493	(105,479)	3,856,583
Total capital assets being depreciated, Net	1,925,172	(98,231)	2,295	1,829,236
Governmental activities capital assets, Net	$ 2,552,687	$ (1,310)	$ (376,500)	$ 2,174,877

Depreciation expense of $201,493 was charged to the public works function.

Note 5 - Interfund Balances and Transfers

The composition of interfund balances at June 30, 2024, is as follows:

Receivable Fund	Payable Fund	Amount
RFCD Construction	Regional Flood Control District	$ 16,000,000
Total		$ 16,000,000

Interfund balances resulted from the time lag between the dates that (1) interfund goods and services were provided or reimbursable expenditures occur, (2) transactions were recorded in the accounting system and (3) payments between funds are made.

Interfund transfers for the year ended June 30, 2024, consisted of the following:

	Transfers Out:		
Transfers In:	Regional Flood Control District	RFCD Construction	Totals
Regional Flood Control District	$ -	$ 350,000	$ 350,000
Flood Control Debt Service	47,870,385	-	47,870,385
RFCD Construction	97,000,000	-	97,000,000
Total Transfers In and Out	$ 144,870,385	$ 350,000	$ 145,220,385

Transfers were used to: 1) move revenues from the fund that statute or budget requires to collect them to the fund that statute or budget requires to expend them; 2) move receipts restricted to debt service from the funds collecting the receipts to the debt service fund as debt service payments become due; and 3) use unrestricted revenues collected in the general fund to finance various programs accounted for in other funds in accordance with budgetary authorization.

Note 6 - Long-Term Liabilities

General Obligation Bonds

Bonds payable at June 30, 2024, are comprised of the following individual issues:

Series	Purpose	Date Issued	Date of Final Maturity	Interest Rate	Original Amount	Balance June 30, 2024
2014	Building	12/11/2014	11/01/2024	5.00%	$ 100,000,000	$ 3,855,000
2015	Refunding	03/31/2015	11/01/2035	3.00-5.00%	186,535,000	145,465,000
2017	Refunding	12/07/2017	11/01/2038	2.38-5.00%	109,955,000	93,220,000
2019	Building	03/26/2019	11/01/2038	3.00-5.00%	115,000,000	91,365,000
2020A	Refunding	10/28/2020	11/01/2038	0.29-2.80%	185,465,000	180,515,000
2020B	Building	10/28/2020	11/01/2045	2.25-5.00%	85,000,000	78,935,000
Total general obligation bonds					$ 781,955,000	$ 593,355,000

Summary of Debt Services – The annual debt service requirements to maturity are as follows:

Year ending June 30,	Total Principal	Total Interest	Total
2025	$ 27,195,000	$ 20,045,488	$ 47,240,488
2026	28,430,000	18,810,908	47,240,908
2027	29,500,000	17,596,309	47,096,309
2028	31,570,000	16,313,658	47,883,658
2029	33,755,000	15,026,341	48,781,341
2030-2034	188,105,000	55,822,525	243,927,525
2035-2039	223,185,000	20,729,649	243,914,649
2040-2044	22,025,000	2,562,916	24,587,916
2045-2046	9,590,000	241,250	9,831,250
	$ 593,355,000	$ 167,149,044	$ 760,504,044

There are a number of limitations and restrictions contained in the bond indentures. The District is in compliance with all significant limitations and restrictions.

Pledged Revenues

The District has pledged future receipts from the one-quarter cent sales tax levy authorized by NRS 543.600 to repay its general obligation bonds. The total principal and interest remaining to be paid on the bonds is $760,504,044. Principal and interest paid for the current year and pledged revenues received were as follows:

Pledged revenues - sales tax	$ 159,483,862
Debt service	47,230,640
Coverage	3.38

Compensated Absences

The following is the change in long-term accrued sick leave and vacation benefits recorded as a non-current liability in the statement of net position as of June 30, 2024:

Long-term portion of accrued sick leave and vacation benefits at June 30, 2023	$ 1,134,466
Additional amount accrued during the year	539,082
Less amount used during the year	(416,341)
Long-term portion of accrued sick leave and vacation benefits at June 30, 2024	$ 1,257,207

The employees of the District have historically earned more sick leave, and vacation benefits each year than they have used. Since the compensated absences liability has typically increased each year over the prior year, none of the above amounts is considered to be current and due within the next year. The District recognizes the amounts utilized on the last-earned-first-taken basis.

Arbitrage Rebate Requirements

Tax-exempt bond arbitrage involves the investment of governmental bond proceeds which are derived from the sale of tax-exempt obligations in higher yielding taxable securities that generate a profit. The federal Tax reform Act of 1986 imposes a rebate requirement with respect to some bonds issued by the County for the District. Under this Act, an amount may be required to be rebated to the United States Treasury ("arbitrage") for interest on the bonds to qualify for exclusion from gross income for federal income tax purposes. The District's estimated arbitrage liability at June 30, 2024, and 2023, was $32,863 and $295,766, respectively. The decrease in arbitrage liability from FY 2023 to FY 2024 was attributable to excess yield in Series 2019.

The District is current on all required arbitrage payments. Future calculations may result in adjustments to this determination.

Changes in Long-Term Liabilities

	Beginning Balance	Additions	Reductions	Ending Balance	Due Within One Year
Bonds payable:					
General obligation bonds	$ 619,285,000	$ -	$ (25,930,000)	$ 593,355,000	$ 27,195,000
Plus: issuance premiums	41,519,587	-	(3,170,780)	38,348,807	-
Total bonds payable	660,804,587	-	(29,100,780)	631,703,807	27,195,000
Compensated absences	1,134,466	539,082	(416,341)	1,257,207	-
Total long-term liabilities	$ 661,939,053	$ 539,082	$ (29,517,121)	$ 632,961,014	$ 27,195,000

For governmental activities, compensated absences and claims and judgments payable are liquidated by the Regional Flood Control District general operating fund.

In 2015, GASB Statement No. 70, *Accounting and Financial Reporting for Nonexchange Financial Guarantees*, became effective. This requires disclosure of financial guarantees that are nonexchange transactions of an obligation of an individual or legally separate entity in which the guarantor would indemnify a third-party obligation holder under certain conditions. As Clark County has been the issuer of all debt for the District, Clark County guarantees the repayment of the debt with a general obligation pledge. Currently, the amount of the guarantee is $760,504,044 and the length of time the debt will be outstanding is through fiscal year 2046. At no time, past or present, has Clark County paid any amount on behalf of the District as part of the debt guarantee.

Note 7 – Retirement System

Plan Description

Public Employees' Retirement System of Nevada (PERS or System) administers a cost-sharing, multiple-employer, defined benefit public employees' retirement system which includes both Regular and Police/Fire members. The System was established by the Nevada Legislature in 1947, effective July 1, 1948. The System is administered to provide a reasonable base income to qualified employees who have been employed by a

public employer and whose earnings capacities have been removed or substantially impaired by age or disability.

Benefits Provided

Benefits, as required by the Nevada Revised Statutes (NRS or statute), are determined by the number of years of accredited service at time of retirement and the member's highest average compensation in any 36 consecutive months with special provisions for members entering the System on or after January 1, 2010, and July 1, 2015. Benefit payments to which participants or their beneficiaries may be entitled under the plan include pension benefits, disability benefits, and survivor benefits.

Monthly benefit allowances for members are computed as 2.50% of average compensation for each accredited year of service prior to July 1, 2001. For service earned on and after July 1, 2001, this factor is 2.67% of average compensation. For members entering the System on or after January 1, 2010, there is a 2.50% service time factor and for regular members entering the System on or after July 1, 2015, there is a 2.25% factor. The System offers several alternatives to the unmodified service retirement allowance which, in general, allow the retired employee to accept a reduced service retirement allowance payable monthly during his or her lifetime and various optional monthly payments to a named beneficiary after his or her death.

Post-retirement increases are provided by authority of NRS 286.575 -.579.

Vesting

Regular members are eligible for retirement at age 65 with five years of service, or age 60 with 10 years of service, or any age with 30 years of service. Regular members entering the System prior to January 1, 2010, are eligible for retirement at age 65 with five years of service, or age 60 with 10 years of service, or any age with 30 years of service. Regular members entering the System on or after July 1, 2015, are eligible for retirement at age 65 with five years of service, or age 62 with 10 years of service, or age 55 with 30 years of service, or any age with 33 1/3 years of service.

Police/Fire members entering the System prior to January 1, 2010, are eligible for retirement at age 65 with five years of service, or age 55 with 10 years of service, or age 50 with 20 years of service, or any age with 25 years of service. Police/Fire members entering the System on or after January 1, 2015, are eligible for retirement at 65 with five years of service, or age 60 with 10 years of service, or age 50 with 20 years of service, or any age with 30 years of service. Only service performed in a position as a police officer or firefighter may be counted towards eligibility for retirement as Police/Fire accredited service.

The normal ceiling limitation on monthly benefits allowances is 75% of average compensation. However, a member who has an effective date of membership before July 1, 1985, is entitled to a benefit of up to 90% of average compensation. Both Regular and Police/Fire members become fully vested as to benefits upon completion of five years of service.

Contributions

The authority for establishing and amending the obligation to make contributions and member contribution rates, is set by statute. New hires, in agencies which did not elect the Employer-Pay Contribution (EPC) plan prior to July 1, 1983, have the option of selecting one of two contribution plans. In one plan, contributions are shared equally by employer and employee. In the other plan, employees can take a reduced salary and have contributions made by the employer (EPC).

The System's basic funding policy provides for periodic contributions at a level pattern of cost as a percentage of salary throughout an employee's working lifetime in order to accumulate sufficient assets to pay benefits when due.

The System receives an actuarial valuation on an annual basis indicating the contribution rates required to fund the System on an actuarial reserve basis. Contributions actually made are in accordance with the required rates established by the Nevada Legislature. These statutory rates are increased/decreased pursuant to NRS 286.421 and 286.450.

The actuarial funding method used is the Entry Age Normal Cost Method. It is intended to meet the funding objective and result in a relatively level long-term contributions requirement as a percentage of salary. For the fiscal year ended June 30, 2023, the statutory Employer/Employee matching rate was 15.50% for Regular members and 22.75% for Police/Fire. The Employer-pay contribution (EPC) rate was 29.75% for Regular members and 44.00% for Police/Fire.

The District's contributions to the plan for the year ended June 30, 2024, were $442,384, equal to the required contributions for each year.

Summary of Significant Accounting and Reporting Policies

For purposes of measuring the net pension liability, deferred outflows of resources, deferred inflows of resources and pension expense, information about the net position of the State of Nevada Public Employees Retirement System (PERS or System), and additions to/deductions from PERS' fiduciary net position have been determined on the same basis as they are reported by PERS. For this purpose, benefit payments, (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Basis of Accounting

Employers participating in PERS cost sharing, multiple-employer, defined benefit plans are required to report pension information in their financial statements in accordance with Governmental Accounting Standards Board (GASB) *Statement No. 68, Accounting and Financial Reporting for Pensions*. The Schedule of Employer Allocations and Schedule of Pension Amounts by Employer provide employers with the required information for financial reporting.

The underlying financial information used to prepare the pension allocation schedules is based on PERS' financial statements. PERS' financial statements are prepared in accordance with accounting principles generally accepted in the United States of America (GAAP) that apply to governmental accounting for fiduciary funds.

Contributions for employer pay dates that fall within PERS' fiscal year ending June 30, 2023, are used as the basis for determining each employer's proportionate share of the collective pension amounts.

The total pension liability is calculated by PERS' actuary. The plan's fiduciary net position is reported in PERS' financial statements and the net pension liability is disclosed in PERS' notes to the financial statements. An annual report containing financial statements and required information for the System may be obtained by writing to PERS, 693 W. Nye Lane, Carson City, Nevada 89703-1599, or by calling (775) 687-4200.

Investment Policy

The System's policies which determine the investment portfolio target asset allocation are established by the Board. The asset allocation is reviewed annually and is designed to meet the future risk and return needs of the System.

The following was the Board adopted policy target asset allocation as of June 30, 2023:

Asset Class	Target Allocation	Long-term Geometric Expected Real Rate of Return*
U.S. stocks	42%	5.50%
International stocks	18%	5.50%
U.S. bonds	28%	0.75%
Private markets	12%	6.65%
Total	100%	

* As of June 30, 2023, PERS' long-term inflation assumption 2.50%

Pension Liability

Net Pension Liability

At June 30, 2024, the District reported a liability of $6,028,349 for its proportionate share of the net pension liability. The net pension liability was measured as of June 30, 2023, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of that date. The employer allocation percentage of the net pension liability was based on the total contributions due on wages paid during the measurement period. Each employer's proportion of the net pension liability is based on their employer contributions relative to the total employer contributions for all employers for the period ended June 30, 2023.

Pension Liability Discount Rate Sensitivity

The following presents the net pension liability of the PERS as of June 30, 2023, and the District's proportionate share of the net pension liability of PERS as of June 30, 2023, calculated using the discount rate of 7.25%, as well as what PERS net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower (6.25%) or 1- percentage-point higher (8.25%) than the current discount rate:

	1% Decrease in Discount Rate (6.25%)	Discount Rate (7.25%)	1% Increase in Discount Rate (8.25%)
Net Pension Liability	$ 9,380,996	$ 6,028,349	$ 3,261,431

At June 30, 2024, and June 30, 2023, the District's proportionate share of the collective net pension liability was 0.03303% and 0.03335% respectively.

Pension Plan Fiduciary Net Position

Detailed information about the pension plan's fiduciary net position is available in the PERS' Comprehensive Annual Financial Report, available on the PERS website www.nvpers.org.

Actuarial Assumptions

The System's net pension liability was measured as of June 30, 2023, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of that date. The total pension liability was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Inflation rate	2.50%
Payroll growth	3.50%, including inflation
Investment rate of return	7.25%
Productivity pay increase	0.50%
Projected salary increases	Regular: 4.20% to 9.10%, depending on service Police/Fire: 4.60% to 14.50%, depending on service Rates include inflation and productivity increase
Other assumptions	Same as those used in the June 30, 2023, funding actuarial valuation

The actuarial assumptions used in the June 30, 2023, valuation was based on the results of the experience study for the period July 1, 2016, through June 30, 2020. The discount rate used to measure the total pension liability was 7.25% as of June 30, 2023. The projection of cash flows used to determine the discount rate assumed plan contributions will be made in amounts consistent with statutory provisions and recognizing the plan's current funding policy and cost-sharing mechanism between employers and members. For this purpose, all contributions that are intended to fund benefits for all plan members and their beneficiaries are included, except that projected contributions that are intended to fund the service costs for future plan members and their beneficiaries are not included.

Based on those assumptions, the pension plan's fiduciary net position at June 30, 2023, was projected to be available to make all projected future benefit payments for current plan members. Therefore, the long-term expected rate of return on pension plan investments was applied to all periods of projected benefit payments to determine the total pension liability as of June 30, 2023.

Pension Expense, Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions

As of June 30, 2024, the total employer pension expense is $737,459. At June 30, 2023, the District reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflow of Resources	Deferred Inflows of Resources
Differences between expected and actual experience [1]	$ 785,758	$ -
Net Difference between projected and actual earnings on investments	-	56,425
Changes in proportion and differences between actual contributions and proportionate share of contributions [1]	229,517	270,343
Changes of assumptions	564,971	-
Contributions to PERS after measurement date	442,384	-
Total	$ 2,022,630	$ 326,768

[1] Average expected remaining service lives: 5.63 years

Deferred outflows of resources related to pension resulting from contributions subsequent to the measurement date, totaling $442,384, will be recognized as a reduction of the net pension liability in the year ending June 30, 2025. Other amounts reported as deferred outflows/(inflows) of resources related to pension will be recognized in pension expense as follows:

Fiscal year ending June 30:	
2025	$ 194,348
2026	168,942
2027	768,348
2028	102,116
2029	19,724
	$ 1,253,478

Note 8 - Other Post-Employment Benefits (OPEB)

General Information about the Other Post Employment Benefit (OPEB) Plans

Plan Description

Public Employees' Benefits Plan (PEBP) is a non-trust, agent multiple employer defined benefit OPEB plan administered by the State of Nevada. The District subsidizes eligible retirees' contributions to PEBP. NRS 287.041 assigns the authority to establish and amend benefit provisions to the PEBP eleven-member board of trustees. The plan is now closed to future retirees, however, District employees who previously met the eligibility requirement for retirement within the Nevada Public Employee Retirement System had the option upon retirement to enroll in coverage under the PEBP with a subsidy provided by the District as determined by their number of years of service. The PEBP issues a publicly available financial report. That report may be obtained at www.pebp.state.nv.us/resources/fiscal-utilization-reports/.

Retiree Health Program Plan (RHPP) provides OPEB to all permanent full-time employees of the District. The RHPP is a non-trust, single employer defined benefit OPEB Plan administered by the District.

Benefits Provided

PEBP provides medical, dental, prescription drug, Medicare Part B, and life insurance coverage to eligible retirees and their spouses. Benefits are provided through a third-party insurer.

RHPP provides medical, dental, prescription drug, and life insurance benefits to eligible retirees and beneficiaries. Retirees are eligible to continue coverage in the Clark County Self-Funded Group Medical and Dental Benefit Plan as a participant with active employees at a blended premium rate, resulting in an implicit subsidy. Benefit provisions are established and amended through negotiations between the respective unions and the District.

Employees Covered by Benefit Terms

At the June 30, 2023, measurement date, the following employees were covered by the benefit terms:

	PEBP	RHPP
Inactive employees or beneficiaries currently receiving benefit payments	1	5
Active employees	-	20
Total	1	25

As of November 1, 2008, PEBP was closed to any new participants.

Total OPEB Liability

The District's total OPEB liability of $1,539,048 was measured as of June 30, 2023, and was determined by an actuarial valuation as of that date.

Actuarial assumptions: The total OPEB liability for all plans as of June 30, 2023, was determined using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified:

Inflation	2.50%
Salary increases	3.00%
Discount rate	3.65% (EOY)
Healthcare cost trend rates	6.50% decreasing to an ultimate rate of 4.00%
Retirees share of benefit related costs	0% to 100% premium amounts based on years of service

The discount rate was based on Bond Buyer 20-Bond GO Index.

Mortality Rates were based on the following:

PUB-2010 headcount weighted mortality table, projected generationally using Scale MP-2021, applied on a gender-specific and job class basis.

The demographic assumptions are based on the Nevada PERS Actuarial Experience Study based on the 2021 Nevada PERS Actuarial Valuation. Salary scale and inflation assumptions are based on the 2021 Nevada PERS Actuarial Valuation.

Changes in the Total OPEB Liability

	PEBP	RHPP	Total OPEB Liability
Balance at June 30, 2023	$ 37,013	$ 1,520,316	$ 1,557,329
Changes Recognized for the Fiscal Year			
Service Cost	-	47,625	47,625
Interest	1,271	53,969	55,240
Differences between expected and actual experiences	-	-	-
Changes in assumptions	(119)	(32,268)	(32,387)
Benefit payments	(2,000)	(86,759)	(88,759)
Net Changes	(848)	(17,433)	(18,281)
Balance at June 30, 2024	$ 36,165	$ 1,502,883	$ 1,539,048

Changes in Assumptions: The discount rate was updated from 3.54% as of June 30, 2022, to 3.65% as of June 30, 2023. The discount rate basis is the Bond Buyer 20-Bond General Obligation Index as of the measurement date. All other underlying census data, actuarial assumptions, methods, and plan provisions used to determine the results are the same.

Sensitivity of the total OPEB liability to changes in the discount rate. The following presents the total OPEB liability of the District, as well as what the District's total OPEB liability would be if it were calculated using a discount rate that is 1-percentage-point lower (2.65%) or 1-percentage point higher (4.65%) than the current discount rate:

	1% Decrease 2.65%	Discount Rate 3.65%	1% Increase 4.65%
PEBP	$ 40,000	$ 36,165	$ 32,000
RHPP	1,809,000	1,502,883	1,264,000
Total OPEB Liability	$ 1,849,000	$ 1,539,048	$ 1,296,000

Sensitivity of the total OPEB liability to changes in the healthcare cost trend rates. The following presents the total OPEB liability of the District, as well as what the District's total OPEB liability would be if it were calculated using healthcare cost trend rates that are 1-percentage-point lower (5.50% decreasing to 3.00%) or 1-percentage-point higher (7.50% decreasing to 5.00%) than the current healthcare cost trend rates:

	1% Decrease	Current Trend Rate	1% Increase
PEBP	$ 32,000	$ 36,165	$ 40,000
RHPP	1,248,000	1,502,883	1,837,000
Total OPEB Liability	$ 1,280,000	$ 1,539,048	$ 1,877,000

OPEB Expense and Deferred Outflows of Resources and Deferred Inflows of Resources Related to OPEB

For the year ended June 30, 2024, the District recognized OPEB expense of $(4,592). The breakdown by plan is as follows:

	PEBP	RHPP	Total All Plans
OPEB Expense (Income)	$ 1,152	$ (5,744)	$ (4,592)

At June 30, 2024, the District reported deferred outflows of resources and deferred inflows of resources from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
PEBP		
Benefit payments made after measurement date	$ 2,000	$ -
Total PEBP	$ 2,000	$ -
RHPP		
Difference between expected and actual experience	$ -	$ 959,866
Changes in assumptions	412,126	356,894
Benefit payments after measurement date	37,000	-
Total RHPP	$ 449,126	$ 1,316,760
Total All Plans		
Difference between expected and actual experience	$ -	$ 959,866
Changes in assumptions	412,126	356,894
Benefit payments made after measurement date	39,000	-
Total All Plans	$ 451,126	$ 1,316,760

Deferred outflows of resources related to OPEB resulting from contributions subsequent to the measurement date totaling $39,000 will be recognized as a reduction of the total OPEB liability in the year ending June 30, 2025. Other amounts reported as deferred outflows/ (inflows) of resources related to OPEB will be recognized in OPEB expense as follows:

Fiscal year ending June 30:	RHPP
2025	$ (106,758)
2026	(105,552)
2027	(105,552)
2028	(105,552)
2029	(105,552)
Thereafter	(375,668)
	$ (904,634)

District Assets

The District utilizes the General Fund to allocate Other Post-Employment Benefits costs, based on employee count. As of June 30, 2024, $1,557,329 in cash, investments and interest receivable are set aside for this purpose. The District intends to use these assets for future OPEB funding. These assets cannot be included in the plan assets considered in the OPEB funding schedules because they are not held in trust.

Note 9 - Risk Management

The District, through various interlocal agreements, uses Clark County for risk management administration. Participation is voluntary and is billed based on payroll.

The District is exposed to various risks of loss related to torts; theft of, damage to, and destruction of assets; errors and omissions; injuries to employees; and natural disasters. Over the past three years, settlements have not exceeded insurance coverage. The County maintains the following types of risk exposures, which also include the District's coverage.

Self-Funded Group Insurance and Group Insurance Reserve

The County has established self-insurance funds for insuring medical benefits provided to participating employees and covered dependents. Employees are offered a choice between a self-insured PPO plan and a self-insured EPO plan. An independent claims administrator performs all claims-handling procedures. Incurred but not reported claims have been accrued as a liability based upon a variety of actuarial and statistical techniques.

Clark County Workers' Compensation

The County has established a fund for self-insurance related to workers' compensation claims. Self-insurance is in effect up to an individual stop loss amount of $1,000,000 per occurrence. Coverage from private insurers is maintained for losses in excess of the claim stop loss amount up to $500,000,000. Incurred but not reported claims have been accrued as a liability based upon a variety of actuarial and statistical techniques.

County Liability Insurance

The County has established a general liability self-insurance fund for losses up to a $25,000 per occurrence retention limit. Losses in excess of this retention are covered by the County's liability insurance pool fund for the benefit of County funds and other participating agencies, including the District. An independent claims administrator performs all claims-handling procedures. Incurred by not reported claims have been accrued as a liability based upon a variety of actuarial and statistical techniques.

County Liability Insurance Pool

The County has established a general liability insurance pool for the benefit of County funds and other participating agencies including the District. The County's self-insurance is in effect for loss amounts over the $25,000 retention up to $5,000,000 per occurrence, accident, or loss. Effective fiscal year 2024, coverage from private insurers is maintained for losses in excess of the stop loss amount up to $10,000,000. An independent claims administrator performs all claims-handling procedures. Incurred but not reported claims have been accrued as a liability based upon a variety of actuarial and statistical techniques.

Note 10 - Encumbrances and Construction Commitments

The District utilizes encumbrance accounting in its government funds. Encumbrances are recognized as a valid and proper charge against a budget appropriation in the year in which a purchase order, contract, or other commitment is issued. In general, unencumbered appropriations lapse at year end. Open encumbrances at fiscal year-end are included in restricted, committed, or assigned fund balance, as appropriate. The following schedule outlines significant encumbrances included in governmental fund balances:

	Encumbrances as of June 30, 2024:		
	Restricted Fund Balance	Committed Fund Balance	Assigned Fund Balance
General Fund	$ -	$ 5,789,350	$ 5,466,731
RFCD Construction	49,548,592	144,901,219	157,397,457
Total	$ 49,548,592	$ 150,690,569	$ 162,864,188

During the fiscal year, the District entered into several contracts for engineering studies and for the maintenance and construction of flood control infrastructure projects. As of June 30, 2024, the District had outstanding construction contracts totaling $194,449,811, which will be financed from the capital projects funds. Other significant commitments include maintenance and engineering contracts totaling $11,256,081, which will be funded from the general fund. Commitments will be met with existing committed fund balances and future revenue.

Note 11 - Related Party Transactions

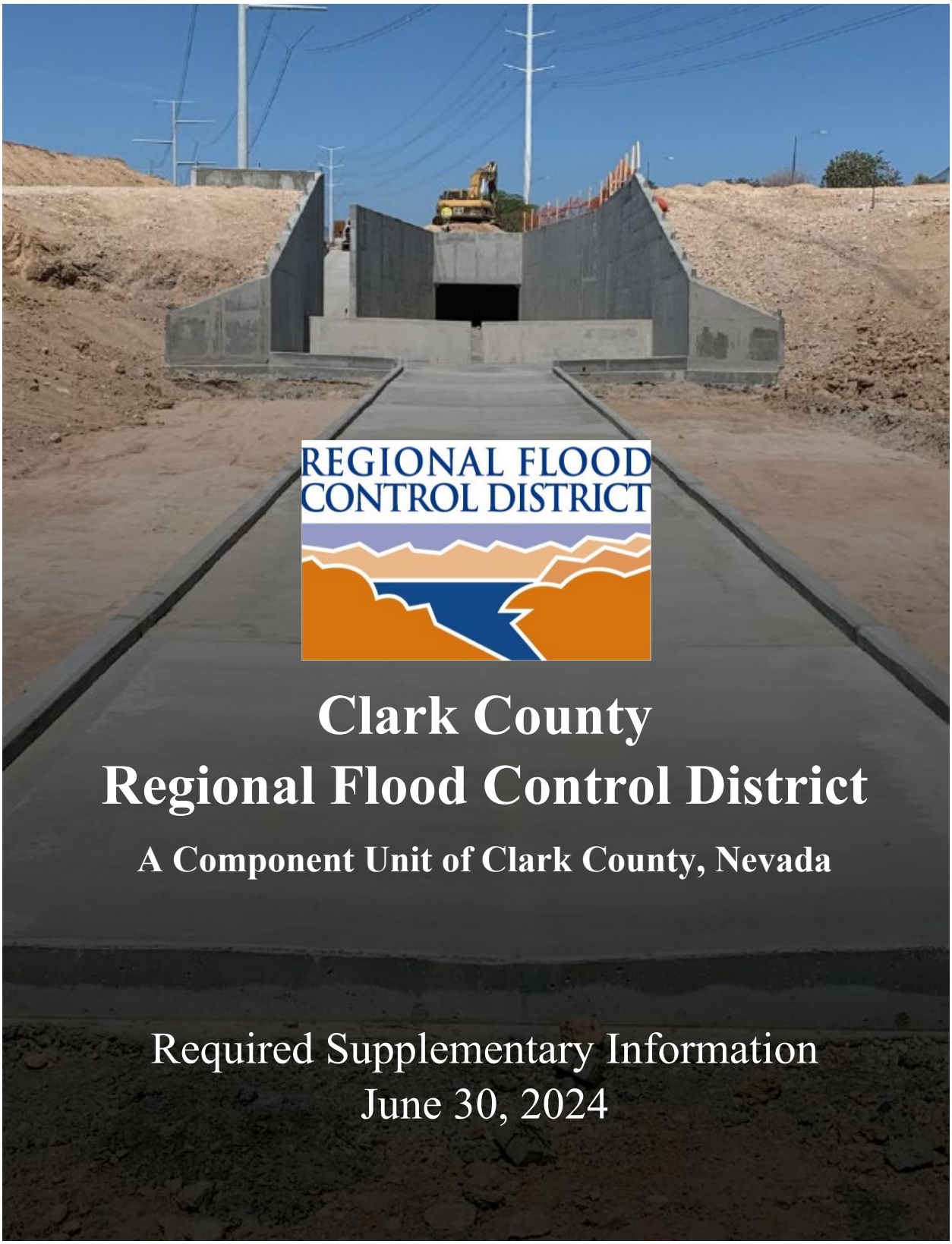
The District is a component unit of Clark County, Nevada (County). The County is also a member-entity of the District, and as such, enters into interlocal contracts with the District for the construction and maintenance of flood control projects, which are funded and paid for by the District. As of June 30, 2024, the County had open interlocal contracts totaling $236,990,748. Of those contracts, $169,690,377 was spent, and there remains outstanding contract balances totaling $67,300,371.

During the fiscal year, the District reimbursed the County for $28,881,638 for flood control construction and maintenance projects. At the end of the fiscal year, accounts payable directly allocated to the County total $4,691,376. There were no outstanding account receivables.

Note 12 - Fund Balances

Governmental fund balances as provided in the Balance Sheet are aggregated as restricted, committed, assigned, or unassigned. The table below provides a detail of the programs that correspond to each fund balance.

	General Fund	Debt Service Fund	Construction Fund	Total Fund Balances
Restricted				
Debt Service	$ -	$ 21,578,313	$ -	$ 21,578,313
Construction	-	-	49,548,592	49,548,592
Committed				
Construction	-	-	144,901,219	144,901,219
Maintenance	5,280,230	-	-	5,280,230
Engineering	509,120	-	-	509,120
OPEB	1,557,329	-	-	1,557,329
Assigned				
Debt Service	-	3,524,983	-	3,524,983
Construction	-	-	157,397,457	157,397,457
Maintenance	5,362,734	-	-	5,362,734
Engineering	103,997	-	-	103,997
Unassigned	19,175,993	-	-	19,175,993
Total Fund Balances	$ 31,989,403	$ 25,103,296	$ 351,847,268	$ 408,939,967



Clark County
Regional Flood Control District

A Component Unit of Clark County, Nevada

Required Supplementary Information
June 30, 2024

Clark County Regional Flood Control District
A Component Unit of Clark County, Nevada
General Fund (Regional Flood Control District Fund)
Schedule of Revenues, Expenditures and Changes in Fund Balances – Budget and Actual
For the Fiscal Year Ended June 30, 2024
(Budgetary Basis with Comparative Actual Amounts for Fiscal Year Ended June 30, 2023)

	2024				2023
	Original Budget	Final Budget	Actual	Variance	Actual (Unaudited)
Revenues					
Intergovernmental revenue					
State Grants	$ -	$ -	$ -	$ -	$ 35,257
Sales Tax	158,900,000	158,900,000	159,483,862	583,862	154,269,560
Interest	152,147	152,147	1,192,934	1,040,787	575,631
Other	10,000	10,000	50,120	40,120	655
Total revenues	159,062,147	159,062,147	160,726,916	1,664,769	154,881,103
Other Financing Sources					
Transfers from other funds	350,000	350,000	350,000	-	1,168,750
Total revenues and other financing sources	159,412,147	159,412,147	161,076,916	1,664,769	156,049,853
Expenditures					
Salaries and wages	3,407,975	3,407,975	2,752,201	(655,774)	2,780,331
Employee benefits	1,537,261	1,537,261	1,208,695	(328,566)	1,053,684
Service and supplies	6,777,532	6,777,532	4,532,855	(2,244,677)	3,898,146
Capital outlay	312,000	312,000	189,841	(122,159)	186,078
Total expenditures	12,034,768	12,034,768	8,683,592	(3,351,176)	7,918,239
Other Financing Uses					
Transfers to other funds	161,870,386	161,870,386	161,870,385	(1)	160,366,589
Total expenditures and other financing uses	173,905,154	173,905,154	170,553,977	(3,351,177)	168,284,828
Excess (deficiency) of revenues and other financing sources over (under) expenditures and other financing uses	(14,493,007)	(14,493,007)	(9,477,061)	5,015,946	(12,234,975)
Fund Balance					
Fund balances – beginning	29,553,651	29,553,651	30,823,500	1,269,849	43,058,475
Fund balances – ending	$ 15,060,644	$ 15,060,644	$ 21,346,439	$ 6,285,795	$ 30,823,500

See Notes to Required Supplementary Information

Clark County Regional Flood Control District
A Component Unit of Clark County, Nevada
Reconciliation of General Fund Budgetary Information to
General Fund GAAP Information
For the Fiscal Year Ended June 30, 2024

	General Fund (Regional Flood Control District Fund) Budgetary Basis	Regional Flood Control District Maintenance Fund (Internally Reported)	Eliminations	General Fund as Reported on Statement of Revenues, Expenditures and Changes in Fund Balances (GAAP Basis)
Revenues				
Intergovernmental revenue				
Sales tax	159,483,862	-	-	159,483,862
Interest	1,192,934	376,891	-	1,569,825
Other	50,120	-	-	50,120
Total revenues	160,726,916	376,891	-	161,103,807
Other Financing Sources				
Transfers from other funds	350,000	17,000,000	(17,000,000)	350,000
Total revenues and other financing sources	161,076,916	17,376,891	(17,000,000)	161,453,807
Expenditures				
Salaries and wages	2,752,201	-	-	2,752,201
Employee benefits	1,208,695	-	-	1,208,695
Service and supplies	4,532,855	15,433,501	-	19,966,356
Capital outlay	189,841	-	-	189,841
Total expenditures	8,683,592	15,433,501	-	24,117,093
Other Financing Uses				
Transfers to other funds	161,870,385	-	(17,000,000)	144,870,385
Total expenditures and other financing uses	170,553,977	15,433,501	(17,000,000)	168,987,478
Excess (deficiency) of revenues and other financing sources over (under) expenditures and other financing uses	(9,477,061)	1,943,390	-	(7,533,671)
Fund Balance				
Fund balances – beginning	30,823,500	8,699,574	-	39,522,534
Fund balances – ending	$ 21,346,439	$ 10,642,964	$ -	$ 31,989,403

See Notes to Required Supplementary Information

PEBP Plan

Total OPEB Liability[2]	2018[1]	2019	2020	2021	2022	2023	2024
Service Cost	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interest	4,428	3,110	2,787	2,607	1,878	1,838	1,271
Changes of benefit terms	-	-	-	-	-	-	-
Difference between actual and expected Experience	(2,546)	(109)	-	(1,881)	-	(42,484)	-
Changes of assumptions or other inputs	(11,840)	(68,299)	3,768	13,886	1,281	(6,299)	(119)
Benefit payments	(4,164)	(3,936)	(3,936)	(4,264)	(3,926)	(2,236)	(2,000)
Net Change in Total OPEB Liability	(14,122)	(69,234)	2,619	10,348	(767)	(49,181)	(848)
Total OPEB Liability – Beginning	157,350	143,228	73,994	76,613	86,961	86,194	37,013
Total OPEB Liability – Ending	$ 143,228	$ 73,994	$ 76,613	$ 86,961	$ 86,194	$ 37,013	$ 36,165
Covered-Employee Payroll	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total OPEB Liability as a Percentage of Covered Payroll	N/A	N/A	N/A	N/A	N/A	N/A	N/A

(1) Fiscal year 2018 was the first year of implementation. As it becomes available this schedule will ultimately present information for the ten most recent fiscal years.

(2) The amounts presented for each fiscal year were determined as of the year-end that occurred one year prior.

See Notes to Required Supplementary Information

RHPP

Total OPEB Liability[2]	2018[1]	2019	2020	2021	2022	2023	2024
Service Cost	$ 133,566	$ 125,140	$ 53,472	$ 63,959	$ 66,013	$ 55,152	$ 47,625
Interest	88,281	101,999	59,780	58,507	39,910	39,692	53,969
Changes of benefit terms	-	-	-	-	-	-	-
Difference between actual and expected experience	(2,134)	(1,097,305)	-	(374,102)	-	(85,500)	-
Changes of assumptions or other inputs	(369,545)	(227,373)	109,463	462,555	16,422	(230,364)	(32,268)
Benefit payments	(38,224)	(137,844)	(132,572)	(80,015)	(77,387)	(82,192)	(86,759)
Net Change in Total OPEB Liability	(188,056)	(1,235,383)	90,143	130,904	44,958	(303,212)	(17,433)
Total OPEB Liability – Beginning	2,980,962	2,792,906	1,557,523	1,647,666	1,778,570	1,823,528	1,520,316
Total OPEB Liability – Ending	$ 2,792,906	$ 1,557,523	$ 1,647,666	$ 1,778,570	$ 1,823,528	$ 1,520,316	$ 1,502,883
Covered-Employee Payroll	2,127,561	2,280,994	2,318,741	2,153,702	2,266,156	2,374,611	2,505,277
Total OPEB Liability as a Percentage of Covered Payroll	131.27%	68.28%	71.06%	82.58%	80.47%	64.02%	59.99%

(1) Fiscal year 2018 was the first year of implementation. As it becomes available this schedule will ultimately present information for the ten most recent fiscal years.

(2) The amounts presented for each fiscal year were determined as of the year-end that occurred one year prior.

See Notes to Required Supplementary Information

Clark County Regional Flood Control District
A Component Unit of Clark County, Nevada
Schedule of Proportionate Share of Net Pension Liability
June 30, 2024

	2015[1]	2016	2017	2018	2019
Proportion of Plan's net pension liability	0.03%	0.03%	0.03%	0.03%	0.03%
Proportion share of the net pension liability[2]	$ 3,485,328	$ 3,818,635	$ 4,630,117	$ 4,382,337	$ 4,680,245
Covered payroll	$ 1,932,696	$ 1,880,346	$ 2,083,337	$ 2,121,732	$ 2,280,779
Proportionate share of the net pension liability as a percentage of the covered payroll	180%	203%	222%	207%	205%
Plan fiduciary net position	$ 33,575,081,157	$ 34,148,195,967	$ 35,002,028,906	$ 38,686,253,408	$ 41,431,686,852
Plan fiduciary net position as a percentage of the total pension liability	76.30%	75.10%	75.30%	74.40%	75.24%

	2020	2021	2022	2023	2024
Proportion of Plan's net pension liability	0.04%	0.03%	0.03%	0.03%	0.03%
Proportion share of the net pension liability[2]	$ 4,856,326	$ 4,751,625	$ 2,957,587	$ 6,022,147	$ 6,028,349
Covered payroll	$ 2,456,843	$ 2,567,393	$ 2,424,779	$ 2,549,614	$ 2,738,421
Proportionate share of the net pension liability as a percentage of the covered payroll	198%	185%	122%	236%	220%
Plan fiduciary net position	$ 44,284,252,583	$ 46,735,117,356	$ 58,458,484,355	$ 54,514,012,008	$ 58,315,106,777
Plan fiduciary net position as a percentage of the total pension liability	76.46%	77.04%	86.51%	75.12%	76.16%

[1] Fiscal year 2015 was the first year of implementation and presents information for the ten most recent fiscal years.
[2] The amounts presented for each fiscal year were determined as of the year-end that occurred one year prior.

See Notes to Required Supplementary Information

Clark County Regional Flood Control District
A Component Unit of Clark County, Nevada
Schedule of Defined Benefit Plan Contributions
June 30, 2024

Plan Year Ending June 30[1]	Contractually required contribution (actuarially determined)	Contributions in relation to the actuarially determined contributions	Contribution deficiency (excess)	Covered payroll	Contributions as a percentage of the covered payroll
2024	$ 442,384	$ 442,384	$ -	$ 3,159,886	14%
2023	$ 383,379	$ 383,379	$ -	$ 2,738,421	14%
2022	$ 356,946	$ 356,946	$ -	$ 2,549,614	14%
2021	$ 339,469	$ 339,469	$ -	$ 2,424,779	14%
2020	$ 359,435	$ 359,435	$ -	$ 2,567,393	14%
2019	$ 343,958	$ 343,958	$ -	$ 2,456,843	14%
2018	$ 319,309	$ 319,309	$ -	$ 2,280,779	14%
2017	$ 297,043	$ 297,043	$ -	$ 2,121,732	14%
2016	$ 291,667	$ 291,667	$ -	$ 2,083,337	14%
2015	$ 263,249	$ 263,249	$ -	$ 1,880,346	14%

[1] Fiscal year 2015 was the first year of implementation and presents information for the ten most recent fiscal years.

See Notes to Required Supplementary Information

Note 1 - Budgetary Information

The District's budget is included in the County's budget. The County uses the following procedures to establish, modify, and control the budgetary data presented in the financial statements:

a. Prior to April 15, the County Manager submits to the Nevada State Department of Taxation the tentative budget for the next fiscal year, commencing on July 1. The budget as submitted contains the proposed expenditures and means of financing them.

b. The Nevada State Department of Taxation notifies the County of its acceptance of the budget.

c. Public hearings are conducted on the third Monday in May.

d. After all changes have been noted and hearings closed, the County Commission adopts the budget on or before June 1.

e. The District's General Manager/Chief Engineer is authorized to transfer budgeted amounts within functions or funds, but any other transfers between funds or increases to a fund's original appropriated level must be approved by the District's Board.

f. Increases to a fund's budget (augmentations) other than by transfers are accomplished through formal District Board action.

g. Formal budgetary control is employed for all District funds.

h. Statutory regulations require budget control to be exercised at the function level within the Regional Flood Control District fund, which serves as the District's general fund. Budget control is exercised at the fund level for all other funds. The District administratively exercises control at the budgeted item level.

i. All appropriations lapse at the end of the fiscal year. Encumbrances are reappropriated in the ensuing fiscal year.

j. Budgets are adopted on a basis consistent with the method used to report on governmental funds, which are prepared in accordance with the accounting principles generally accepted in the United States of America.

k. Budgeted expenditure amounts for the year ended June 30, 2024, as originally adopted, were augmented for grants and other Board actions.

Note 2 - Reconciliation of General Fund Budgetary Information to General Fund GAAP Information

This statement reconciles the General Fund as presented for budget purposes to the presentation required under the modified accrual basis of accounting.

Note 3 - Postemployment Benefits Other Than Pensions

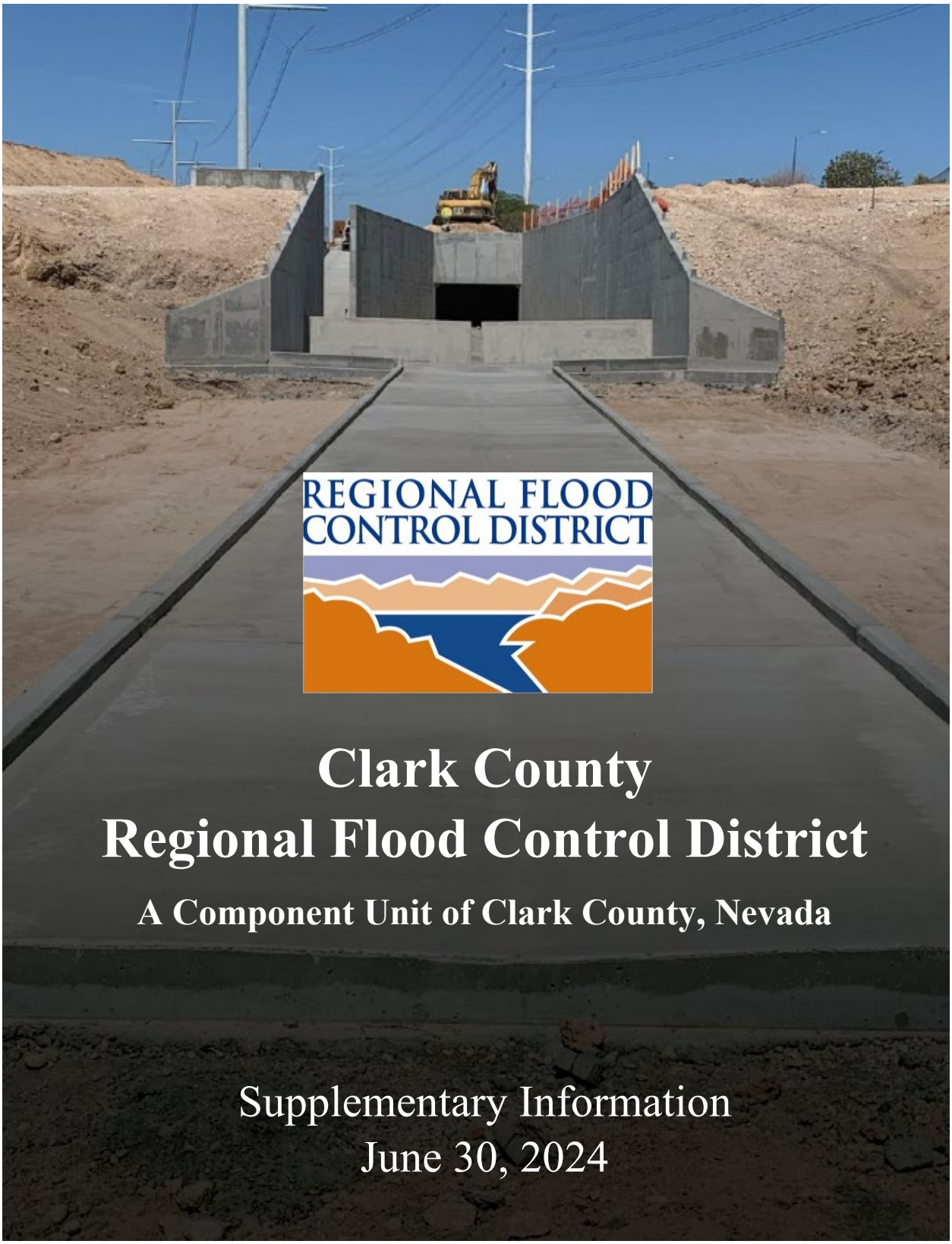
There are no assets accumulated in a trust to pay related benefits.

Changes of Assumptions PEBP Plan

The $119 decrease in the liability from June 30, 2023, to June 30, 2024, is due to the increase in the assumed discount rate from 3.54% to 3.65% as of June 30, 2023. There was no change in the actuarial cost method which remained the same using Entry age level percentage of salary.

Changes of Assumptions RHPP

The $32,268 decrease in the liability from June 30, 2023, to June 30, 2024, is due to the increase in the assumed discount rate from 3.54% to 3.65% as of June 30, 2023. There was no change in the actuarial cost method which remained the same using Entry age level percentage of salary.



Clark County
Regional Flood Control District

A Component Unit of Clark County, Nevada

Supplementary Information
June 30, 2024

Clark County Regional Flood Control District
A Component Unit of Clark County, Nevada
Regional Flood Control District Maintenance
Schedule of Revenues, Expenditures and Changes in Fund Balances – Budget and Actual
For the Fiscal Year Ended June 30, 2024
(with Comparative Actual Amounts for Fiscal Year Ended June 30, 2023)

	2024				2023
	Original Budget	Final Budget	Actual	Variance	Actual (Unaudited)
Revenues					
Interest	$ 100,000	$ 100,000	$ 376,891	$ 276,891	$ (107,825)
Other	50,000	50,000	-	(50,000)	365,373
Total revenues	150,000	150,000	376,891	226,891	257,548
Other Financing Sources					
Transfers from other funds	17,000,000	17,000,000	17,000,000	-	16,000,000
Total revenues and other financing sources	17,150,000	17,150,000	17,376,891	226,891	16,257,548
Expenditures					
Service and supplies	20,000,000	22,910,348	15,433,501	(7,476,847)	10,613,424
Total expenditures	20,000,000	22,910,348	15,433,501	(7,476,847)	10,613,424
Excess (deficiency) of revenues and other financing sources over (under) expenditures and other financing uses	(2,850,000)	(5,760,348)	1,943,390	7,703,738	5,644,124
Fund Balance					
Fund balances – beginning	5,789,226	8,699,574	8,699,574	-	3,055,450
Fund balances – ending	$ 2,939,226	$ 2,939,226	$ 10,642,964	$ 7,703,738	$ 8,699,574

Clark County Regional Flood Control District
A Component Unit of Clark County, Nevada
Flood Control Debt Service
Schedule of Revenues, Expenditures and Changes in Fund Balances – Budget and Actual
For the Fiscal Year Ended June 30, 2024
(with Comparative Actual Amounts for Fiscal Year Ended June 30, 2023)

	2024				2023
	Original Budget	Final Budget	Actual	Variance	Actual (Unaudited)
Revenues					
Interest	$ 1,000,000	$ 1,000,000	$ 1,080,856	$ 80,856	$ 352,630
Total revenues	1,000,000	1,000,000	1,080,856	80,856	352,630
Other Financing Sources					
Transfers from other funds	47,870,386	47,870,386	47,870,385	(1)	46,205,003
Total revenues and other financing sources	48,870,386	48,870,386	48,951,241	80,855	46,557,633
Expenditures					
Service and supplies	1,000,000	1,000,000	1,500	(998,500)	1,750
Debt Service					
Principal	25,930,000	25,930,000	25,930,000	-	24,735,000
Interest and other charges	21,300,642	21,300,642	21,300,640	(2)	22,491,334
Total expenditures	48,230,642	48,230,642	47,232,140	(998,502)	47,228,084
Total expenditures and other financing uses	48,230,642	48,230,642	47,232,140	(998,502)	47,228,084
Excess (deficiency) of revenues and other financing sources over (under) expenditures and other financing uses	639,744	639,744	1,719,101	1,079,357	(670,451)
Fund Balance					
Fund balances – beginning	24,028,314	24,028,314	23,384,195	(644,119)	24,054,646
Fund balances – ending	$ 24,668,058	$ 24,668,058	$ 25,103,296	$ 435,238	$ 23,384,195

Clark County Regional Flood Control District
A Component Unit of Clark County, Nevada
RFCD Construction
Schedule of Revenues, Expenditures and Changes in Fund Balances – Budget and Actual
For the Fiscal Year Ended June 30, 2024
(with Comparative Actual Amounts for Fiscal Year Ended June 30, 2023)

	2024				2023
	Original Budget	Final Budget	Actual	Variance	Actual (Unaudited)
Revenues					
Interest	$ 700,000	$ 700,000	$ 14,701,667	$ 14,001,667	$ 4,403,379
Other	50,000	50,000	77,006	27,006	77,739
Total revenues	750,000	750,000	14,778,673	14,028,673	4,481,118
Other Financing Sources					
Transfers from other funds	97,000,000	97,000,000	97,000,000	-	98,161,586
Total revenues and other financing sources	97,750,000	97,750,000	111,778,673	14,028,673	102,642,704
Expenditures					
Services and supplies	-	-	295,766	295,766	-
Capital outlay to others	82,337,663	82,337,663	82,337,663	-	-
Capital outlay	331,958,345	331,958,345	-	(331,958,345)	72,375,013
Total expenditures	414,296,008	414,296,008	82,633,429	(331,662,579)	72,375,013
Other Financing Uses					
Transfers to other funds	350,000	350,000	350,000	-	1,168,750
Total expenditures and other financing uses	414,646,008	414,646,008	82,983,429	(331,662,579)	73,543,763
Excess (deficiency) of revenues and other financing sources over (under) expenditures and other financing uses	(316,896,008)	(316,896,008)	28,795,244	345,691,252	29,098,941
Fund Balance					
Fund balances – beginning	316,896,008	316,896,008	323,052,024	6,156,016	293,953,083
Fund balances – ending	$ -	$ -	$ 351,847,268	$ 351,847,268	$ 323,052,024

INDEPENDENT AUDITOR'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

Board of Directors
Clark County Regional Flood Control District
Las Vegas, Nevada

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the governmental activities and each major fund of the Clark County Regional Flood Control District (the "District"), a component unit of Clark County, Nevada, as of and for the year ended June 30, 2024, and the related notes to the financial statements, which collectively comprise the District's basic financial statements, and have issued our report thereon dated October 31, 2024.

Report on Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered District's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, we do not express an opinion on the effectiveness of the District's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses or significant deficiencies may exist that have not been identified.

(Continued)

Report on Compliance and Other Matters

As part of obtaining reasonable assurance about whether the District's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the financial statements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Crowe LLP

Crowe LLP

Sacramento, California
October 31, 2024

REGIONAL FLOOD CONTROL DISTRICT
CLARK COUNTY, NEVADA

600 SOUTH GRAND CENTRAL PARKWAY, SUITE 300
LAS VEGAS, NV 89106-4511
702-685-0000

www.regionalflood.org

@RegionalFlood

RegionalFloodControlDistrict

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

ANNUAL REPORT
FISCAL YEAR 2023-2024

RECOMMENDATION SUMMARY

STAFF: Adopt.

TECHNICAL ADVISORY: The Technical Advisory Committee did not hear this item.

CITIZENS ADVISORY: The Citizens Advisory Committee did not hear this item.

RFCD AGENDA
ITEM #19
DATE: 11/14/2024

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT
AGENDA ITEM

SUBJECT:

FISCAL YEAR 2023-2024 ANNUAL REPORT

PETITIONER:

STEVEN C. PARRISH, P.E., GENERAL MANAGER/CHIEF ENGINEER

RECOMMENDATION OF PETITIONER:

THAT THE BOARD ADOPT THE FISCAL YEAR 2023-2024 ANNUAL REPORT AND AUTHORIZE THE GENERAL MANAGER TO PROVIDE IT TO THE PUBLIC AT NO COST (FOR POSSIBLE ACTION)

FISCAL IMPACT: None by this action.

BACKGROUND:

In accordance with Nevada Revised Statutes (NRS) 543.5955, the District publishes an annual report summarizing the District's accomplishments and highlighting the flood control improvements completed in that year. The report also provides information about District finances, programs, partnerships and outreach efforts, among other things. The District produced the report electronically, which helps promote sustainability of our natural resources.

I would like to acknowledge the dedicated support of the District's staff in accomplishing the wide variety of tasks highlighted in this annual report. Without their commitment, the District could not achieve its goals, complete the magnitude of construction projects included in this year's annual report, nor address the dynamic needs of the community we serve.

It is recommended that the Board authorize the General Manager to provide the annual report to the public at no cost.

Respectfully submitted,

RFCD AGENDA
ITEM # 19
Date: 11/14/2024

Steven C. Parrish, P.E.
General Manager/Chief Engineer

Regional Flood Control District
AGENDA ITEM DEVELOPMENT

Staff Discussion:

Date: 11/04/2024

FISCAL YEAR 2023-2024 ANNUAL REPORT

In accordance with Nevada Revised Statutes (NRS) 543.5955, the District publishes an annual report summarizing the District's accomplishments and highlighting the flood control improvements completed in that year. The report also provides information about District finances, programs, partnerships and outreach efforts, among other things. The District produced the report electronically, which helps promote sustainability of our natural resources.

I would like to acknowledge the dedicated support of the District's staff in accomplishing the wide variety of tasks highlighted in this annual report. Without their commitment, the District could not achieve its goals, complete the magnitude of construction projects included in this year's annual report, nor address the dynamic needs of the community we serve.

It is recommended that the Board authorize the General Manager to provide the annual report to the public at no cost.

Staff Recommendation:

Adopt and authorize the General Manager to provide the annual report to the public at no cost.

Discussion by Technical Advisory Committee:

AGENDA # Date:

The Technical Advisory Committee did not hear this item.

Recommendation:

Discussion by Citizens Advisory Committee:

AGENDA # Date:

The Citizens Advisory Committee did not hear this item.

Recommendation:

ANNUAL REPORT

2023/24

REGIONAL FLOOD CONTROL DISTRICT

CLARK COUNTY, NV

MISSION

To improve the protection of life and property for existing residents, future residents and visitors from the impacts of flooding while also protecting the environment.

VISION

Premier regional agency providing a community safe from the devastation of floods while protecting the surface water environment.

ANNUALREPORT 2023/24

Table of Contents

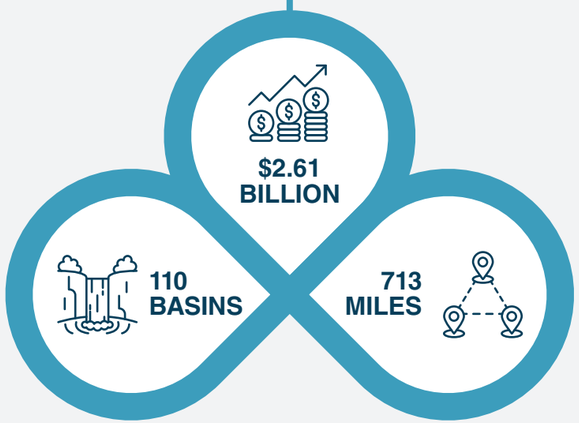
“SINCE THE DISTRICT’S INCEPTION ALMOST FOUR DECADES AGO, APPROXIMATELY 713 MILES OF CHANNELS, UNDERGROUND STORM DRAINS, AND 110 BASINS HAVE BEEN CONSTRUCTED THROUGHOUT CLARK COUNTY. THE NETWORK OF FLOOD CONTROL FACILITIES IS STILL A WORK IN PROGRESS.”

District Message

If you’re a longtime Clark County resident, you probably have memories of flash floods over the years and the parts of town that were especially prone to flooding. Decades ago, the Charleston Underpass would often collect several feet of water after heavy rains. The fiercely flowing Flamingo Wash at Boulder Highway was once where rushing water would damage homes and property when storms hit the valley.

In 2024, it’s a different story. The Charleston Underpass drains properly, even during heavy rains. Water flows throughout the Flamingo Wash are contained and controlled by channels and basins. These are just two examples that reflect the significant progress made by the District over the past three decades.

This Annual Report provides an overview of our ongoing commitment to safeguarding the community from floods, a dedication that has remained unwavering since the District was established in the mid-1980s.



Approximately 713 miles of channels, underground storm drains, and 110 basins have been constructed throughout Clark County. Completing these facilities has resulted in the removal of 65 square miles of special flood hazard areas by the Federal Emergency Management Agency, which means hundreds of thousands of people are better protected from flooding risks. Every piece of this infrastructure is part of the District’s strategic flood control Master Plan, which outlines the long-term vision for even more comprehensive protection against flooding risks. In the past year alone, we completed four projects amounting to more than $29 million dollars, including installing several miles of storm drains and a new peaking basin.

This year, we also celebrated a groundbreaking ceremony for the newest detention basin to be built, Jim McGaughey Detention Basin, Collection, and Outfall. Mr. McGaughey is considered one of Southern Nevada’s founding fathers of flood control. The detention basin will collect stormwater draining off Frenchman Mountain and temporarily store the runoff until it drains safely into the flood network downstream. This will reduce flooding in the area and help protect homes, schools, and businesses.

We still have more work to do. Despite tremendous progress, over the past 12 months, three people have tragically lost their lives in flood events. One of the victims was a 13-year-old boy playing in dangerous flood waters. Since the inception of the District, a total of 41 people have died in flash flooding in Clark County. This is a reminder of the importance of flood control and the value of the District’s ongoing efforts to educate Southern Nevadans of all ages about the dangers of flooding.

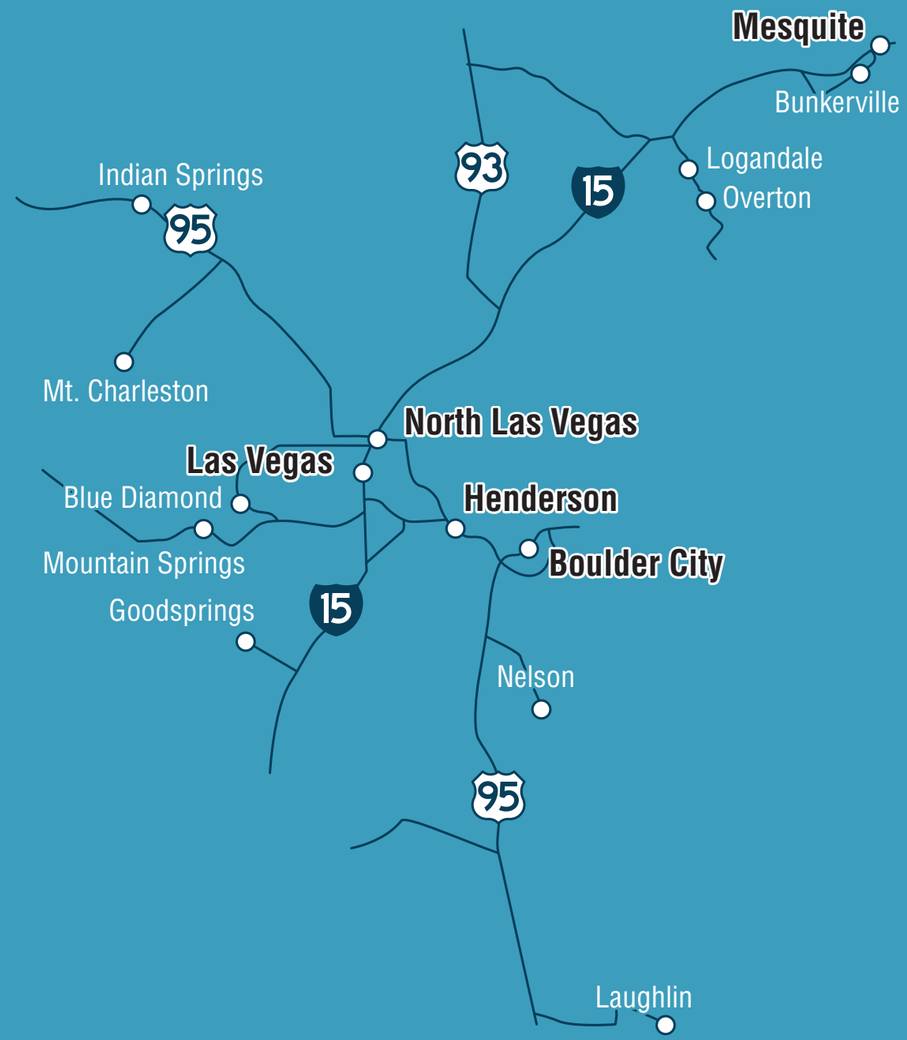
Over the past three decades, the District has invested $2.61 billion in flood control efforts. Through collaboration with member entities and partner agencies and the expertise of our dedicated staff, the District is equipped to tackle the challenges ahead. We will continue to strive to enhance the quality of life in Southern Nevada by protecting the surface water environment and keeping communities safe from flood devastation.

History of The District

Southern Nevada is no stranger to damaging floods. News reports from the early 1900s describe the disruptive effects of flooding on trains that traversed present-day Clark County, and problematic storms persisted throughout most of the 20th century. The population of Clark County boomed in the 1960s due to the success of the downtown Las Vegas casinos and the eventual creation of megaresorts on the now-famous Las Vegas Strip. Eventually, high-profile floods in the Las Vegas Valley during the 1970s and early 1980s led to requests for a coordinated response and uniform solutions to flooding.

The Nevada Legislature authorized the creation of flood control districts in 1985. In 1986, Clark County residents overwhelmingly voted to approve a dedicated funding mechanism for the Clark County Regional Flood Control District to develop and implement coordinated and comprehensive master plans to solve flooding problems in Clark County. Funding for designing, constructing, and maintaining flood control facilities comes from one-quarter of one percent sales tax in Clark County.

The District is a distinct local government agency led by a general manager/chief engineer responsible for analyzing the extent of flood control problems and presenting solutions and recommendations to two advisory committees and a Board of Directors. In addition to the general manager/chief engineer, there are 27 full-time equivalent staff positions in engineering, flood safety, and administration. The District contracts with Clark County for various legal and administrative services, including the Comptroller, District Attorney, Enterprise Resource Planning, Finance, Purchasing, Risk Management, Human Resources, and Treasurer.



THE DISTRICT BOARD OF DIRECTORS INCLUDES **TWO REPRESENTATIVES FROM CLARK COUNTY, TWO FROM THE CITY OF LAS VEGAS, AND ONE FROM HENDERSON, NORTH LAS VEGAS, BOULDER CITY, AND MESQUITE.** BOARD LEADERSHIP IS ELECTED ANNUALLY AMONG THESE MEMBERS. PUBLIC MEETINGS OF THE BOARD ARE GENERALLY HELD ON THE SECOND THURSDAY OF EACH MONTH TO ENACT POLICY, AUTHORIZE EXPENDITURES, AND CONSIDER OTHER FLOOD CONTROL MATTERS.

Board of Directors

JUSTIN JONES

CHAIR
CLARK COUNTY

ISAAC BARRON

VICE-CHAIR
CITY OF NORTH LAS VEGAS

BRIAN KNUDSEN

MAYOR PRO TEM
CITY OF LAS VEGAS

TICK SEGERBLOM

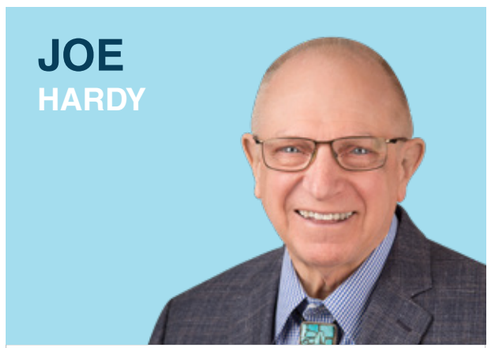
COMMISSIONER
CLARK COUNTY

CAROLYN GOODMAN

MAYOR
CITY OF LAS VEGAS

DAN SHAW

COUNCILMAN
CITY OF HENDERSON



JOE HARDY

MAYOR
CITY OF BOULDER CITY

PAUL WANLASS

COUNCILMAN
CITY OF MESQUITE

Technical Advisory Committee

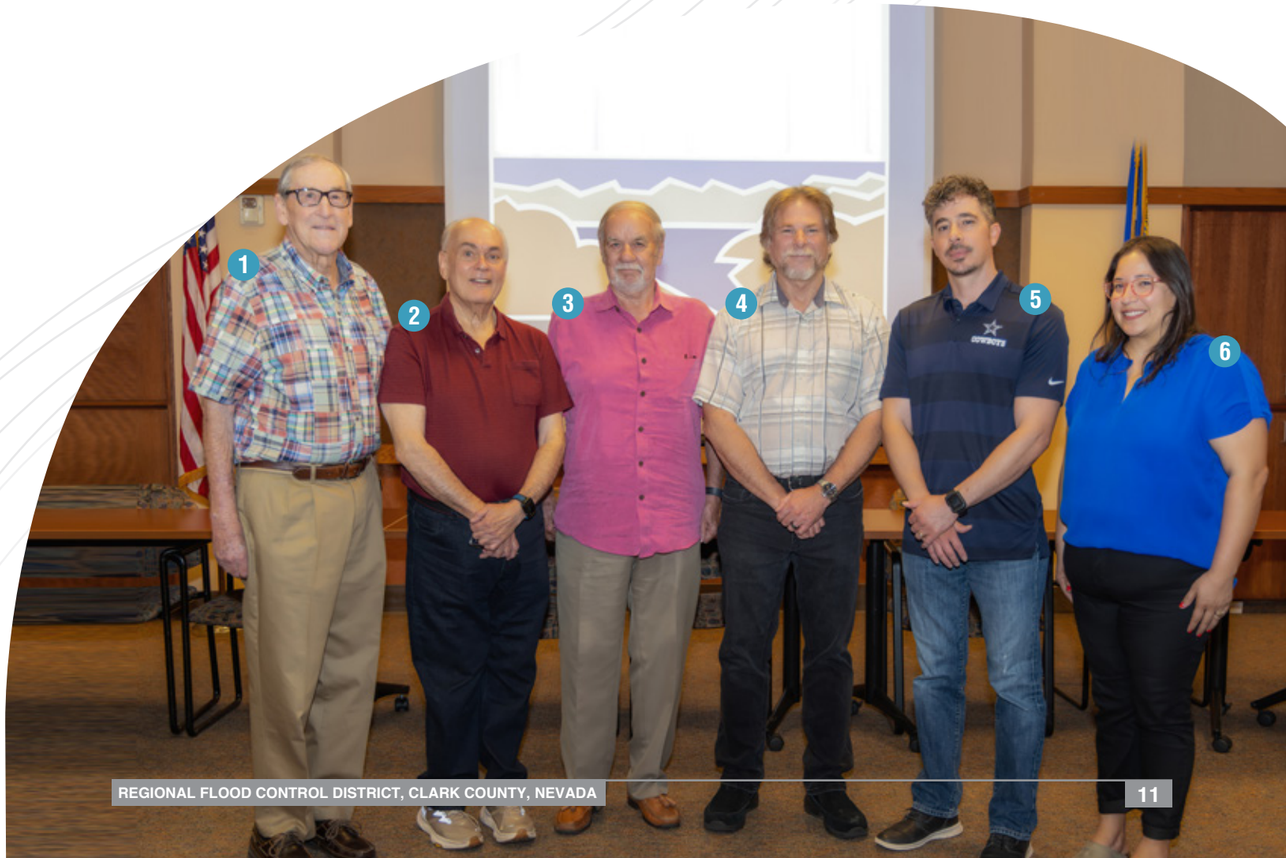
KAIZAD YAZDANI, CLARK COUNTY, ALTERNATE	1
TRAVIS ANDERSON, CITY OF MESQUITE	2
LANCE OLSON, VICE-CHAIR, CITY OF HENDERSON	3
MIKE HUDGEONS, CITY OF NORTH LAS VEGAS	4
ROSA CORTEZ, CITY OF LAS VEGAS	5
GARY POINDEXTER, CITY OF BOULDER CITY	6
JOSEPH LEEDY, CLARK COUNTY WATER RECLAMATION DISTRICT, ALTERNATE	7

NOT SHOWN IN PICTURE

DENIS CEDERBURG, CHAIR, CLARK COUNTY

JOEY PASKEY, CITY OF LAS VEGAS

JOHN SOLVIE, CLARK COUNTY WATER RECLAMATION DISTRICT



Citizens Advisory Committee

BILL STARMER, VICE-CHAIR, CITY OF LAS VEGAS	1
LARRY SCHULTZ, CITY OF LAS VEGAS	2
NORMAN ASHFORD, CITY OF MESQUITE	3
LARRY KARR, CITY OF BOULDER CITY	4
JOSHUA WILKERSON, CITY OF NORTH LAS VEGAS	5
BERTHA GUTIERREZ, CLARK COUNTY	6

NOT SHOWN IN PICTURE

RONALD NEWELL, CHAIR, CLARK COUNTY

KARINA BARRAGAN, CITY OF NORTH LAS VEGAS

JASON GROSS, CITY OF BOULDER CITY

JIM JORDANO, CITY OF HENDERSON

Regional Flood Control District Staff

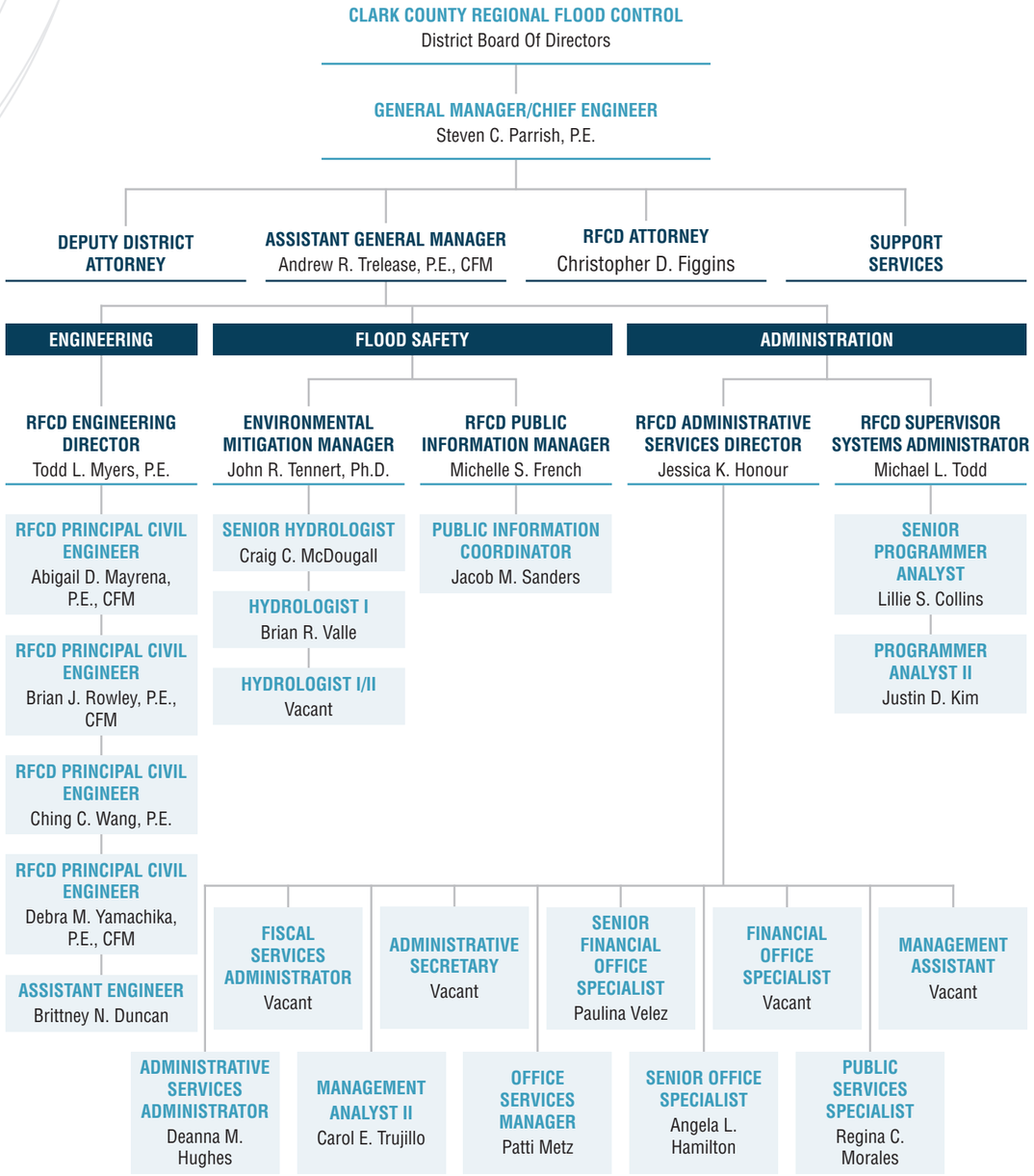
FRONT ROW - LEFT TO RIGHT	
JACOB SANDERS	5
DEBRA YAMACHIKA	4
REGINA MORALES	3
PAULINA VELEZ	2
ABIGAIL MAYRENA	1

ROW TWO – LEFT TO RIGHT	
ANDREW TRELEASE	12
JUSTIN KIM	11
TODD MYERS	10
MICHAEL TODD	9
JESSICA HONOUR	8
LILLIE COLLINS	7
BRIAN VALLE	6

ROW THREE – LEFT TO RIGHT	
MICHELLE FRENCH	20
CRAIG MCDOUGALL	19
CHING WANG	18
BRIAN ROWLEY	17
STEVEN PARRISH	16
BRITTNEY DUNCAN	15
ANGELA HAMILTON	14
PATTI METZ	13

NOT SHOWN IN PICTURE
DEANNA HUGHES
JOHN TENNERT
CAROL TRUJILLO
CHRISTOPHER FIGGINS

Organizational Chart



About Our Region

Clark County is a treasure trove of geographical and cultural diversity, from the charming rural towns of Goodsprings, Moapa, and Overton to the bustling Las Vegas metropolitan area and growing cities of Las Vegas, Henderson, North Las Vegas, Boulder City, Mesquite, and the Town of Laughlin.

The Las Vegas Valley is surrounded by mountains, providing excellent opportunities for outdoor activities. From skiing on Mt. Charleston to hiking at Red Rock Canyon and boating on Lake Mead, southern Nevada has something for every outdoor enthusiast.

The Las Vegas Strip, a unique and vibrant centerpiece of Clark County, is home to iconic attractions such as the dancing fountains, a replica of the Eiffel Tower, a 366' tall Sphere, and some of the world's largest and most beautiful resorts. With more than 154,000 hotel rooms, fine dining, a dazzling array of stores, and luxurious spas, it's no wonder millions of people visit annually. Las Vegas is also a top business event destination, attracting convention-goers from all over the world.

The weather in southern Nevada is as unique as its tourist attractions. With hot, dry summers and mild winters, the climate of Clark County is an intriguing feature of the southern Nevada desert. The average annual precipitation of 4.18 inches is a testament to the arid resilience of this region and its two common types of storms:

LONGER-DURATION LOW-INTENSITY WINTER RAINFALL EVENTS

SHORTER-DURATION, HIGH-INTENSITY SUMMER THUNDERSTORMS

Winter storms in this area are typically associated with low-pressure systems that form over the Pacific Ocean and move eastward. The precipitation from these storms is generally widespread and only occasionally intense.

On the other hand, summer storms typically occur between July and September and are characterized as localized convective thunderstorms that are often very intense. During these hot summer months, moist and unstable air from the Gulf of Mexico is rapidly forced upwards by hot air currents. This process often results in spectacular displays of lightning in the desert sky. Unfortunately, it can also lead to severe thunderstorms, intense rainfall on steep mountain slopes, and armored or caliche-laden desert surfaces. The rainwater runs off rapidly and concentrates in urbanized areas at lower elevations, which can often cause flash floods that are extremely dangerous for anyone near the path of flood waters.

According to the Las Vegas Convention and Visitors Authority, Las Vegas continues to be a thriving destination for tourists and conventioneers. In 2023, the city welcomed 40.8 million visitors, an increase of 5.3% over the previous year. The gaming revenue in Clark County also saw a significant increase, reaching $13.4 billion, up 5.5% over 2022. This growth is a testament to the county's economic potential and business appeal.

Over the past 12 months, the county's population increased by 1.7% to just over 2.3 million residents. The average number of new residents per month is 3,304. It's also one of the larger counties, at more than 7,800 square miles, an area larger than three states.

154,000 HOTEL ROOMS, FINE DINING, A DAZZLING ARRAY OF STORES, AND LUXURIOUS SPAS, IT'S NO WONDER MILLIONS OF PEOPLE VISIT ANNUALLY

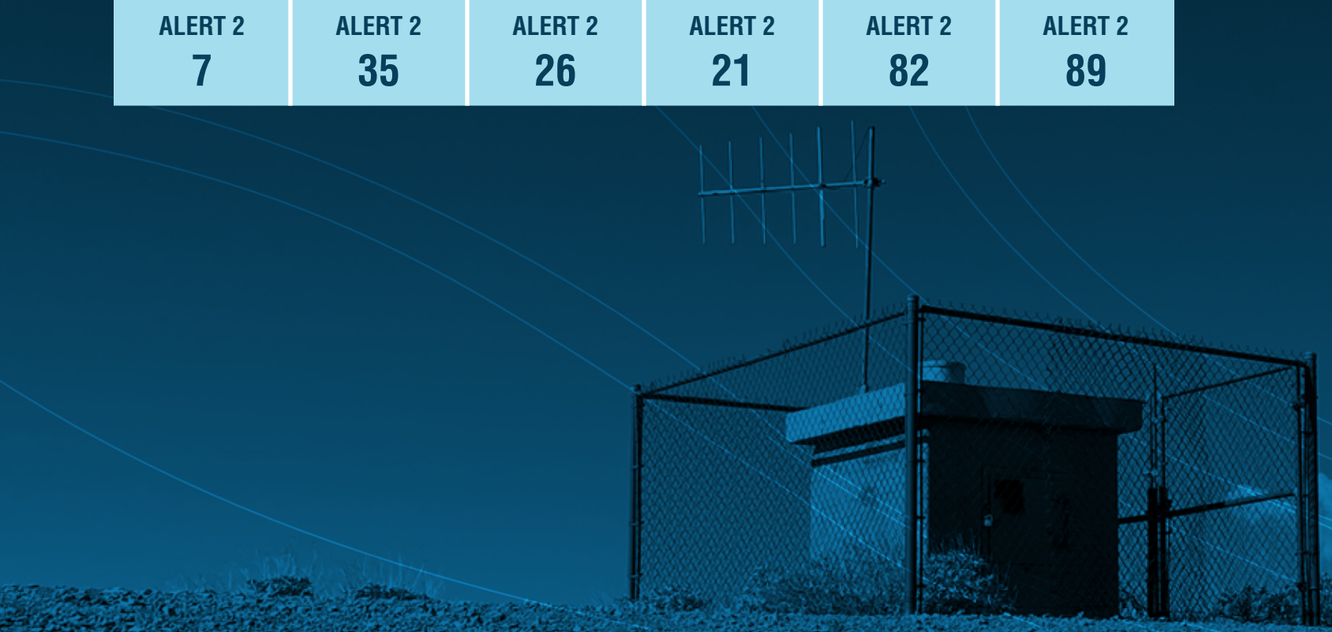
THE GAMING REVENUE IN CLARK COUNTY ALSO SAW A SIGNIFICANT INCREASE, REACHING $13.4 BILLION, UP 5.5% OVER 2022

40.8 MILLION VISITORS, AN INCREASE OF 5.3% OVER THE PREVIOUS YEAR, REACHING $13.4 BILLION, UP 5.5% OVER 2022

POPULATION INCREASED BY 1.7% TO JUST OVER 2.3M RESIDENTS, AVERAGE NUMBER OF NEW RESIDENTS PER MONTH IS 3,304

Monitoring the Weather

REPEATER SITES	RAINFALL GAUGES	FULL WEATHER STATIONS	WATER LEVEL STATIONS	TOTAL W/O REPEATERS	TOTAL W/ REPEATERS
COUNT 7	COUNT 51	COUNT 44	COUNT 124	COUNT 219	COUNT 226
ALERT 1 0	ALERT 1 16	ALERT 1 18	ALERT 1 103	ALERT 1 137	ALERT 1 137
ALERT 2 7	ALERT 2 35	ALERT 2 26	ALERT 2 21	ALERT 2 82	ALERT 2 89



The District maintains a vast network of rain, water level, and meteorological gauges known as the Flood Threat Recognition System (FTRS). The FTRS captures near-real-time weather data from stations throughout Clark County and makes this information publicly available online. This versatile resource makes it easier for local agencies and Southern Nevada residents to be more informed about potential flooding risks.

During the past year, one ALERT 1 water level site was upgraded to ALERT 2, a significant enhancement that ensures more reliable data reception. Additionally, one new rain gauge was installed in Summerlin. Two water level monitoring stations near Centennial Hills remain temporarily decommissioned but are anticipated to be reactivated in July 2024. An ALERT 2 weather station was deactivated in CalNevAri as it was located on U.S. Coast Guard property, and the Coast Guard is preparing to transfer the site back to the Bureau of Land Management. District staff are investigating possible replacement locations for this weather station in the same area.

Keeping Our Water Clean

Southern Nevada's water resources are unique and vital for survival in the arid climate of the Southwest. Runoff from rain in the Las Vegas Valley travels untreated to the Las Vegas Wash and Lake Mead, the community's primary drinking water source. The District works with Clark County and the cities of Henderson, Las Vegas, and North Las Vegas to make sure stormwater is as clean as practicable. This involves developing and implementing a comprehensive stormwater quality management program.

The District is committed to ensuring flood control facilities' construction, operation, and maintenance comply with all applicable local, state, and federal environmental laws and regulations. Compliance with applicable environmental permitting is required as a condition of District funding for flood control projects.

When rain falls on an active construction site, pollutants can be picked up by stormwater runoff and discharged into the storm sewer system if active measures – referred to as Best Management Practices (BMPs) – are not implemented. To enhance awareness of BMPs, the District hosted several outreach activities during the past fiscal year to educate the construction community about environmental regulations associated with the industry. In partnership with local municipalities and Clark County, the District facilitated four training sessions to educate construction contractors about applicable stormwater regulations and how construction affects nonpoint source pollution[1]. More than 150 people attended the training, which provided attendees with information on how to comply with state and local regulations and ordinances.

Finally, the District continues to partner with Clark County to develop an in-lieu fee habitat mitigation program for southern Nevada. The program aims to provide long-term mitigation for impacts to federally regulated "waters of the United States" (WOTUS) that result from construction activities in these areas. Flood control structures funded by the District in Clark County are often located in areas designated as WOTUS. Once established, the in-lieu fee program will allow public and private entities to purchase habitat mitigation credits in exchange for impacts on the WOTUS. The funding from the credits is then used to restore habitat and wetlands in other areas of Clark County, such as the Muddy and Virgin Rivers or the Pittman Wash. A draft In-lieu fee instrument was submitted to the U.S. Army Corps of Engineers (USACE) in June 2024. Review and approval by the USACE and the Inter-Agency Review Team is expected in the next fiscal year.

On February 4, 2024, the Nevada Division of Environmental Protection (NDEP) issued a new National Pollutant Discharge Elimination System (NPDES) permit for the Municipal Separate Storm Sewer System (MS4) in the Las Vegas Valley. This permit requires the municipalities in the Las Vegas Valley, Clark County, and the District to reduce the amount of nonpoint source pollution[1] entering the storm sewer system to the maximum extent practicable. NDEP is responsible for issuing and enforcing the permit. The Permittees to the MS4 permit have begun updating the Stormwater Management Plan (SWMP) and Stormwater Monitoring Plan as required by the permit. The finalization of these two plans is anticipated to be completed in 2025.

[1]According to the U.S. Environmental Protection Agency (EPA), nonpoint source pollution occurs when runoff from rain and snowmelt carries pollutants into waterways such as rivers, streams, lakes, wetlands, and even groundwater. The name "nonpoint source pollution" is derived from the concept that there is no single point from which the pollution comes; it comes from everyone and everywhere. Nonpoint source pollution is the nation's and the state's highest threat to water quality.

KEEPING OUR WATER CLEAN
ANNUALREPORT 2023/24

THE DISTRICT WORKS WITH CLARK COUNTY AND THE CITIES OF HENDERSON, LAS VEGAS, AND NORTH LAS VEGAS TO MAKE SURE STORMWATER IS AS CLEAN AS PRACTICABLE

THE PROGRAM AIMS TO PROVIDE LONG-TERM MITIGATION FOR IMPACTS TO FEDERALLY REGULATED "WATERS OF THE UNITED STATES" (WOTUS)

COMPLIANCE WITH APPLICABLE ENVIRONMENTAL PERMITTING IS REQUIRED AS A CONDITION OF DISTRICT FUNDING FOR FLOOD CONTROL PROJECTS

Floodplain Management

A comprehensive floodplain management program helps reduce the risk of flooding throughout Southern Nevada. Components include a Regulatory Program, the Community Rating System (CRS), Flood Control Master Planning, and Land Development Reviews.

REGULATORY PROGRAM

FEMA established the National Flood Insurance Program (NFIP) in 1968 to make flood insurance available at a reasonable cost for property owners in participating communities. NFIP members in Clark County are unincorporated Clark County, Fort Mojave Indian Reservation, City of Boulder City, City of Henderson, City of Las Vegas, City of Mesquite, and City of North Las Vegas.

NFIP BENEFITS TO THE COMMUNITY

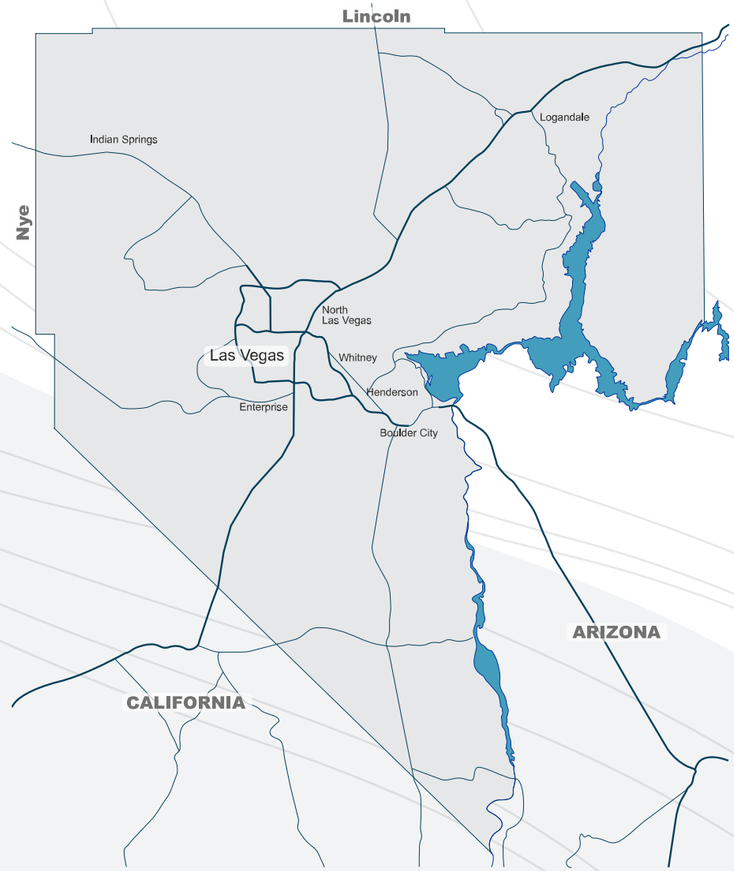
- Minimum standards for development (Uniform Regulations for the Control of Drainage)
- Floodplain mapping
- Flood insurance
- Disaster assistance

THE COMMUNITY RATING SYSTEM (CRS)

FEMA sponsors the CRS, offering reduced flood insurance premiums in areas where community activities exceed the NFIP's minimum standards.

The District cooperates with Clark County and the cities of Henderson, Las Vegas, Mesquite, and North Las Vegas to help citizens realize potential flood insurance premium reductions of up to 25 percent within Special Flood Hazard Areas (SFHA) and reductions of up to 10 percent outside SFHA. These communities received credit for the following District activities:

- Public Information Program
- Flood Control Maintenance Funding
- Flood Hazard Mapping and Remapping
- Flood Control Construction Funding
- Flood Threat Recognition System
- The District's Flood Control Master Plan
- The Hydrologic Criteria and Drainage Design Manual and the Uniform Regulations for the Control of Drainage

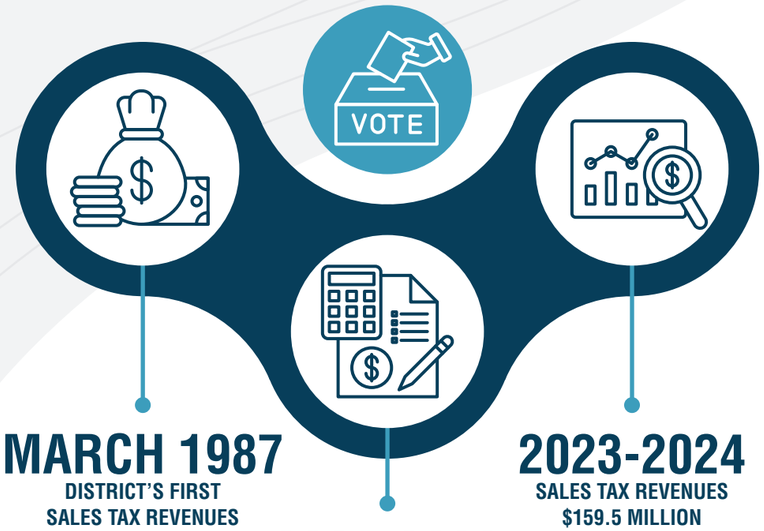


FLOOD CONTROL MASTER PLANNING

The Nevada Revised Statutes requires the District to update Flood Control Master Plans every five years to assess the progress and identify changes. Flood Control Master Plans include an inventory of community flood control facilities and locations, descriptions, and cost estimates of proposed future facilities. The District's Master Plan Update for the Las Vegas Valley was completed at the end of March 2024. The Flood Control Master Plans Update for the Outlying Areas of Clark County was initiated in January 2024, and is expected to be adopted by the end of the calendar year.

Demonstrating Fiscal Integrity

1986
CLARK COUNTY VOTERS APPROVED A ONE-QUARTER OF ONE PERCENT SALES TAX LEVY



MARCH 1987
DISTRICT'S FIRST SALES TAX REVENUES

2023-2024
SALES TAX REVENUES $159.5 MILLION

2022-2023
$ 154.3 MILLION SALES TAX REVENUE

In 1986, Clark County voters approved a one-quarter of one percent sales tax levy to fund flood control improvements. The District's first sales tax revenues were received in May 1987 after becoming effective in March 1987. **For the fiscal year 2023-2024, sales tax revenue was $159,483,862, a 3.38 percent increase over the prior fiscal year (2022-2023).** Since its inception, the District has overseen the design and construction of approximately $2.61 billion in publicly funded flood control improvements throughout Clark County.

Traditionally, the driving force in the Southern Nevada economy has been the tourism and hospitality industries, where hospitality accounts for one in four jobs and one in three dollars. The Las Vegas Convention and Visitors Authority reported that visitor volume in 2023 increased by 5.3 percent, and convention center attendance was up 19.9 percent compared to the previous year. According to the Center for Business and Economic Research (CBER) at the University of Nevada, Las Vegas, gaming revenue in November surged by 14.3 percent year-over-year, the highest on record, boosted by the Formula 1 Las Vegas Grand Prix event, despite only a 0.7 percent increase in visitor volume. The economic impact of tourism, including accommodations, transportation, entertainment, and attractions, directly influences the District's revenue.

Real estate activity, directly and indirectly, impacts sales tax collections as homeowners tend to buy merchandise or spend money on home improvements for their new and existing residences. Existing and new home prices continued a recovery and year-over-year gains, according to CBER. Housing permits have also shown year-over-year gains since June 2023 despite high interest rates amid a tight inventory. The District's ability to fund projects depends mainly on sales tax and, in turn, Clark County's economy. The last several months have seen significant growth-over the previous several months and generated record sales tax receipts. However, this level of growth may not be sustainable. Sales tax is the District's primary source of revenue, and we are mindful that adverse economic changes can negatively impact tax receipts.

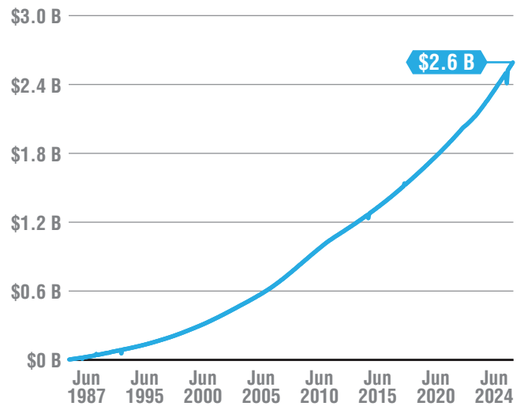
THE DISTRICT HAS BEEN AWARDED THE DISTINGUISHED BUDGET PRESENTATION AWARD BY THE GOVERNMENT FINANCE OFFICERS ASSOCIATION (GFOA) THE UNITED STATES AND CANADA EVERY YEAR FOR THE PAST 30 YEARS

THIS SIGNIFICANT ACHIEVEMENT REFLECTS THE DISTRICT'S COMMITMENT TO MEETING THE HIGHEST PRINCIPLES OF GOVERNMENTAL BUDGETING.

Over 90% of sales tax revenue collected by the District continues to be used to design, build, and maintain flood control projects and pay for the associated debt service. During FY 2023-2024, the District expended approximately $97.77 million for flood control projects and maintenance. Another large share of sales tax revenue was spent on debt service, amounting to $47.23 million. **The remaining sales tax revenue is used for salaries and benefits, professional services, and other administrative expenses. In FY 2023-2024, $8.68 million was spent on these operating expenses.**

The District has been awarded the Distinguished Budget Presentation Award by the Government Finance Officers Association (GFOA) of the United States and Canada every year for the past 30 years. This significant achievement reflects the District's commitment to meeting the highest principles of governmental budgeting. Annually, the District continues to receive favorable audit opinions, which demonstrate the District's financial statements are presented fairly in all material respects. These positive opinion assessments help demonstrate to the public the District follows proper accounting principles and procedures.

TOTAL REVENUES DERIVED FROM SALES TAX SINCE 1987 CHART



FISCAL INTEGRITY – THE FUTURE OUTLOOK

Following three years of economic extremes, from historic high unemployment and business lockdowns to the pandemic-prompted bust and stimulus-sparked boom, the expectation going into 2024 is the Southern Nevada economy will remain relatively stable coming off solid performances following the height of the pandemic. In the last 24 months, the nation, as a whole, has experienced elevated consumer spending, partially as a result of pent-up demand because of the pandemic, partially as a result of stimulus funding flowing through the economy, and partially due to shifts in consumer behavior and attitudes.

Southern Nevada's economy has become more resilient. For example, the hospitality industry alone is more diversified than in the past. The economy is positioned to continue on a path of growth with strong sales tax revenues. Recent data indicate an upward economic trend in the near future. As a result, the District anticipates sales tax revenue to modestly increase next fiscal year to $167.10 million. However, economic indicators will continue to be monitored and adjusted as needed.

Ten-Year Construction Program

Staff develops a 10-year forecast of District project funding each year in conjunction with the Ten-Year Construction Program (TYCP). The forecast incorporates sales tax revenues, interest earnings, bond proceeds from debt issuance, and proposed expenditures.

This long-range financial plan drives the TYCP project funding schedule, including planning upcoming design and construction projects. Approximately $96.55 million in new resources were available for programming projects in FY 2023-24.

Total available resources for the TYCP were estimated to be $1.27 billion, including the issuance of bonds totaling $300 million. To expedite the design and construction of flood control projects from 1991 to the present, the District has issued $955 million in general obligation bonds, of which $593.36 million remains outstanding.

10-YEAR FORECAST

SALES TAX REVENUES
INTEREST EARNINGS
BOND PROCEEDS FROM DEBT ISSUANCE
PROPOSED EXPENDITURES

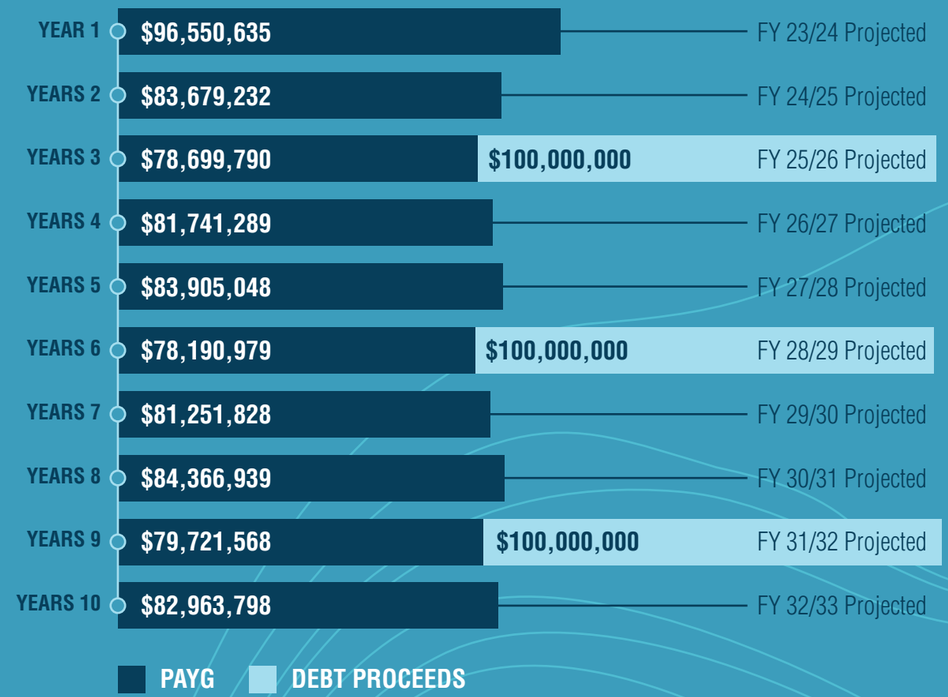
$96.55 M

NEW RESOURCES AVAILABLE FOR PROGRAMMING PROJECTS IN FY 2023-2024

TOTAL ESTIMATED RESOURCES FOR TYCP
$1.27 BILLION

ESTIMATED BOND FUNDING FOR TYCP
$300 MILLION

FY 2023-24 TOTAL 10-YEAR ESTIMATED RESOURCES



Maintaining Flood Control Facilities

The Board has adopted an Operations and Maintenance Manual to establish performance standards and guidelines for the maintenance of flood control facilities located within the District's service area. Each of the separate entities in Clark County is provided District funds to maintain the regional flood control facilities within their respective jurisdictions.

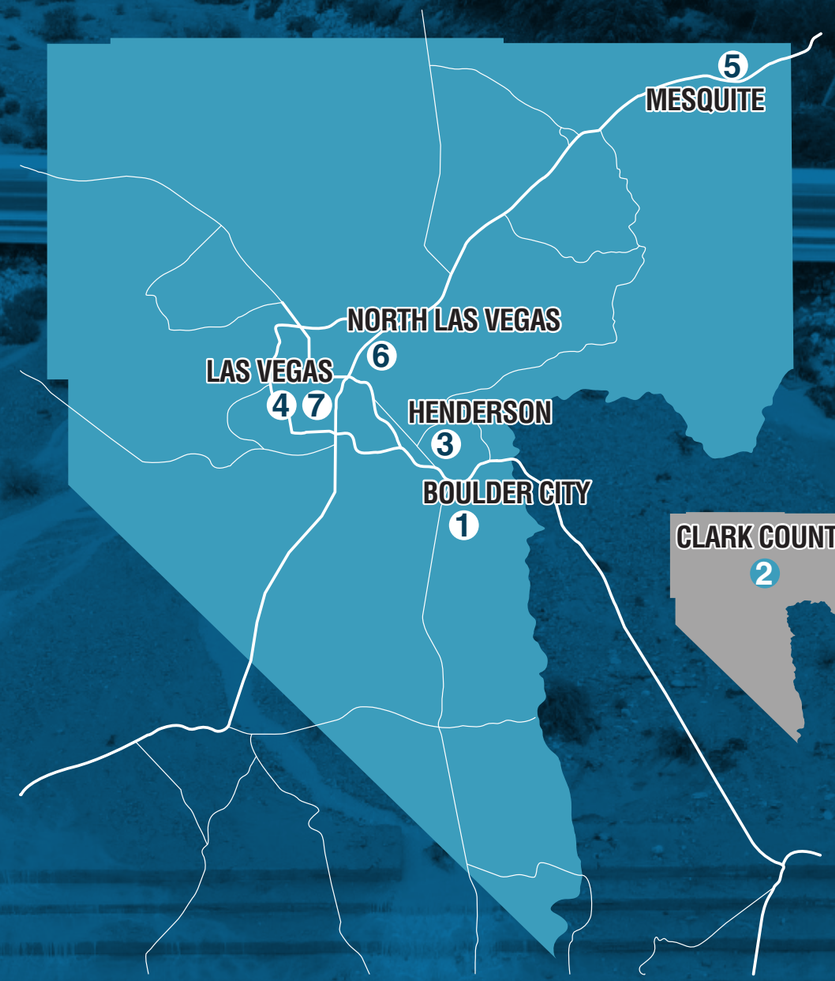
The District worked with member entities to develop the fiscal year 2023-2024 Maintenance Work Plans and Budgets, which were approved by the Board on June 8, 2023, in the amount of $19,413,731. This included a funding allocation for the annual Las Vegas Wash Long-Term Operating Plan Interlocal Agreement in the amount of $614,616.

The Board approved one supplemental budget request for the fiscal year 2023-2024 totaling $1,300,000. The City of Las Vegas requested an increase in the amount of $1,300,000 for additional funding needed for maintenance and repair of detention basins. Major storm events from Tropical Storm Hilary in August 2023 occurred in the drainage area upstream of the detention basins and deposited significant debris and sediment. This debris and sediment needed to be removed from the detention basins to provide adequate storage volume to protect the downstream area. In addition, the additional funds were to repair a damaged portion of the basins and erosion caused by the tropical storm. With the approval of the supplemental budget request, Maintenance Work Plans and Budgets totaled $20,713,731 for fiscal year 2023-2024.

Flood control facility maintenance was performed using a combination of private contractors and entity maintenance staff. During this fiscal year, entity staff inspected and/or maintained numerous facilities throughout the District service area including 110 detention basins and 713 miles of channel and underground storm drains.

"110 DETENTION BASINS AND 713 MILES OF CHANNEL AND UNDERGROUND STORM DRAINS, OF WHICH 135 MILES ARE NATURAL WASHES."

MAINTAINING FLOOD CONTROL FACILITIES
ANNUALREPORT 2023/24



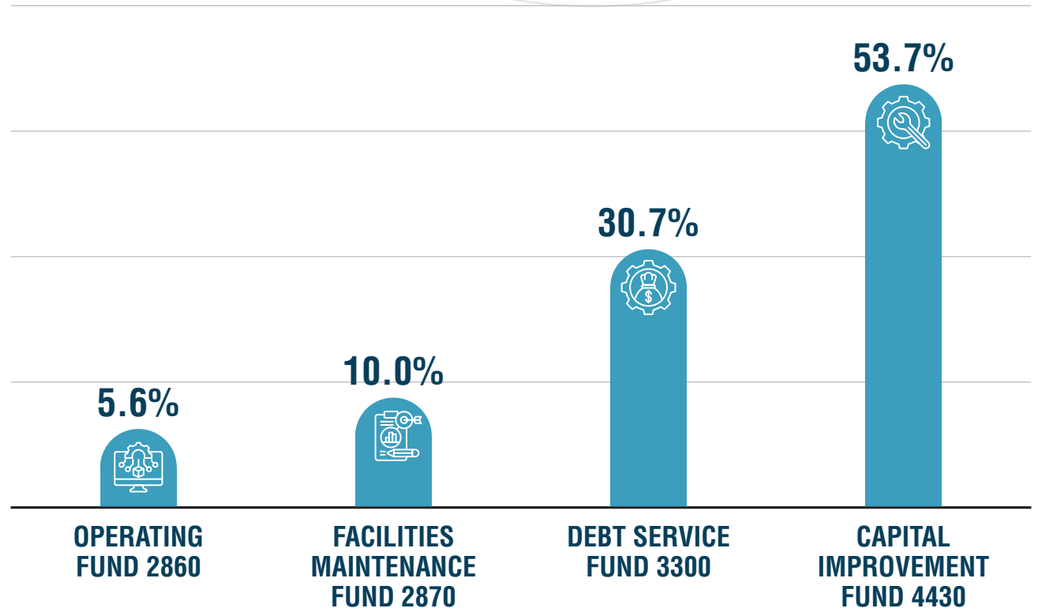
		BUDGET	EXPENDED	% EXPENDED
1	BOULDER CITY	$918,550	$279,532	30.43%
2	CLARK COUNTY	$5,577,500	$4,496,170	80.61%
3	HENDERSON	$5,700,000	$3,318,721	58.22%
4	LAS VEGAS	$4,500,000	$4,500,000	100.00%
5	MESQUITE	$420,265	$420,265	100.00%
6	NORTH LAS VEGAS	$2,982,800	$1,804,197	60.49%
7	LAS VEGAS WASH ACTIVITIES	$614,616	$614,616	100.00%
		$20,713,731	$15,433,501	

Clark County Regional Flood Control District Funding

Clark County Regional Flood Control District Governmental Funds - Fiscal Year 2023-24 Sources and Uses of Funds Summary - Unaudited [1]	OPERATING FUND 2860	FACILITIES MAINTENANCE FUND 2870	DEBT SERVICE FUND 3300	CAPITAL IMPROVEMENT FUND 4430	TOTAL REGIONAL FLOOD CONTROL DISTRICT FUNDS
Beginning Balance (July 1, 2023)	$30,823,500	$8,699,574	$23,384,195	$323,052,024	$385,959,293
SOURCES OF FUNDS					
Sales Tax Revenue	$159,483,862	-	-	-	$159,483,862
Interest/Other	$1,243,054	$376,891	$1,080,856	$14,778,673	$17,479,474
Transfers From Other Funds	$350,000	$17,000,000	$47,870,385	$97,000,000	$162,220,385
Total Sources Of Funds	$161,076,916	$17,376,891	$48,951,241	$111,778,673	$339,183,721
USES OF FUNDS					
Salaries and Wages	($2,752,201)	-	-	-	($2,752,201)
Employee Benefits	($1,208,695)	-	-	-	($1,208,695)
Services and Supplies	($4,532,855)	($15,433,501)	($1,500)	($295,766)	($20,263,622)
Capital Outlay	($189,841)	-	-	($82,337,663)	($82,527,504)
Principal	-	-	($25,930,000)	-	($25,930,000)
Interest	-	-	($21,300,640)	-	($21,300,640)
Transfers to Other Funds	($161,870,385)	-	-	($350,000)	($162,220,385)
Total Uses of Funds	($170,553,977)	($15,433,501)	($47,232,140)	($82,983,429)	($316,203,047)
Fiscal Year Net Change	($9,477,061)	$1,943,390	$1,719,101	$28,795,244	$22,980,674
Ending Balance (June 30, 2024)	$21,346,439	$10,642,964	$25,103,296	$351,847,268	$408,939,967

[1] Audited financial statements are expected to be available in November 2024.

TOTAL PERCENT OF EXPENDITURES



Public Information Efforts: Keeping The Community Informed

The District's Public Information Program is dedicated to educating Southern Nevadans about the risks of flash flooding and providing updates on the progress of flood control infrastructure in Clark County. The program also aims to raise awareness about stormwater quality and how residents can improve the cleanliness of urban runoff and rainwater draining to Lake Mead.

The Board of Directors designated July 2023 as "Flash Flood Awareness Month," and the District launched the season with a news conference. This garnered coverage from major news outlets, including local Spanish stations, and helped increase public awareness about the elevated threat of flash floods during summer.

The Citizens' Advisory Committee members attended an educational tour in October 2023. To promote awareness of local issues, projects, and facilities, the tour's 25 attendees visited various projects in different construction stages within the Las Vegas Valley.

PUBLIC INFORMATION EFFORTS: KEEPING THE COMMUNITY INFORMED
ANNUALREPORT 2023/24

In May 2024, the District and Clark County hosted a groundbreaking ceremony for the new 71-acre-foot Jim McGaughey Detention Basin, Collection, and Outfall. The event featured speeches from prominent figures such as past and current Clark County Commissioners, Regional Flood Control District General Managers/Chief Engineers, and Mr. Jim McGaughey, a former Nevada State Assemblyman known as the Clark County Regional Flood Control District pioneer.

The District also prioritizes educating students about the dangers of flood water and the importance of avoiding flood control facilities. Nearly 3,200 Clark County students were educated throughout the school year with engaging classroom presentations incorporating informative resources such as a Drainger Danger video, interactive flood table, and take-home Drainger Danger activity book.

Since March 2022, more than 2,200 new Clark County employees have received flash flood safety and stormwater quality training during their onboarding experience. The training equips longtime locals and newcomers alike with valuable information about District's flood control facilities, Clark County's flooding history, and safety measures to prevent being caught in a flash flood.

District staff prepared the annual Community Rating System (CRS) Report to help reduce local flood insurance costs. Sponsored by the Federal Emergency Management Agency (FEMA), the CRS eases flood insurance premiums in areas where community activities exceed the National Flood Insurance Program's minimum standards. Participating communities can receive CRS credits, which generally contribute to lower flood insurance premiums for residents and businesses. Staff also created a flyer about the Flood Insurance Rate Map and Flood Zone Information for local realtors.

Throughout the year, the District continued to conduct Stormwater Quality and Flood Safety Awareness campaigns using various media platforms to inform residents about flooding risks, especially during heavy rain seasons. This includes educational efforts at more than 100 local events that reached nearly 10,000 residents and visitors with messaging about flood safety and stormwater quality.

History of Flooding

The dry, hot region of Clark County has experienced periods of intense rainfall and subsequent flash flooding throughout modern history. In a special report entitled “History of Flooding, Clark County, Nevada 1905-1975,” the U.S. Soil Conservation Service documented 184 flooding events that damaged private property and public facilities. Since the District’s inception in the mid-1980s, 41 lives have been lost in flash floods.

While floods can occur in any month of the year, the most damaging storms typically happen between July and September in the monsoon season. During these hot summer months, moist, unstable air – usually from the Gulf of Mexico or the Gulf of California – is rapidly forced upward by hot air currents.

The dynamics of this process often result in spectacular lightning displays in the desert sky. They also cause severe thunderstorms, intense rainfall on steep mountain slopes, and excessive runoff over armored desert surfaces. The rainwater runs off rapidly and concentrates in urbanized areas at lower elevations.

Residents and visitors must recognize the potential flooding risks, as these storms can be deadly and destructive to property. They can also create minor inconveniences, such as flooded roadways and storm debris. It’s important to remain vigilant and cautious, as being informed and prepared is the best defense against such natural disasters.

The average rainfall in the Las Vegas Valley is 4.18 inches, nearly equally divided between the summer and winter rainy seasons.

The arid southwest landscape with steep slopes, poor soils, and little vegetation can create rapid stormwater runoff during intense rainfall events.

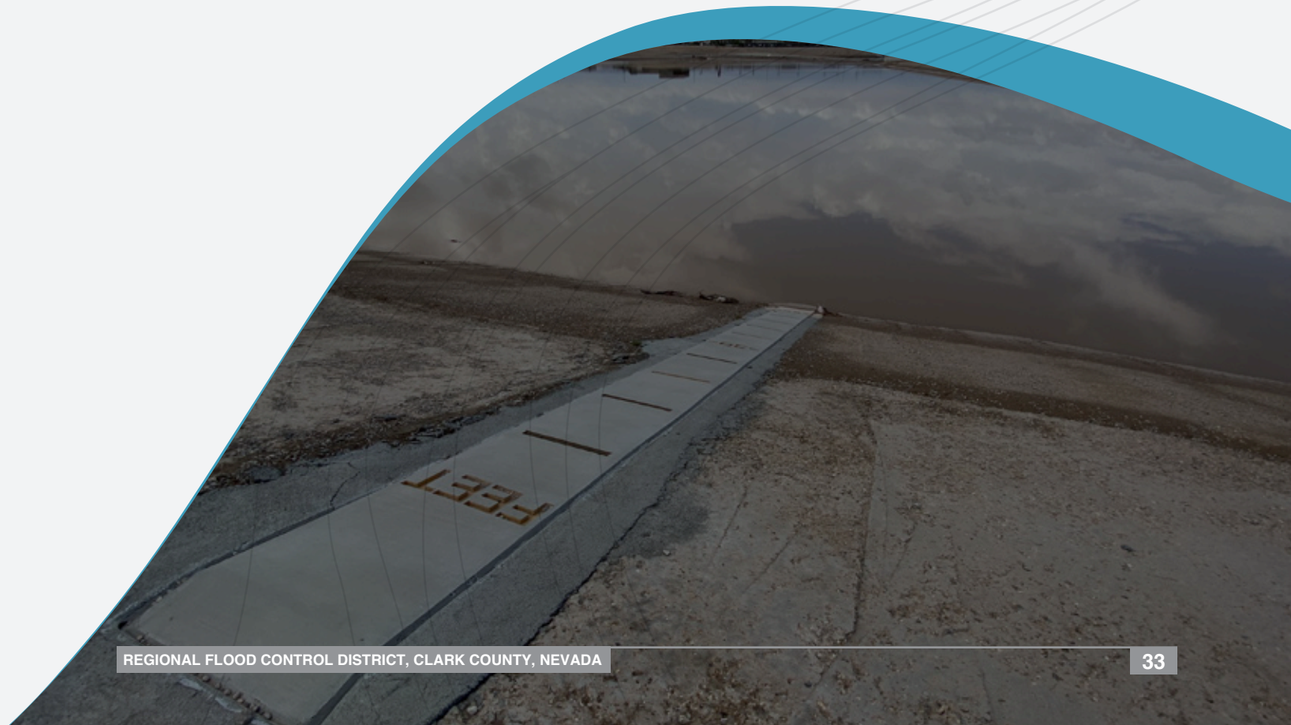
The District’s website, regionalflood.org, contains reports describing significant rainfall and flood events in Clark County. The website also includes all the data collected by its state-of-the-art Flood Threat Recognition System, which is designed to monitor the weather before and during rainfall events.

1905-1975, U.S. SOIL CONSERVATION SERVICE DOCUMENTED 184 FLOODING EVENTS

MOST DAMAGING STORMS JULY THROUGH SEPTEMBER IN THE MONSOON SEASON

CLARK COUNTY RESIDENTS AND VISITORS MUST RECOGNIZE THE POTENTIAL FLOODING RISKS

THE DISTRICT'S FLOOD THREAT RECOGNITION SYSTEM MONITORS THE WEATHER BEFORE AND DURING RAINFALL EVENTS



Land Development Reviews

Land development projects of regional significance to the District are reviewed by staff to ensure compliance with the Uniform Regulations for the Control of Drainage. Examples include land development projects that impact the implementation of the flood control Master Plan or lie within a FEMA-designated Special Flood Hazard Area. In either case, District staff will review the drainage study and associated addenda prepared for the projects once approval is obtained from the local community. Once District comments (if any) are adequately addressed, the District will issue a concurrence letter on the approval given by the entity.

YEAR	2023-24	2022-23	2021-22	2020-21	2019-20
DRAINAGE STUDIES RECEIVED	184	221	253	232	234
ADDENDA RECEIVED	334	337	334	278	398
CONCURRENCE LETTERS ISSUED	206	256	273	229	237
RELATED COMMENT LETTERS ISSUED	17	24	18	17	25

LAND DEVELOPMENT REVIEWS
ANNUALREPORT 2023/24

YEAR	2018-19	2017-18	2016-17	2015-16	2014-15
DRAINAGE STUDIES RECEIVED	224	197	186	172	178
ADDENDA RECEIVED	349	351	320	233	286
CONCURRENCE LETTERS ISSUED	229	210	173	181	185
RELATED COMMENT LETTERS ISSUED	32	17	37	24	25

Information Systems and Technology

The District's Information Systems team provides Information Technology (IT) cloud and on-premises infrastructure and maintains the computers and servers.

From hydrologic modeling for long-term construction projects to measuring live weather data, the District relies on various technologies to keep engineers, contractors, planners, and the community equipped with accurate and up-to-date information.

Over the past fiscal year, the IT staff worked on diverse projects to maintain the computer infrastructure and improve the District's ability to efficiently and reliably provide resources to staff, the public, and member entities.

The District updated GIS systems to provide better internal and external support for planning, mapping, and construction project tracking,

The District's website, regionalflood.org, continued to help engage with the community and provide information about District projects. The District regularly updates the website to ensure timely and accurate information is available to the public.

Several in-house desktop and web applications were made more robust through updates that utilize emerging standards and evolving best practices.

Over the past year, one of the District's priorities has been the Continuity of Operations Plan (COOP), which prompted the Information Systems team to relocate several systems off-premises. This change enhances the resiliency of District infrastructure by ensuring staff and technology can return to the full operational level more quickly following an adverse incident.

School Outreach Program

EQUIPPING THE NEXT GENERATION

Every child deserves to be protected from the risks of flooding. In the fall of 2023, the District enhanced its School Outreach Program to better educate Clark County students about the science of flooding and the extreme dangers of flood waters.

The presentation was adapted from a large, auditorium-style assembly to an individual classroom format to enrich student engagement. Key components of the 30-minute classroom experience include:

- A nine-minute Nickelodeon-style animated video, custom designed by Robertson + Partners, takes students through the basics of flood safety with the help of the District's Drainger Danger character.
- Compelling photos and videos from recent Southern Nevada storms showcase flood waters' real-life strength and the dangers of entering flood water.
- A hands-on flood table demonstration that interactively illustrates how flooding happens here in the desert.
- Take-home workbooks for each student, full of activities reinforcing key messaging about floods.

In the 2023-2024 school year, the District presented to approximately 3,200 students, more than any year since 2019-2020.

Following each visit, teachers are emailed a survey to share their thoughts on the effectiveness of the presentation and provide the District with a metric to gauge success over time. Results show a high level of approval among educators. To reach even more young Southern Nevadans in the 2024-2025 school year, District staff continue to schedule visits to various schools, groups, and organizations.

HIGHLIGHTS FROM TEACHER SURVEYS

1

"WATER ALWAYS WINS! THE KIDS KEPT SAYING THIS SLOGAN ALL DAY!"

– 3RD-GRADE TEACHER AT SLAM NV

2

"EVERY ASPECT WAS VERY VALUABLE, FROM THE VIDEO TO THE DEMONSTRATION, THE STUDENTS REALLY ENJOYED EVERYTHING AND ARE STILL TALKING ABOUT IT WEEKS LATER."

– LEAD TEACHER AT SPRINGSTONE MONTESSORI

3

"ABSOLUTELY LOVED THE PRESENTATION, AND SO DID THE STUDENTS! WE DEFINITELY WANT TO HAVE YOU BACK!!!"

– 4TH GRADE TEACHER AT GOYNES STEM ACADEMY

4

"MY STUDENTS LOVED THE MODEL OF THE LAS VEGAS VALLEY FLOOD DEMONSTRATION. THEY ALSO ENJOYED THE SLIDE PRESENTATION WITH ACTUAL FOOTAGE OF THE FLOODS THAT HAPPENED RIGHT HERE IN THE VALLEY. MY STUDENTS WERE TOTALLY ENGAGED AND SPOKE OF IT HIGHLY."

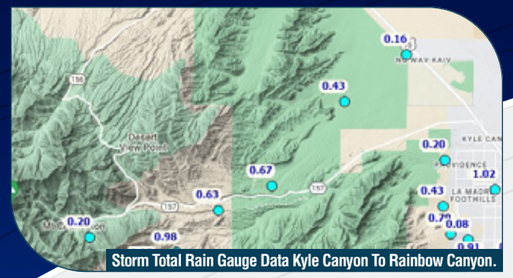
– 3RD-GRADE TEACHER AT COZINE ELEMENTARY

SCHOOL OUTREACH PROGRAM ANNUALREPORT 2023/24

2023 Storm Reports

AUGUST 1, 2023

A monsoon moisture surge entered the southwest border of Clark County. By early afternoon, a cluster of nearly stationary thunderstorms had formed around the District's rain gauge southeast of the town of Jean (Jean SE gauge). In less than one hour, rainfall accumulated a total of 2.09 inches, exceeding the 100-year storm return interval rate of 2.06 inches in one hour. This area of Clark County is remote, so no damages were reported.



Storm Total Rain Gauge Data Kyle Canyon To Rainbow Canyon.

Rain showers developed in the Spring Mountains in the early afternoon, becoming more intense over the next several hours. As these storms moved southeastward, rain gauges in Summerlin and Red Rock began registering high rainfall amounts and rates of accumulation, which necessitated a second Flash Flood Warning.


Flooding at Total Eclipse Street Near Alexander Road, Just West Of US 95

At one point, the rainfall intensity at Brownstone Canyon gauge was the equivalent of a 25-year return interval event. Summerlin NW gauge reported an even higher rainfall rate exceeding the 100-year return interval.

The peak storage for all impacted stormwater detention basins was below 25% capacity.

- Gowan South Detention Basin – Peak depth was 4.17 FT.
- Rancho Detention Basin – Peak depth was 5.90 FT.
- Beltway at Lone Mountain Detention Basin – Peak depth was 10.80 FT.
- Lone Mountain Detention Basin – Peak Depth was 7.96 FT.
- Grand Park Detention Basin – Peak depth was 10.24 FT.
- Red Rock Detention Basin – Peak depth was 6.54 FT.


Kyle Canyon Road Damaged

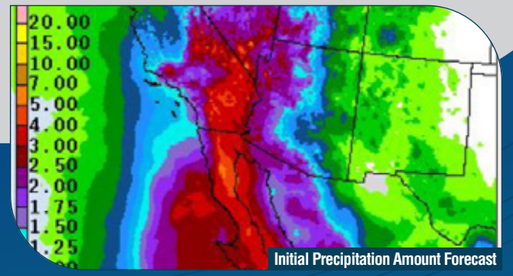
Kyle Canyon Road Damaged

AUGUST 18-21, 2023

TROPICAL STORM HILARY

A tropical cyclone developed off the west coast of Central America on Tuesday, August 15, 2023. After consulting with the Las Vegas NWS office, the District contacted local entities and partners regarding the cyclone with recommendations to prepare for possible heavy rains in southern Nevada and begin outreach to people experiencing homelessness living in the flood control system.

Tropical Storm Hilary Forecast Track



Initial Precipitation Amount Forecast

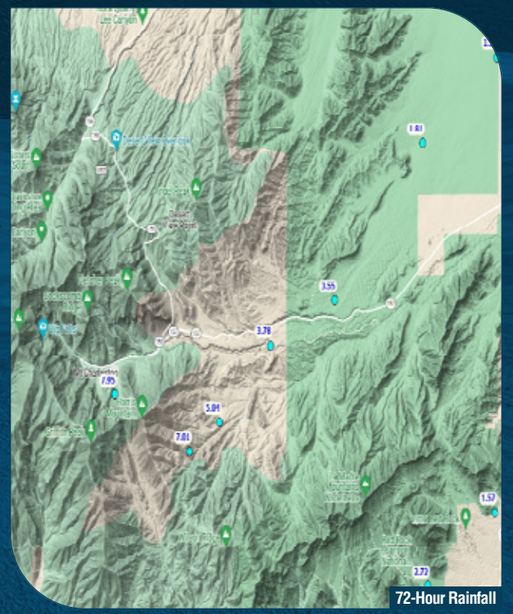
a tropical storm. This was a rare event that had occurred 84 years prior. The NWS Weather Prediction Center forecasted a high chance of flash flooding in California and Nevada.

Widespread showers and thunderstorms erupted throughout Clark County on Friday, August 18, ahead of the main moisture surge from Hilary. Most locations received rainfall between 0.10" and 0.50", while the south-central Las Vegas Valley saw heavier rainfall up to 0.87", and the Desert Tortoise Center weather station reported nearly an inch.

As expected, Hilary maintained Tropical Storm intensity after making landfall. Its closest point of approach to Clark County occurred late Sunday evening. As it continued moving northward, increased atmospheric moisture maintained 24-hour rainfall amounts of around 0.25" to 0.75" throughout much of the county. Increasing orographic lift around higher terrain, especially in the Spring Mountains, allowed higher rainfall amounts exceeding 2 inches as measured by District gauges.

District gauges measured the heaviest total rainfall between August 20, 2023, at 7:00 p.m. and August 21, 2023, at 8:00 a.m., which coincided with Hilary's closest point of approach.

The majority of storm impacts occurred in the Spring Mountains. According to the Clark County Office of Emergency Management & Homeland Security, 12 structures had minor damage, two had significant damage, and one was destroyed. Two individuals and one pet needed rescue. Kyle and Lee Canyons were closed to the public because multiple road segments had been washed out.



72-Hour Rainfall

2023 Storm Reports

AUGUST 25, 2023

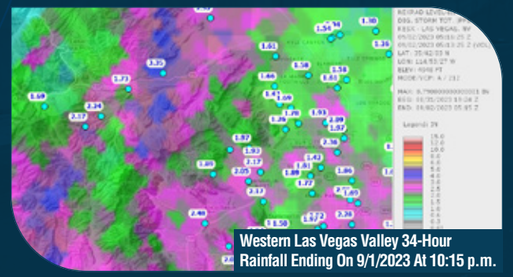
There was one suspected drowning from the flooding. A 56-year-old male from Las Vegas was found in the 5400 block of Club House Drive on August 25, 2023. The cause and manner of his death was ruled a drowning by the Clark County Coroner.

SEPTEMBER 1-2, 2023

High pressure to the east of Nevada and low pressure off the Pacific Northwest United States allowed a strong push of tropical moisture into Southern Nevada. Weather forecast models predicted the increased moisture and heavy rainfall potential days in advance, and the District recommended that the homeless advocate community begin outreach on August 30, 2023.

On the morning of September 1, 2023, widespread thunderstorms swept through Clark County, impacting many streets. Stormwater detention basins functioned properly, quickly containing the runoff.

Additional storms developed during the afternoon, impacting the western half of Clark County. Storm cells moved from southwest to northeast while new storms sprung up where previous storms had developed, creating a back-to-back saturation effect. These lines of storms also slowly drifted eastward over the Spring Mountains, creating rainfall over runoff. Since normally dry detention basins still contained morning runoff, there was some concern about the afternoon storms, with rainfall rates of two to three inches per hour, which could test the limits of some basins. This concern faded a few hours after the storms moved northeastward out of the valley as none of the basins exceeded 50% design capacity.



Western Las Vegas Valley 34-Hour Rainfall Ending On 9/1/2023 At 10:15 p.m.

Station	Maximum Depth (Feet)	Peak Discharge	Peak Storage	Spillway, Embankment or 100-Year WSE	Capacity
Kyle Canyon DB (4029)	7.57	132	95	1300	4%
Upper Las Vegas Wash DB (4024)	14.22	2090	319	1580	18%
Floyd Lamb South RFA (4019)	7.04	43	52	497	12%
Rancho DB (4019)	12.20	123	149	321	46%
Beltway At Lone Mountain DB (4264)	14.90	45	35	270	13%
Grown North DB (4256)	12.24	396	454	960	47%
Grown South DB (4259)	11.34	367	213	630	33%
Red Rock DB (4044)	20.05	1112	502	2000	25%
R-4 DB (4444) (High Water Mark)	5.25	105	18	340	5%
F-1 Debris Basin (4404)	14.64	73	21	55	38%
Upper Flamingo DB (4349)	11.61	189	615	1882	33%
Blue Diamond DB (4414)	16.51	127	232	2268	9%
Upper Duck Creek DB (4639)	8.30	198	166	2578	8%
Duck Creek Railroad DB (4649)	8.11	178	290	818	28%
Tropicana DB North Bay (4474)	30.08	437	148	806	18%
Tropicana DB South Bay (4474)	25.10	n/a	200	806	25%
Lower Flamingo DB (4369)	7.85	672	77	222	35%
Winnick Av. (4302)	4.00	n/a	n/a	n/a	n/a
Las Vegas Wash at Nellis Blvd (4004)	11.59				
Las Vegas Wash East of Nellis Blvd (4395)	11.42				

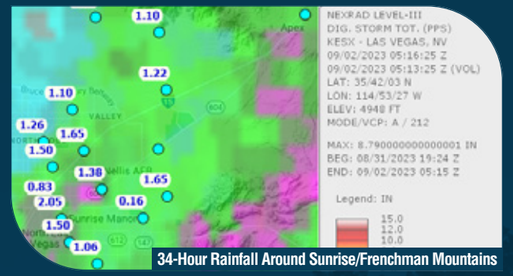
Basin And Channel Maximum Depths

Since the local National Weather Service office first issued a Flash Flood Watch on August 31, 2023, 16 Flash Flood Warnings and four Flash Flood Advisories were issued for Clark County, ending on midnight September 2, 2023.

The Clark County Coroner's Office reported two deaths on September 2, 2023, and a third victim was found on September 6, 2023.

A 13-year-old boy from Las Vegas was found in the 5600 block of Boulder Highway on September 2, 2023, at 3:17 p.m. He reportedly had been floating on an inner tube in floodwater when he was injured and taken to Sunrise Hospital, where he died the next day. The manner of death was ruled accidental by drowning.

The Clark County Office of Coroner/Medical Examiner investigated a second case involving a possible drowning victim from the weekend storms. The body of an unhoused man reported missing on the evening of September 1 was found in a detention basin near Rainbow Boulevard and Westcliff Drive at approximately 4:45 a.m. on September 1, 2023. The cause and manner of his death are drowning/accident and acute meth toxicity.



34-Hour Rainfall Around Sunrise/Frenchman Mountains

Vehicle In Culvert

Significant rainfall also impacted the Sunrise/Frenchman Mountains. Runoff south of East Lake Mead Boulevard traveled westward (downhill) along Piccadilly Drive and entered a drainage culvert near Albertsons Grocery Store. After the storm, it was discovered that an unoccupied passenger vehicle had been swept into the channel by rushing stormwater. This prevented a portion of the flow from entering the underground box culvert, ending up overtopping Hollywood Boulevard.

Debris Across Hollywood Blvd.

Lake Mead Blvd. & Mt. Hood St.

As runoff continued flowing westward, it culminated in significant flow, with ponding on Lake Mead Boulevard at Mt. Hood Street and extending just west of Sloan Channel.

Also on September 2, 2023, I-15 was closed for seven hours after runoff from heavy rainfall near Jean, NV, inundated the interstate, especially the southbound lanes. Although this storm created a significant impact to travel on I-15, there were no reports of damage or injuries resulting from the flooding.

I-15 Flooded

Projects Completed FY 2023-2024

RFCD COST
$26,555,575

TOTAL COST
$29,925,269

GOWAN NORTH - EL CAPITAN BRANCH, ANN RD TO CENTENNIAL PKWY CITY OF LAS VEGAS

This project consisted of approximately one mile of underground storm drain facilities ranging in size from 60-inch reinforced concrete pipe to 8-foot by 6-foot reinforced concrete box culvert within El Capitan Way from Ann Road to Centennial Parkway.

WAGON TRAIL CHANNEL – SUNSET TO TECO CLARK COUNTY

This project included approximately 1,140 linear feet of reinforced concrete box culvert within Procyon Street from Teco Avenue to Sunset Road.

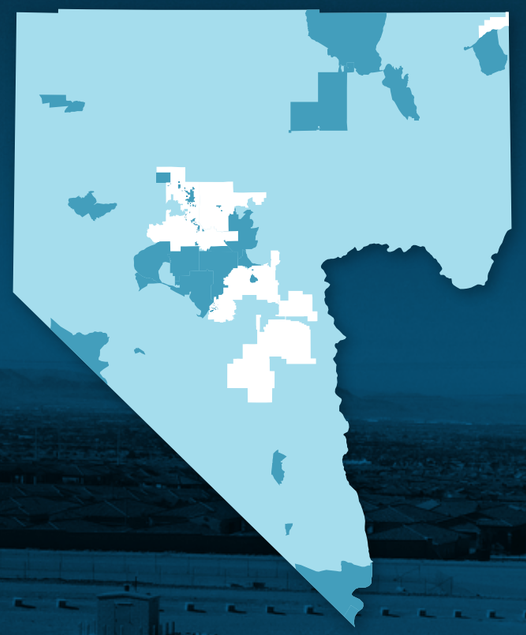
BLUE DIAMOND WASH, ARVILLE STREET TO I-15 CLARK COUNTY

This project included approximately one mile of flood control improvements consisting of reinforced concrete pipe, open channel, and reinforced concrete box culverts on Robindale Road from I-15 to Arville Street.

HARRY REID AIRPORT PEAKING BASIN - EAST OUTFALL CLARK COUNTY

This facility will serve as the outfall for the future Harry Reid Airport Peaking Basin. The project included approximately 4,300 linear feet of reinforced concrete box culvert and reinforced concrete pipe storm drain within University Center Drive from the Tropicana Wash to the outlet of the future peaking basin at Paradise Road.

PROJECTS COMPLETED FY 2023-2024
ANNUALREPORT 2023/24



GOWAN NORTH, EL CAPITAN BRANCH
CITY OF LAS VEGAS
Construction Cost: $10,474,240
Start Date: October 2022
Completed: August 2023

WAGON TRAIL CHANNEL
CLARK COUNTY
Construction Cost: $2,371,530
Start Date: May 2022
Completed: October 2023

BLUE DIAMOND WASH
CLARK COUNTY
Construction Cost: $6,683,730 (RFCD cost)
Start Date: October 2022
Completed: April 2024

HARRY REID AIRPORT PEAKING BASIN EAST OUTFALL
CLARK COUNTY
Construction Cost: $7,026,075 (RFCD cost)
Start Date: November 2022
Completed: June 2024

Projects Completed During FY 2022-23

SEP 2022

DUCK CREEK-JONES BOULEVARD STORM DRAIN

Clark County

DEC 2022

SILVERADO RANCH DETENTION BASIN, COLLECTION, AND OUTFALL

Clark County

FEB 2023

WHITNEY RANCH CHANNEL REPLACEMENT

City of Henderson

PROJECTS COMPLETED DURING FY 2022-23
ANNUALREPORT 2023/24

MAR 2023

ANTHEM PARKWAY CHANNEL, HORIZON RIDGE TO SIENA HEIGHTS

City of Henderson

APR 2023

CHICKASAW STORM DRAIN, LOCAL DRAINAGE IMPROVEMENTS

City of Henderson

JUN 2022

BLUE DIAMOND CHANNEL 02, DECATUR - LE BARON CHANNEL TO RICHMAR, PHASE 1

Clark County

Projects Under Construction or About to Start (As of June 30, 2024)

ANTICIPATED CONSTRUCTION DATES

JUL 2024

FLAMINGO-BOULDER HIGHWAY NORTH, CHARLESTON-BOULDER HIGHWAY TO MARYLAND PARKWAY AND MARYLAND PARKWAY SYSTEM

City of Las Vegas

OCT 2024

GOWAN OUTFALL, ALEXANDER ROAD, DECATUR BOULEVARD TO SIMMONS STREET AND SIMMONS STREET TO CLAYTON

City of North Las Vegas

NOV 2024

OUTLYING AREAS-FAIRGROUNDS DETENTION BASIN AND OUTFALL

Clark County

JUL 2025

CENTENNIAL PARKWAY CHANNEL WEST-FARM ROAD-OSO BLANCA TO TEE PEE

City of Las Vegas

SEP 2025

TOWN WASH-MESA BOULEVARD, EL DORADO TO TOWN WASH

City of Mesquite

OCT 2025

MEADOWS DETENTION BASIN UPGRADE

City of Las Vegas

PROJECTS UNDER CONSTRUCTION OR
ABOUT TO START (AS OF JUNE 30, 2024)
ANNUALREPORT 2023/24

NOV 2025

JIM MCGAUGHEY DETENTION BASIN AND OUTFALL

Clark County

DEC 2025

MEADOWS-CHARLESTON STORM DRAIN, ESSEX TO LINDELL

City of Las Vegas

JAN 2026

VAN BUSKIRK-PARADISE DETENTION BASIN

Clark County

FEB 2026

FLAMINGO-BOULDER HIGHWAY NORTH, CHARLESTON-MAIN STREET TO MARYLAND PARKWAY

City of Las Vegas

JUL 2026

FLAMINGO WASH, MARYLAND TO PALOS VERDE

Clark County

AUG 2026

PITTMAN SUNSET-BURNS TO FOSTER-PHASE 2

City of Henderson

AUG 2026

PITTMAN PABCO BOULDER HIGHWAY, WATER STREET TO LAKE MEAD PARKWAY

City of Henderson

REGIONAL FLOOD CONTROL DISTRICT

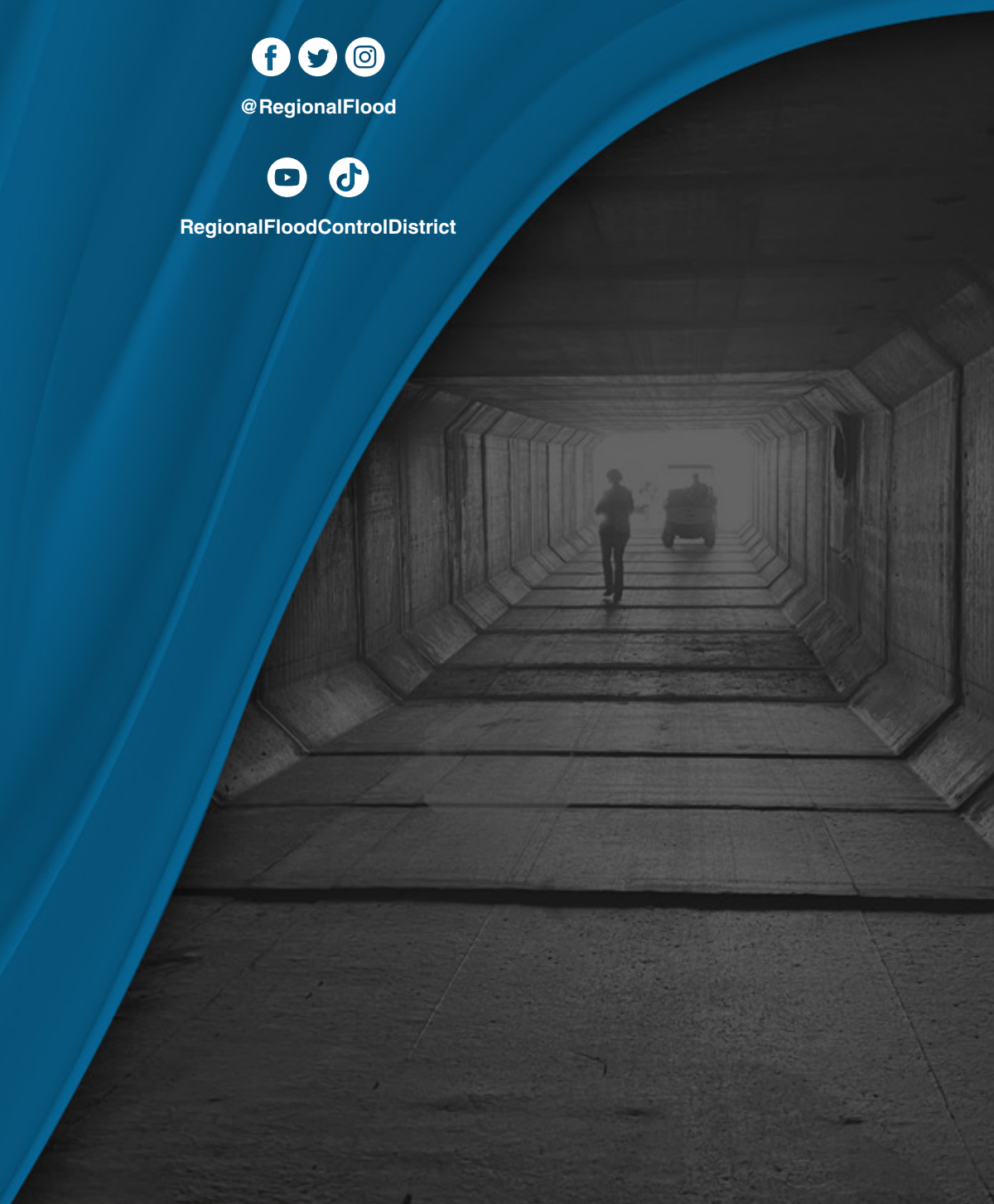
REGIONAL FLOOD CONTROL DISTRICT
CLARK COUNTY, NEVADA

600 SOUTH GRAND CENTRAL PARKWAY, SUITE 300
LAS VEGAS, NV 89106-4511
702-685-0000

www.regionalflood.org

@RegionalFlood

RegionalFloodControlDistrict



CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

APPOINT A COMMITTEE TO EVALUATE THE PERFORMANCE OF THE GENERAL MANAGER
2024 REVIEW

RECOMMENDATION SUMMARY

STAFF:	Appoint a committee to evaluate the performance of the General Manager – 2024 review.
TECHNICAL ADVISORY:	The Technical Advisory Committee did not hear this item.
CITIZENS ADVISORY:	The Citizens Advisory Committee did not hear this item.

RFCD AGENDA
ITEM #20
DATE: 11/14/2024

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

DISCUSSION AND POSSIBLE ACTION TO APPOINT A COMMITTEE TO EVALUATE THE PERFORMANCE OF THE GENERAL MANAGER – 2024 REVIEW

PETITIONER:

STEVEN C. PARRISH, P.E., GENERAL MANAGER/CHIEF ENGINEER

RECOMMENDATION OF PETITIONER:

THAT THE BOARD CONSIDER THE APPOINTMENT OF A COMMITTEE (FOR POSSIBLE ACTION)

FISCAL IMPACT:

None.

BACKGROUND:

It is the policy of the Board to evaluate the performance of the General Manager. In keeping with the Board's past practice, it is recommended that the Board consider appointing a committee of its members to review the General Manager's performance for 2024 and to recommend goals and objectives for 2025. The committee's recommendations will be presented to the Board for consideration.

Respectfully submitted,

RFCD AGENDA
ITEM # 20
Date: 11/14/2024

Steven C. Parrish, P.E.
General Manager/Chief Engineer

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

RESIGNATION OF THE GENERAL MANAGER/CHIEF ENGINEER AND TERMINATION OF THE CONTRACT

RECOMMENDATION SUMMARY

STAFF:	Accept the resignation of the General Manager/Chief Engineer and terminate the contract effective at the close of business April 1, 2025.
TECHNICAL ADVISORY:	The Technical Advisory Committee did not hear this item.
CITIZENS ADVISORY:	The Citizens Advisory Committee did not hear this item.

RFCD AGENDA
ITEM #21a
DATE: 11/14/2024

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT
AGENDA ITEM

SUBJECT:
RESIGNATION OF GENERAL MANAGER/CHIEF ENGINEER

PETITIONER:
STEVEN C. PARRISH, P.E., GENERAL MANAGER/CHIEF ENGINEER

RECOMMENDATION OF PETITIONER:
THAT THE BOARD ACCEPT THE RESIGNATION OF THE GENERAL MANAGER/CHIEF ENGINEER AND ACCEPT THE TERMINATION OF THE CONTRACT EFFECTIVE AT THE CLOSE OF BUSINESS ON APRIL 1, 2025 (FOR POSSIBLE ACTION)

FISCAL IMPACT: None.

BACKGROUND:

Steven C. Parrish joined the staff of the Clark County Regional Flood Control District (District) on June 10, 2000, as a Senior Civil Engineer after his start with Clark County on March 2, 1992. During his years at the District, he also held the positions of Principal Civil Engineer, RFCD Engineering Director, and Assistant General Manager. On March 12, 2015, he was appointed to the position of General Manager/Chief Engineer by the Board of Directors. Included in your backup is Mr. Parrish's announcement of his intention to resign at the close of business on Tuesday, April 1, 2025.

Respectfully submitted,

RFCD AGENDA
ITEM #21a
Date: 11/14/24

Steven C. Parrish, P.E.
General Manager/Chief Engineer

REGIONAL FLOOD CONTROL DISTRICT

November 14, 2024

Chair Jones:

After a 33-year career that included 8 years at Clark County Public Works and 25 years here at the Regional Flood Control District, I will be resigning my position as the General Manager/Chief Engineer of the Clark County Regional Flood Control District effective at the close of business on Tuesday, April 1, 2025, and terminate the employment contract.

I cannot begin to express enough thanks to all that have been with me on this journey. I am proud of the accomplishments that the Regional Flood Control District team have made over the last 3 decades. This organization has been and continues to be very successful, with more work to do. I believe we have significantly improved the quality of life for the residents of Clark County and the sustainability of this community as we continue to work every day to provide flood control facilities to help improve our resiliency to the dangers of flooding.

Thank you to the Board of Directors for continuing to have a regional perspective and showing unwavering support in the management of the District. Thank you to the dedicated District staff past and present, without whom none of the District accomplishments would have happened. Thank you to our member entities and the private sector for aiding us in implementing the programs. Last, thank you to the citizens for allowing the District to invest in drainage infrastructure that makes southern Nevada one of the most resilient and sustainable communities in the nation.

We have an amazing staff at the District, and I have every expectation that the District will continue to be successful and will meet the needs of the community. The District has been my life for the last 24 years and I will do everything I can to ensure continuity of operations and continued success. I wanted to give the Board of Directors ample time to seek a replacement, and thus the early notification of my pending resignation.

Thank you all for the faith and trust in me to manage the Regional Flood Control District.

Steven C. Parrish, PE
General Manager/Chief Engineer

600 S. Grand Central Parkway, Suite 300 • Las Vegas, Nevada 89106-4511
(702) 685-0000 • FAX: (702) 685-0001
Website: https://www.regionalflood.org

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT

AGENDA ITEM

SUBJECT:

RECRUITMENT OF GENERAL MANAGER/CHIEF ENGINEER

RECOMMENDATION SUMMARY

STAFF:	Accept the General Manager/Chief Engineer job description and direct staff regarding recruitment of the General Manager/Chief Engineer.
TECHNICAL ADVISORY:	The Technical Advisory Committee did not hear this item.
CITIZENS ADVISORY:	The Citizens Advisory Committee did not hear this item

RFCD AGENDA
ITEM #21b
DATE: 11/14/2024

CLARK COUNTY
REGIONAL FLOOD CONTROL DISTRICT
AGENDA ITEM

SUBJECT:
RECRUITMENT OF GENERAL MANAGER/CHIEF ENGINEER

PETITIONER:
STEVEN C. PARRISH, P.E., GENERAL MANAGER/CHIEF ENGINEER

RECOMMENDATION OF PETITIONER:
THAT THE BOARD ACCEPT THE GENERAL MANAGER/CHIEF ENGINEER JOB DESCRIPTION AND DIRECT STAFF REGARDING RECRUITMENT OF THE GENERAL MANAGER/CHIEF ENGINEER OR TAKE ACTION AS DEEMED APPROPRIATE (FOR POSSIBLE ACTION)

FISCAL IMPACT: None.

BACKGROUND:

With the pending resignation of the current General Manager/Chief Engineer it is recommended that the District's Board of Directors (Board) accept the job description for the position and provide direction on the Board's desires to select or appoint a candidate to fill the position of General Manager/Chief Engineer in accordance with Nevada Revised Statue 543.

It is expressly understood Mr. Parrish's role in this recruitment will be to aid in the process and will not be reviewing applicants; nor making a recommendation to shape the outcome to the Board.

Respectfully submitted,

RFCD AGENDA
ITEM #21b
Date: 11/14/2024

Steven C. Parrish, P.E.
General Manager/Chief Engineer

Class Title GENERAL MANAGER/CHIEF ENGINEER RFCD

Salary Depends on Qualifications

JOB SUMMARY/CLASS CHARACTERISTICS Benefits Custom Form Fields

ABOUT THE POSITION: This is an exempt position and any rules or procedures governing the competitive process do not apply.

JOB SUMMARY:

Responsible for surveying, investigating, reporting and estimating the extent of flood problems and plans; organizes and administers comprehensive programs for a comprehensive regional flood control district; directs and manages day-to-day operations, provides staff support and program oversight for the Regional Flood Control District (RFCD) Board of Directors.

CLASS CHARACTERISTICS:

This class coordinates the efforts of all local, state, and federal agencies in the planning, development, and funding of regional flood control projects and programs, including the development and implementation of a regional master plan for all hydrographic areas. Responsibilities include administering engineering, personnel, budgetary, capital funding, and contract administration support functions.

SUPERVISION RECEIVED/EXERCISED:

This classification performs duties and responsibilities of unusual difficulty under the administrative direction of the RFCD Board of Directors and directs all activities of the RFCD primarily through an Assistant General Manager and two subordinate directors.

MINIMUM REQUIREMENTS:

Equivalent to a Bachelor's Degree in civil engineering, or a closely related field, and seven (7) years of full-time progressively responsible experience in professional engineering and engineering management, two (2) years of which were in flood control management and planning. Possession of an appropriate advanced degree is desirable.

Licensing and Certification:

Must possess a valid Nevada Class C driver's license. Must possess valid registration as a professional engineer in the State of Nevada. If registered in another state, must obtain Nevada registration within one (1) year of date of hire.

Working Conditions:

Attend meetings and functions outside of normal working hours.

Background Investigation: Employment is contingent upon successful completion of a background investigation. Periodically after employment background investigations may be conducted.

EXAMPLES OF DUTIES:

Responsible for developing and directing the implementation of goals, objectives, policies, procedures and work standards for the District; directs the preparation and administration of the District's budget and capital improvement program. Plans, organizes, supervises, reviews and evaluates the activities of management staff who have responsibility for specified administrative and/or operational areas of the District. Works with the RFCD Board, various advisory boards and commissions, citizen groups and agency management to formulate and implement policies and plans related to flood control, a comprehensive flood warning, mitigation and control system; directs master plan and design criteria updates. Prioritizes and allocates available resources; reviews and evaluates program and service delivery. Coordinates the acquisition of land rights and the project design and control of construction plans for flood control projects; oversees required relocation of facilities or individuals for such projects. Directs the preparation of federal grant and other funding requests; ensures appropriate record keeping and reporting to various funding agencies. May represent the District in local and state-wide forums, make oral and/or written presentations before the RFCD Board of Directors and various advisory committees, citizens, state and federal legislative bodies, regulatory and community groups. Directs the selection of staff and provides for their training and professional development; interprets regulations and agency policies and procedures to employees; ensures effective morale, productivity and discipline of District staff. Directs the conduct of and conducts analytical and technical studies; develops and reviews reports of findings, alternatives and recommendations; directs the maintenance of accurate records and files. Monitors and interprets changes in laws and regulations related to flood control planning, development and program implementation; evaluates their impact upon agency activities and develops and implements policy and procedural changes as required. Ability to communicate effectively during crisis management.

EXAMPLES OF ADDITIONAL DUTIES:

Contributes to the overall quality of the District's service provision by developing and coordinating work teams and by reviewing, recommending and implementing improved policies and procedures. Prepares and directs the preparation of a variety of written correspondence, reports, procedures and other written materials. Uses standard office equipment, including a computer, in the course of the work; drives a personal or District motor vehicle to attend meetings and visit off-site locations.

PHYSICAL DEMANDS:

Mobility to work in a typical office setting, use standard office equipment, and to drive a motor vehicle in order to visit work sites and attend meetings; vision to read printed materials and a computer screen; and hearing and speech to communicate in person or over the telephone. Accommodation may be made for some of these physical demands for otherwise qualified individuals who require and request such accommodation.

KNOWLEDGE, SKILLS & ABILITIES:

Knowledge of:

Principles and practices of flood control programs and requirements; civil engineering principles and practices; public agency contract negotiation and administration; funding sources and practices for flood control project development and construction; administrative principles and practices, including budgeting, goal setting, program development, implementation and evaluation, and the management of employees through multiple levels of supervision; principles and practices of developing teams, motivating employees and managing in a team environment; applicable laws, codes and regulations; computer applications related to the work; record management principles and practices; techniques for dealing with a variety of individuals, at all levels of responsibility, in person and over the telephone; techniques for making effective public presentations.

Skill in:

Planning, organizing and administering a regional flood control program; plans, organizes, assigns, supervises, reviews and evaluates the work of professional, technical and office support staff; training others in policies and procedures related to the work and providing for their professional development; assisting in developing and implementing goals, objectives, policies, procedures and work standards; developing effective work teams and motivating individuals to meet goals and objectives and provide project development, funding and implementation in the most cost effective and efficient manner; interpreting, applying and explaining complex federal, state and local laws related to the areas of responsibility; preparing clear and concise reports, correspondence and other written materials; using initiative and independent judgment within general policy guidelines; ability to communicate effectively to different audiences and during crisis management; using tact, discretion and prudence in dealing with those contacted in the course of the work.

SALARY SCHEDULE:

FL

22. **Comments By the General Public**

This is a period devoted to comments by the general public about matters relevant to the Regional Flood Control District's Board of Directors jurisdiction. No vote may be taken on a matter not listed on the posted agenda. If you wish to speak to the Regional Flood Control District's Board of Directors, please step up to the speaker's podium, clearly state your name and address and please spell your last name for the record. Comments will be limited to three minutes. If any member of the Regional Flood Control District's Board of Directors wishes to extend the length of a presentation, this will be done by the Chair or the Regional Flood Control District Board of Directors by majority vote.

All comments should be relevant to the Regional Flood Control District Board of Directors action and jurisdiction.