

**LAS VEGAS METROPOLITAN POLICE DEPARTMENT EMPLOYEES
HEALTH AND WELFARE TRUST**

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SUMMARY OF MATERIAL MODIFICATIONS

To: All Participants
From: Board of Trustees
Re: **Plan Changes**
Date: June 2009

The Board of Trustees of the Las Vegas Metropolitan Police Department Employees Health & Welfare Trust is pleased to announce the following changes to your Plan:

Effective July 1, 2009, the following changes are being made to the Preventive Care Benefit of the Plan's medical benefits:

- the annual deductible no longer applies to Preventive Care;
- the benefit percentage (the amount the Plan will pay) is increasing from 90% to 100% for PPO providers;
- any age or frequency limitations are being removed from the Preventive services provision and all routine services will be covered (unless specifically excluded from the Plan) up to the calendar year maximum of \$2,000 per covered person;
- Preventive Radiology Services will be covered under the Preventive Services benefit at the following benefit percentages:
 - Services rendered by a Preferred Partner (Nevada Imaging or Steinberg Diagnostic Medical Imaging) will be payable at 100% of contract rate, deductible waived;
 - Services rendered by another Beech Street PPO provider will be payable at 75% of contract rate, after the annual deductible;
 - Services rendered by a Non-PPO provider will be payable at 60% of UCR, after the annual deductible has been satisfied;
- Office visits related to smoking cessation will be covered.
- Weight Watchers: The plan will reimburse up to \$250 per calendar year toward the cost of the "program" only. The reimbursed amount will be included as part of your \$2,000 annual Preventive Care Benefit. In order to receive reimbursement, the participant must submit a claim form with copies of receipts and attendance verification (participants must have the group leader initial their card or booklet at the end of each meeting indicating they stayed for the meeting). There is no benefit payable until at least \$250 has been spent. Participants will not receive credit towards the \$250 benefit for missed meetings. If the participant reaches the "lifetime" membership goal with Weight Watchers and has spent less than \$250, they will be reimbursed for the amount they spent. This benefit does not include reimbursement of food, online programs, or associated program materials.

Effective July 1, 2009, the benefit maximum for foot orthotics will increase from \$400 per lifetime to \$500 per calendar year and will include coverage for the Participant and all covered dependents, including children. Orthosis devices (such as braces or supports) are considered Durable Medical Equipment and are not subject to the Orthotics maximum.

Effective July 1, 2009, the following changes are being made to the Dental Plan:

- The LVMPD Employee's Health and Welfare Trust Dental PPO network will change to Preferred Dental Network (PDN). What this means is you should no longer utilize dental providers in the Diversified Dental Network. Please verify that your current dental provider is "in-network" with PDN by checking their website, www.mydentalppo.com, or by calling PDN at 702-240-8166 or toll free at 866-752-1885.
- Routine Preventive Dental services rendered by a PPO provider will now be covered at 100%, not subject to your annual deductible; however, these services will still be included as part of your Dental calendar year maximum. Preventive dental services rendered by a Non-PPO provider will remain at 80% of the Non-PPO allowance.
- Basic and Major Dental services rendered by a PPO dental provider will increase to 90% of the contracted rate; services rendered by a Non-PPO provider will remain at 80% of the Non-PPO allowance.
- Dental implants will no longer be excluded. Implants will be covered, subject to your Dental calendar year deductibles, coinsurance, and calendar year maximum. Precertification will no longer be required.
- The Plan has implemented a Non-PPO fee schedule that limits the allowable amounts for Non-PPO dental services. All Non-PPO allowances will be determined upon receipt of the claim and payments are subject to the Non-PPO benefits described above.

Effective July 1, 2009, the following change is being made to the Plan's Care Management Program:

- All care management services will be administered by UMR Care Management. This includes utilization reviews, prior authorizations, and case management services. This change will not affect your medical benefits in any way. UMR Care Management will be responsible for precertification (prior authorization) and case management in accordance with the rules and regulations outlined in the Plan Document. Watch for additional information with details as well as new Identification Cards that will contain the new information for easy reference.

Effective July 1, 2009, Human Growth Hormones (HGH) will be a covered benefit when used in the treatment of:

- Children with one of the following diagnoses: short stature, Turner's syndrome, Prader-Willi syndrome, Noonan syndrome, or growth delay due to chronic renal failure; or
- Adults with one of the following diagnoses: AIDS wasting or short bowel syndrome.

Precertification of HGH is required. For coverage under your Prescription Drug Plan, authorization may be obtained by calling EnvisionRxOptions at (800) 361-4542. Once authorization is obtained, you will pay the applicable RX copayment based on the medication prescribed. Remember, generic medications are free if available. If the medication is administered by your physician, precertification may be obtained by calling UMR Care Management at (888) 545-6687. The benefits for the medication under your medical plan will be subject to the annual deductible and paid at the applicable benefit level (PPO-90% of contracted rate / Non-PPO-60% of UCR).

Additional Prescription Drug Program Changes

EnvisionRxOptions and your Plan are always working together to find ways to provide better prescription coverage while managing the rising costs of prescription medications. We use tools, such as \$0 copays and step therapies, to achieve these goals. These programs are all about value – the aim is to help you choose a medication that's proven safe and

effective for your condition, while getting it at the lowest possible cost. By using the most cost-effective first line medications you will not only save money with lower copayments, but your prescription plan saves as well; helping to ensure that the plan can continue to provide excellent coverage for you and your family.

Effective July 1, 2009, the following medications will be subject to Step-Therapy:

Singulair®
Lipitor®, Crestor®, Lescol/XL®
Vytorin®
Zetia®
Tricor®
Boniva®, Actonel®
Benicar®/BenicarHCT®
Diovan®/Diovan HCT®
Cozzar®/Hyzaar®
Atacand®/Atacand HCT®
Macardis®/Micardis HCT®
Avapro®/Avalide®
Tekturma®

Effective July 1st, 2009, a Prior Authorization will be required for:

Topamax® and its generic equivalent (Topiramate), and
Solodyn® and its generic equivalent (Minocycline).

Should you have any questions about the above Prescription Drug plan changes please do not hesitate to contact the EnvisionRxOptions Helpdesk at 1-800-361-4542.

Family Medical Leave Act

The Family Medical Leave Act (FMLA) has been amended to allow new military family leave entitlements enacted under the National Defense Authorization Act for 2008. Under FMLA, some employers are required to give their employees up to 12 weeks of unpaid leave during any 12-month period for one or more of the following reasons:

- for the birth and care of the newborn child of the employee;
- for placement with the employee of a son or daughter for adoption or foster care;
- to care for an immediate family member (spouse, child, or parent) with a serious health condition; or
- to take medical leave when the employee is unable to work because of a serious health condition.

As of January 16, 2009, the National Defense Authorization Act created two new forms of FMLA leave related to a family member's military service, which are described below:

Leave to Care for Service Member - An employee may take up to 26 weeks during one 12-month period if his/her parent, spouse, son or daughter (any age) or "next of kin" has suffered a serious injury or illness in the line of active duty and is undergoing medical treatment, recuperation or therapy, or is in outpatient status or on the "temporary disability retirement list". The term "next of kin" means the nearest blood relative (other than a parent, spouse, son or daughter).

Qualifying Exigency Leave - An employee whose parent, spouse, son or daughter (any age) is on active-duty status or on call to active-duty status in support of a U.S. military "contingency operation" may take FMLA leave due to "qualifying exigencies". The term "qualifying exigencies" means:

- (a) short-notice deployment;
- (b) military events and related activities;
- (c) childcare and school activities;
- (d) financial and legal arrangements;
- (e) counseling;
- (f) rest and recuperation;
- (g) post-deployment activities; and
- (h) additional activities where the employer and employee agree to the leave.

Please note that this form of leave is only available if the family member is called to active duty as a member of the Reserve or National Guard, or as a retired regular member of the U.S. Armed Forces.

All other provisions related to FMLA leave remain the same. Please keep in mind that it is up to your employer and the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada, Local #525 to determine whether you are entitled to FMLA leave, not the Health and Welfare Plan.

Children's Health Insurance Program Reauthorization Act

On February 4, 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) was signed into law by President Obama. CHIPRA allows states to subsidize premiums for employer-provided group health coverage for eligible children, but it also imposes certain requirements on plan sponsors:

- 1. Plan sponsors must notify employees of a new special enrollment opportunity.
- 2. Plan sponsors must provide disclosure to their employees.
- 3. Plan sponsors must provide disclosure to state agencies.

CHIPRA applies to both fully insured and self-insured group health plans. The most pressing of these three obligations is the special enrollment changes.

Effective April 1, 2009, a plan sponsor of a group health plan must permit employees and dependents who are eligible but not enrolled for coverage to enroll in that coverage under two scenarios:

- (a) The employee's or dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility
- (b) The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP

An employee must request this special enrollment within 60 days of the loss of coverage in the first scenario, and within 60 days of when eligibility is determined in the second scenario.

We are distributing this Summary of Material Modifications (SMM) to outline changes that have occurred in your Health and Welfare plan. This SMM is only intended to provide a brief overview of changes made to the Plan. The terms of the Plan are governed by the Plan Document.

As always, if you have any questions regarding any information contained in this notice, please feel free to contact your administrator, UMR, at (866) 868-1395.